Psychological Treatment for Individuals with Co-occurring Mental Health and Substance Misuse Needs: A Qualitative Study From the Psychologist's Perspective

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Abstract

Background: Despite this, treatment rates for individuals with mental health and substance use needs remain low and access to treatment remains problematic. Research has furthered our understanding of the associations between mental health and substance use, and treatment approaches, but the attitudes and perspective of clinical psychologists, working with individuals who present with these co-occurring needs have been less researched.

Objective: This study aims to explore clinical psychologist's attitudes and perspectives towards working with individuals who use substances and will consider the wider social impact of professional's regard for this patient group in relation to psychological treatment accessibility and outcome.

Methods: Semi structured interviews were used with eight clinical psychologists. Interview data was analysed using thematic analysis using six stages outlined by Braun and Clarke (2006).

Findings: Three over-arching themes were identified: 1. Professional and the Personal Self, 2. Organisations, Systems and Services, 3. Willingness to Treat

Conclusions: The findings suggest co-occurring mental health and substance use needs can present a challenge for clinical psychologists and can bring added complexity for non-specialist services. The findings illustrated disparate views between and within services as to roles and remits of clinical psychologists in substance use issues. Findings also suggested that a lack of focus on substance use issues within professional training programmes may influence how clinical psychologists have come to view their role within this area. The findings highlighted a need for an increased focus on the role of psychology in the treatment of co-occurring mental health and substance use in professional training programmes, which could have implications for increasing access to psychological treatment for this client group

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Declaration

I declare that I designed and conducted the research reported in this thesis and that it has not been submitted for a degree in this, or any other institution. To the best of my knowledge, this thesis does not contain material that has been published or written elsewhere by another person, except where acknowledgment and due reference is made in the text.

Chapter 1   INTRODUCTION

1.1 Introduction to the Research

Associations between substance use/misuse and mental health problems, while complex, are increasingly acknowledged as a key issue for communities, healthcare services and policy makers. In 2010 worldwide, mental health and substance use disorders accounted for 183.9 million DALYS (disability-adjusted life years). In 2013-14, over 1.7 million adults accessed NHS services for severe or enduring mental health problems, and a further 947,640 were referred to Improving Access to Psychological Therapies (IAPT) (NHS Digital, 2017). Research has reported an estimated 50 – 70% of individuals accessing mental health services may also be using psychoactive substances (Weaver et al. 2003). Despite repeated calls for improved access to psychological treatment for individuals who present both with mental health and substance misuse needs, access to treatment remains problematic. As our understanding of these disorders and substances develop, it is likely that the number of individuals affected will also increase.

While issues of causality continue to be researched and debated, there is substantial evidence that supports a strong association between mental health and substance use/misuse, yet there remains a lack of consensus of how, where and who should be involved in delivering the treatment for this patient group. This in turn has been shown to contribute to increased levels of social and clinical severity in this population group (Carey et al. 1991; Hunt et al. 2002; EMCDDA 2016). In addition to this, unclear treatment pathways increase the individual's risk of falling between the gaps in services, which can lead to poorer treatment outcomes, and

disengagement from services (Bradizza et al. 2006; Baker and Velleman, 2007; Van Dam, 2012).

Clinical psychologists are very likely to face addiction in their clinical work and are well placed to provide psychosocial interventions for both mental health and substance misuse problems. Clinical psychologists are trained to draw from a wide range of psychological theories to provide a comprehensive and coherent understanding of an individual's needs, which is particularly pertinent for individuals with co-occurring conditions as many have multiple and interlinked difficulties, yet provision and access to psychological therapies remains limited.

This study seeks to examine the perspectives of clinical psychologists when working with individuals who use substances, in an attempt to build our understanding of why access to therapy for this patient group is often limited. Within this introductory chapter, existing research on psychologists who work with co-occurring mental health and substance use needs will be explored and a narrative review of relevant literature will be presented. Finally, a rationale for the study and its aims is provided.

1.2 Literature Search Procedure

A literature search using online databases including, Psychinfo, Science Direct, Pubmed and Medline was conducted to review current research on psychologists who work with co-occurring mental health and substance use needs. In my search strategy I was particularly interested in identifying research that focused on the clinical psychologist's experience of this work.

Searches were undertaken using varied combinations of the following terms: (psychologist OR clinical psychologist OR therapist) AND (mental health OR mood OR distress OR depression OR anxiety) AND (substance use disorder OR substance use OR substance misuse OR drug use OR drug misuse) AND (co-existing OR co-occurring OR co-morbidity OR dual diagnosis). This search strategy revealed 575 articles. Duplicates were removed and study titles and abstracts were reviewed to identify those deemed relevant for further data extraction. Where abstracts were unavailable or insufficient, full article reviews were conducted to determine relevance. Articles included were published prior to November 2018. Through this process approximately 30 research articles were deemed relevant.

In addition to the databases, bibliography searches of full texts to assess for eligibility were undertaken to identify further relevant papers. I was also able to draw from 'grey' literature in the form of government publications and well-known organisations such as the British Psychological Society, DCP Faculty for Addictions.

1.3 Global Mental Health and Substance Use Disorders

Historically, mental health and substance use disorders have not been a priority for many countries and have typically been segregated from mainstream healthcare. However, associations between substance use and mental health problems, while complex are acknowledged as key issues for communities, healthcare services and policy makers making it increasingly more difficult to ignore.

The Global Burden of Disease Attributable to Mental and Substance Use Disorders Study (2010) reported that worldwide, mental and substance use disorders accounted for 183.9 million disability-adjusted life years (DALYs), or 7.4% of total global disease burden in 2010. Overall, mental and substance use

disorders were the fifth leading disorder category of global DALYs and were directly responsible for 8.6 million years of life lost to premature mortality (YLLs), which is equivalent to 232,000 deaths (Whiteford, 2013).

Studies have estimated the cumulative global effect of mental disorders could amount to $16 trillion in the next 20 years (Bloom et al. 2011) and despite this, treatment rates for people living with mental and substance use disorders globally remain low and often provided years after a difficulty begins to develop (Whiteford, 2013).

1.4 United Kingdom

The Office of National Statistics reported that in 2016, 56.9% of adults aged 16 years and above had consumed alcohol in the week before being interviewed, which equates to 29 million people, while 1 in 11 adults aged 16-59 had taken an illicit drug in the last year, which equates to 2.7 million people (ONS, 2016).

The Adult Psychiatric Morbidity Survey (APMS) provides England's national statistics for the monitoring of mental illness and treatment access in the household population. The latest survey (2014) reported that 1 in 6 adults (16 years and above) currently lived with a common mental health disorder. Of these, signs of drug dependence were evident in 1 in 30, with similar levels noted for alcohol dependence (McMannus et al. 2016).

Of the treatment seeking mental health population in England, an estimated 75% of users of drug services and 85% of users of alcohol services were experiencing mental health problems (Weaver et al. 2003).

Despite these figures the survey revealed that only a quarter of adults with probable alcohol dependence were receiving treatment and services for a mental or emotional problem. Adults showing signs of drug dependence were more likely to have requested but not received a particular mental health treatment in the past 12 months compared to other adults. The majority of respondents in active treatment who reported signs of alcohol or drug misuse were most likely to be using medication only, with the minority receiving psychological therapy or a combination of both (McMannus et al. 2016).

The Mental Health Foundation estimated that even if prevalence rates for mental disorders remained the same, there would be a further 2 million adults in the UK with mental health problems by 2030.   These figures alongside the continuing research and understanding of mental health, substance use and their associations suggest rates of individuals accessing treatment for co-existing mental health and substance use needs will continue to grow. Currently there appears to be a lack of consensus of how, where and who should be involved in delivering the treatment for this patient group which contributes to increased levels of social and clinical severity (Carey et al. 1991; Hunt et al. 2002; EMCDDA, 2016). In addition to this, unclear treatment pathways increase the individual's risk of falling between the gaps in services (Bradizza et al. 2006; Baker and Velleman, 2007; Van Dam, 2012).

1.5 Substance Use Disorder definition

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) combined the DSM-IV 'Substance Abuse Disorder' and 'Substance Dependence Disorder' into a single 'Substance Use Disorder' category described as 'a problematic pattern of using alcohol or another substance that results in impairment in daily life or noticeable distress'. Level of severity is defined as 'mild, moderate or severe' and determined by the number of diagnostic criteria met by an individual over a 12 month period.

Substance-related disorders are divided into two groups: Substance Use Disorders and Substance Induced Disorders.

Substance-related disorders include 10 separate classes of drugs: alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics & anxiolytics, stimulants, tobacco and other (or unknown) substances.

Substance Induced Disorders include intoxication, withdrawal and other substance/medication-induced mental disorders (e.g. substance-induced psychotic disorder, substance-induced depressive disorder).

1.6 Key policies and Guidance

Mental health problems account for 28% of the national disease burden in England but only 13% of NHS spending is on mental health care which has led to real-term fall in investment (DH 2014). In more recent years there has been an increasing demand for 'parity of esteem' in health services response to physical and mental illness and current policies and guidance aim to address this.

1.6.1 HM Government

The cross-government National Drug Strategy (2010; 2017) and mental health strategy *No Health Without Mental Health* (2011) published a few months apart, acknowledged the association between mental health and substance misuse and the need for effective joint working between services. The government's mental health strategy explicitly aims to improve individual's mental health by

putting mental health on an equal footing with physical health through the provision of high quality services that are accessible to all.

At the same time the mental health strategy was launched, the Government published details of a 4-year plan for the expansion of *The Improving Access to Psychological Therapies (IAPT)* programme that began in 2008 (DH, 2011). A year later further guidance for IAPT workers was released by The National Treatment Agency and Drugscope, *Positive Practice Guide For Working With People Who Use Drugs and Alcohol* (2011), as IAPT services were not typically trained to work with drug and alcohol issues. This guide highlighted that individuals with co-occurring mental health and substance misuse needs should have access to NICE recommended psychological interventions and that there is no evidence that substance misuse *per se* impacts on the effectiveness of these psychological therapies (NICE, 2007).

1.6.2 <u>NICE Guidelines</u>

The most recent NICE guidance for *Coexisting Severe Mental Health and Substance Misuse: Community Health and Social Care Service* (2016) and the earlier NICE guidance for *Coexisting severe and mental illness (psychosis) and substance misuse: Assessment and management in healthcare settings* (2011) state that individuals should not be excluded from mental health services because of their substance misuse and a person centered approach should be adopted to reduce stigma and any inequity to access to services.

Common mental health problems: Identification and pathways to care (2011) guidelines aims to improve how mental health problems are identified and assessed. It also makes recommendations on local care pathways. This guidance does not make explicit reference to co-existing mental health and substance misuse needs but does advise that individuals presenting with a common mental health disorder and harmful or dependent alcohol use, should

be referred for treatment of the alcohol misuse in the first instance in line with *Alcohol-Use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence guidance* (NICE, 2011). Of note, it also acknowledges that 'despite the publication of the *Models of Care for Alcohol* by the Department of Health in 2007 (National Treatment Agency), alcohol service structures are poorly developed, with care pathways often ill defined'.

The management of specific mental health problems are covered by NICE Guidelines on *Depression* (2009), *Generalised Anxiety Disorder* (2011), *Panic Disorder* (2011), *Obsessive Compulsive Disorder* (2018), *Post Traumatic Stress Disorder (PTSD)* (2018) and *Social Anxiety Disorder* (2013); with varying levels of guidance for co-existing substance misuse. While guidelines for depression advise referring individuals identified with co-existing difficulties to specialist mental health services, guidance highlights substance misuse should not preclude treatment for co-existing anxiety disorders (Generalised, Panic and Social) or PTSD. Guidelines also suggest sequencing of the problems identified to assist in determining the nature of the substance misuse and if it is primarily a consequence of the mental health disorder.

The management of specific substance misuse problems is covered in several NICE guidelines documents: *Drug Misuse in over 16s: Opioid Detoxification* (2007), *Alcohol Use Disorders: Prevention* (2010), *Alcohol Use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence* (2011), and *Drug misuse prevention: Targeted interventions* (2017). Each contains varying levels of guidance for co-existing mental health problems. The NICE guidelines Drug misuse in over 16s: Psychosocial interventions (2007) recommends that 'talking therapies' are offered by key workers to help increase motivation and prevent relapse but do not appear to reference the role of these therapeutic approaches in supporting individuals in drug treatment with co-existing mental health difficulties but more in regards to substance misuse. There is little to no reference to Improving Access to Psychological Therapies (IAPT) services - which exist for mild to moderate

mental health difficulties, such as depression, anxiety and phobias and may be considered an appropriate setting for some individuals presenting with co-existing substance misuse needs.

This was further highlighted in Public Health England's (2017) guide 'Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for commissioners and service providers'. Developed with the support of NHS England, the guide highlighted how people who use alcohol and/or drugs often find themselves excluded from Improving Access to Psychological Therapies (IAPT) services, in spite of NICE guidelines they should be able to access psychological interventions (PHE, 2017).

The NICE guidelines outlined highlight individuals with mental health difficulties being a 'group at risk' of substance misuse and vice versa. While there is acknowledgment of the association between these difficulties, health professionals are presented with guidelines, which for the most part consider mental health and substance misuse as quite separate issues to be managed.

1.6.3 <u>Department of Health</u>

In 2017 The Department of Health published *Drug Misuse and Dependence: UK Guidelines on clinical management* (2017), which highlights the need to consider the role of substances in relation to the mental health problem. These guidelines also acknowledge that if an individual has been using substances in an attempt to manage the emotional distress, it is understandable that they may have concerns about dropping this perceived way of coping. The guidance recommends the first line of intervention to be the standard drug treatment with the view to stabilising/reducing/abstaining from the substance use.

In particularly 'severe or acutely risky' cases, guidance suggests that a mental health assessment should be prioritised, which it also acknowledges may only

be available from a specialist mental health team who in turn will have specific referral criteria.

1.6.4 Public Health England

In 2017 Public Health England published its guidance for *Better care for people with co-occurring mental health and alcohol/drug conditions: A guide for commissioners and service providers as an action from the Mental Health Crisis Care Concordant National Action Plan* (2014). This proposed to develop bespoke guidance and model service specifications to support commissioners in delivering an integrated and responsive approach to meeting the needs of individuals experiencing mental health difficulties, where there may also co-existing substance misuse issues. The 2017 guidance highlights that in spite of shared responsibility, local authority commissioners and the NHS have to provide treatment and that individuals with co-occurring mental health and substances misuse needs are often excluded from services.

This guidance outlines two key principles to address this disparity:

Everyone's job. Commissioners and providers of mental health and alcohol and drug use services have a joint responsibility to meet the needs of individuals with co-occurring conditions by working together to reach shared solutions.

No wrong door. Providers in alcohol and drug, mental health and other services have an open door policy for individuals with co-occurring conditions, and make every contact count. Treatment for any of the co-occurring conditions is available through every contact point.

1.6.5 <u>NHS England</u>

Public Health England's guidance also supports the implementation of the *Five Year Forward View for Mental Health* (2016) which sets out a new shared vision for the future of the NHS based around seven new models of care. This included a seven day NHS providing urgent and emergency mental health crisis care 24 hours a day and mental health services delivered by multi-disciplinary integrated teams with named, accountable clinicians, across primary, secondary and social care – which include the provision of care for substance misuse issues.   The report reveals that there will be a further £37 billion spent on services for mental health conditions of which £1.5 billion has been allocated to substance misuse services.

Despite this increased focus on mental health in health policies, at the same time there has been a fall in investment in drug and alcohol and mental health services for a significant period of time (DH, 2014).

1.7 Service contexts/changing landscape

While there is mounting acknowledgement of the high prevalence of co-occurring conditions in mental health and substance misuse across communities, and a substantial evidence base for the effectiveness of psychological treatments for both problems, evidence also shows that people living with these co-existing difficulties are often unable to access the care that they need.   When treatment is provided it is typically many years after the difficulties begin and this can be for a range of reasons including, availability of human and financial resources, inequalities in distribution and inefficiencies in their use (Whiteford et al. 2013).

The 2012 Health and Social Care Act resulted in the transfer of commissioning of alcohol and substance misuse services from the NHS to local authorities.

While it has been suggested that this has brought some positive changes including alignment of substance misuse treatment with other local authority and public health-related issues, there has been a deepening of new and existing concerns, including challenges to local authority budgets.

Following the transfer of commissioning responsibility to local authorities there was a reported 30-50% cut in the substance misuse treatment budget. This saw the closure of many specialist NHS addiction services at a time of increased drug and alcohol related acute hospital admissions and the highest level of opiate related deaths on record (ONS, 2016). With reduced government funding, local authorities have been forced to cut services to make savings, while those services that remain have had to make further cuts in the workforce, meaning fewer specialist addictions roles.

Cuts to drug and alcohol services has meant those who may have been best served in substance misuse services increasingly fall to already over stretched NHS emergency departments and mental health services. In 2009/10 the Government estimated that there were more than 7.1 million alcohol attributable A&E attendances, which cost the NHS £696 million. An increasing disconnect of substance misuse services with wider health commissioning and provision has meant referral pathways have become more complex.

This falls against a backdrop of frequent re-procurement of services, and while this may be an attempt to make efficiency savings it can mean vital resources are exhausted which can mean individuals living with mental health and substance use problems no longer receiving planned, holistic care (NHS England, 2015).

The Advisory Council on the Misuse of Drugs concluded in their inquiry report into the *Commissioning impact on drug treatment* (2017) that the increasing

disconnection between substance misuse services and other health structures has culminated in the fragmentation of referral pathways (ACMD, 2017).

A report by the Making Every Adult Matter (MEAM) coalition describes a persistent failure of services to work collaboratively to support people with multiple and complex needs. It also highlights an inadequacy of a support system which "treats people based on what it considers to be their primary need, be that mental ill-health, dependence on drugs and alcohol, homelessness or offending" (MEAM, 2018). As a consequence substance misuse services where they exist, can be poorly joined up with local mental health services that are also being increasingly stretched with fewer resources. It is not uncommon for mental health services to exclude people because of co-occurring alcohol or drug use who may also be excluded from substance misuse services due to the severity of their mental illness, who are left 'stuck' between services not meeting either services criteria.

1.8 Role of Psychology

Historically, there was a strong emphasis on self-help for substance use difficulties, which sets it aside from many other forms of psychopathology. The DSM-III (1980) saw a shift from addiction being regarded as a manifestation of personality pathology to it being understood as a medical disorder with both biological and psychological features (Nathan et al. 2016). This created a more definite role for psychology in the treatment of both mental health and substance misuse. Today clinical psychologists are very likely to face addiction in their clinical work over the course of their career, yet psychology training has not kept pace with the rise in need for individuals with co-occurring mental health and substance misuse needs.

Research conducted by the British Psychological Society's Faculty of Addictions (2014) found that half of all clinical training courses offer one day or less

throughout the teaching programme, and that specialty placements are sparse. This is despite several policy reports and guidelines prioritising psychological aspects of substance misuse treatment (Scottish Government, 2008; 2012, NICE, 2011).

The agreed therapeutic approach to tackle dual diagnosis is to take into account both disorders. However, these individuals often do not 'fit' with how mental health and substance misuse services are currently configured and both services may lack sufficient expertise to treat both problems, which can impact on both the accessibility of psychological therapies and treatment outcomes (Darke, 2013; Shora et al. 2009). This is further evidenced in the 60% decrease of training posts in addictions psychiatry since 2006/07, while training around substance misuse for clinical psychologists remains a neglected area (Drummond, 2017).

Clinical psychologists are well placed to provide psychosocial interventions for both mental health and substance misuse problems, and are trained to draw from a wide range of psychological theories to provide a comprehensive and coherent understanding of an individual's needs.   This is particularly pertinent for individuals with co-occurring conditions as many have multiple, complex and interlinked difficulties. Psychological approaches for individuals with mental health and substance misuse needs can be used as either a standalone treatment or delivered in combination with pharm logical interventions and should be available in inpatient and residential settings as in community settings.

The Department of Health publication of Drug Misuse and Dependence: UK guidelines on clinical management (2017) highlight a wide range of psychosocial interventions that have been found to be effective in the treatment of coexisting substance use and mental health problems. The guidance proposes a dual focus on the coexisting needs of these individuals, either with

the adaption of a single treatment approach and/or the 'blending of two evidenced-based treatments'. The main interventions are broadly described as;

Cognitive and cognitive-behavioural-therapy (CBT) approaches that offer a discrete, time-limited, structured psychological intervention for the treatment of comorbid depression and anxiety disorders in line with existing NICE guidance (Beck et al. 1993; Maude-Griffin et al. 1998; Carroll & Onken, 2005). Dual-focus treatments that combine cognitive (e.g. cognitive restructuring), behavioural (e.g. behavioural activation) and motivational (e.g. motivational interviewing) components have been shown to be superior to no treatment, with better outcomes at follow-up than parallel treatments (PHE, 2017).

Behavioural approaches that target classically conditioned cues to using drugs including contingency management as recommended by NICE to promote abstinence, are not yet widely implemented in the NHS. A number of major studies looking at the uptake of contingency management in the US, Australia and Europe have reported a beneficial impact on the lives of people who misuse drugs (McGOvern et al. 2004; Kellogg et al. 2005; Kirby et al. 2006; Ritter and Cameron 2007).

Family, couple or social network interventions should be considered for individuals who are in close contact with a non-substance-misusing partner and in line with NICE guidelines (2007). Currently NICE recommended psychological approaches include behavioural couples therapy (BCT) (Fals-Stewart et al. 2002) and family based interventions (Copello et al. 2005), which have been found to be associated with abstinence both at the end of treatment and follow up (Fals-Stewart et.al 1996; Kelly et al. 2002; Winter et al. 2002).

Psychological formulations can also help to move beyond the simplistic use of diagnostic labels, which can restrict an individual's access to specific services

and can help facilitate access to a wider range of services that may be more appropriate for the individual, including mainstream psychological services.

The provision of psychological therapies for people with common mental health problems has expanded hugely in recent years. But it is still meeting only 15 per cent of need for adults. To meet current need NHS England have reported that their provision should increase access to evidence-based psychological therapies to reach 25 per cent of need so that at least 600,000 more adults with anxiety and depression can access care (and 350,000 complete treatment) each year by 2020/21 (NHS England, 2016). NHS England estimate that by 2030 there will be approximately two million more adults in the UK living with a mental health difficulty of which, a third will also have concurrent substance misuse needs (NHS Confederation, 2014), and as such there is a pressing need for psychology to establish a clear role in the provision of both mental health and substance misuse treatment.

1.9 Stigma and Barriers

From the late 18th century with the industrial revolution and international trade, the misuse of drugs quickly established itself as a major public health issue, drawing the attention of governments, policy makers and communities.   As the empirical evidence base of the physiological effects and psychological impacts of substance misuse developed, medical professions actively disassociated themselves from what had historically been considered 'sinful' behavior. Despite scientific advances in the understanding of psychoactive substances, substance use remains a heavily moralised behavior in many societies (Kulesza et al. 2013).

Room (2005) notes that psychoactive substances can be viewed as 'prestige commodities', whereas another form of their use can attract near universal stigma and marginalisation. Indeed, while some substances have permeated

cultures i.e. tobacco, alcohol, caffeine, others can mean individuals are exposed to multiple stigmatised statuses which can impact on those individuals' access to health services and furthermore, how they may be viewed by those who may treat them.

Stigma is a complex concept and many differences both between and within disciplines exist. Goffman's (1963) seminal work *'Stigma: Notes on the Management of Spoiled Identity'* defined stigma to be 'an attribute that is deeply discrediting' that reduces a person 'from a whole and usual person to a tainted, discounted one'.

Researchers now posit several types of stigma, including *Public* stigma, which refers to discrimination and devaluation by others. *Perceived stigma*, whereby individuals believe that others hold common negative beliefs about individuals who belong to the same stigmatised group as they do. *Enacted stigma,* when an individual has direct experience of discrimination and exclusion from wider society and *Self-stigma*, which occurs when individuals internalise social stigma, a process which leads to negative thoughts, feelings and poor self-image (Corrigan et al. 2002; 2005, Herek, 2007, Livingston and Boyd, 2010).

Stigma associated with mental health and substance misuse creates serious barriers to access and quality of care. It exists within health systems, among healthcare providers and its practitioners (Knaak et al. 2017). Studies have reported poor regard towards working with patients with substance misuse problems across a number of health professions: including General Practitioners (Deehan et al, 1997, Roche et al, 1997), Physicians (Ding et al. 2005, Todd et al. 2002, Lindberg et al. 2006, Furlan et al. 1990), Psychiatrists (Tantam et al. 1993) Pharmacists (Sheridan et al. 1996) and Nursing staff (Moodley-Kunnie, 1988, Howard, 2000, Carroll, 1993, Foster, 2003, NCETA, 2006).

The Improvement of Access to Treatment for People with Alcohol and Drug Related Problems (IATPAD) is a European multi-centre study, which compared staff, including General Physicians, Psychiatrists, Nurses, Social Workers and clinical psychologist's regard for working with substance users to other patient groups. The study found health professionals reported significantly lower regard for working with substance users, than regard for working with patients with a diagnosis of depression or diabetes. This was most evident in professionals recruited from primary care when compared to professionals from general psychiatry ($P<0.001$) or specialist addiction services ($p<0.001$). This was highlighted as a particular concern as many substance users will access primary care as their first port of call. The study also revealed that those with fewer than 10 years' experience demonstrated higher regard for individuals with problems related to substance misuse than those who had worked between 10 but fewer than 20 years in their professions ($P=0.044$). Psychologists showed higher regard for patients with problems related to alcohol and drugs than Physicians ($p<0.001$), Psychiatrists ($p=0.001$) and Nurses ($p<0.001$) (Gilchrist et al. 2011).

Negative staff attitudes have consistently been identified as a barrier for accessing treatment and research has highlighted a need for this to be considered in the development of substance mis/use policies, as low regard may present a barrier in accessing treatment and subsequently impact negatively on treatment outcomes (Okruhlica et al. 2002; Caplehorn et al. 1994; Digiusto et al. 2007; Gilchrist et al. 2011). A recent review concluded that education and training alone may not be sufficient to change negative attitudes towards substance users. The review also recommended that 'unwillingness' of staff to work with such patients needed to be further understood and addressed (Skinner et al. 2009).

Mental health and substance misuse related stigma and associated barriers to treatment operate on many levels, which may limit the use of available resources, as do inefficiencies and inequalities of distribution of funding and

interventions. The combination of stigma and the very large treatment gaps, has been found to contribute to social exclusion and can breach basic human rights of individuals with mental disorders (GBD, 2010). The configuration of services and their funding can mean that even when individuals are able to access a service, the duration and type of treatment may be limited. Health care providers may be reluctant to treat individual's mental health/substance mis/use because they believe it is beyond their remit or skills set (Van Boekel et. al, 2013). Additionally, 'payment by results' contracts can remove any incentive for services to take on patients who they perceive to have 'complex needs', who are likely to need longer and more intensive treatment (Drummond, 2017). This is further evidenced in service user surveys that suggest that people with co-occurring conditions are often unable to access the care they need from both mental health and addiction services (Recovery Partnership, 2015). Despite NICE guideline recommendations stating that individuals who use alcohol and/or drugs should be able to access psychological interventions, individuals continue to find themselves excluded from services.

While there has been an increase in research, which has sought to understand and overcome barriers to psychological treatments, there remains a paucity of research examining the nature of these barriers (Mohr, 2010). Barriers to psychological treatment and negative regard from health professionals needs to be addressed to improve treatment accessibility for this marginalised group of individuals.

Both stigma and barriers have been identified as key concerns for individuals who experience psychological difficulties and for those seeking treatment (Britt et al. 2008; Cooper, Corrigan &Watson, 2003). Using the perspectives of service users to understand the impact of the service delivery models and perceived barriers to psychological treatment has played an important role in a number of areas in healthcare (Smith and Ross, 2007). This approach has also become increasingly popular among patients (Brody, Khaliq & Thompson, 1997; Churchill et al. 2000; Dwight-Johnson, Sherbourne, Liao & Wells, 2000).

Results from individual interviews and focus groups as part of The Improvement in Access to Treatment for People with Alcohol and Drug Related Problems (IATPAD) found that the stigmatisation of mental health and substance misuse posed a considerable barrier for those looking to access services. In addition to this research, individuals have reported a number of barriers experienced when seeking access to treatment for both mental health and substance misuse, including, *fear of disclosure* and *lack of empathy from professionals* (Gilchrist et al. 2013;2011 Voiceability, 2014); *proximity of services*; either in terms of presenting logistical challenges or concerns of further stigma arising from receiving treatment for mental health and/or substance misuse in the individual's own community (Gilchrist et al, 2013; Rapp et al., 2007; Luoma et al. 2007); Perceived *lack of substance misuse expertise and knowledge* from mental health professionals and vice versa and the subsequent communication within and between these services (Voiceability, 2014; Sheridan et al. 2009); *exclusion criteria* of services meaning individuals are unable to attend appointments if under any level of intoxication and risk being excluded all together (Voiceability, 2014; MEAM 2015, Gilchrist et al. 2013) and long waiting list lists for treatment (BMA, 2017; Gilchrist et al. 2013).

Access to co-occurring mental health and substance misuse treatment is limited and this treatment gap is being increasingly acknowledged within health services. Improvement efforts often focus on the individual patient characteristics and available treatment provision, however research is increasingly interested in the roles, attitudes and perspectives of health professionals towards this patient group (Gilchrist et al. 2013).

While some studies suggest that psychologists report greater therapeutic optimism and regard for people with co-occurring mental health and substance use needs when compared to other health professions (Gilchrist et al. 2013; Wiliams, 1999), individuals with co-occurring mental health and substance misuse use needs continue to be excluded from psychological services.

While there has been a vast improvement in access to psychological therapies for the general population who require support for low level needs i.e. mild to moderate depression and anxiety, these services are not currently designed or configured in a way which can offer the same support to individuals with co-existing substance mis/use. At the same time many individuals referred on to secondary care may not be accepted if they are using substances and may be referred on to substance misuse services, who may in turn not feel they possess the knowledge or expertise around the mental health needs – and so it goes on.

1.10 Rationale

There is mounting acknowledgement of the need to improve access to services to support individuals with co-existing needs. While research has furthered our understanding of the individual patient characteristics and of the existing treatments provided, the role of health professionals and more notably, clinical psychologists is far less understood.

Research is increasingly interested in the attitudes of health professionals towards individuals with co-existing needs. A number of studies have furthered our understanding of negative attitudes towards substance users as reported by GP's (Dehan et al. 1997; Roche et al. 2002; Lindberg et al. 2006; Furlain et al. 1990), Physicians (Ding et al. 2005; Todd et al. 2002; Lindberg et al. 2006; Furlain et al. 1990), Psychiatrists (Tantam et al. 1993), Pharmacists (Sheridan et al. 2996) and Nursing staff (Moodley-Kunnie et al. 1988; Howard et al. 2000; Carrol et al. 1993; Foster et al. 2003). While, clinical psychologists are very likely to face addiction in their clinical work over the course of their career, a review of the literature reveals a paucity in research examining the attitudes and perspectives of this professional group.

This study provides a unique opportunity to advance our current understanding of clinical psychologists attitudes in working with this population group. This could provide better understanding and highlight any existing needs of clinical psychologists in working with individuals with co-existing needs. Results from the study could contribute to the development and formulation of practice guidelines for clinical psychologists in working with individuals and ultimately improve access to psychological treatments.

1.11 Study aim

This study seeks to examine the perspectives of clinical psychologists when working with individuals who use substances, in an attempt to build our understanding of why access to therapy for this patient group is often limited. This study is also interested in understanding how individuals who use substances are conceptualised by clinical psychologists when accessing non-specialist psychological services.

The research set out to gain a better understanding of the following research questions:

i. What are clinical psychologists' experiences of working with individuals with co-exiting mental health and substance use needs

ii. How do clinical psychologists conceptualise the needs of these individuals?

iii. What role does clinical psychology play in supporting individuals with co-existing mental health and substance use needs?

Chapter 2   METHOD

2.1 Epistemological Position

It is widely recognised that when it comes to 'how' and 'what' we can know, observation and description are inevitably selective and as such, 'perception and understanding of the world is partial at best' (Willig, 2012). There is less agreement as to the level to which our understanding of the world can be objective or truly factual.

This study took a critical realist epistemological position, maintaining the focus on the data and 'reality' whilst acknowledging the limits on 'reality' and how our understanding of facts, particularly within the broader social context can influence individual's meanings. This position therefore assumes that real events occur but that 'each person experiences and gives meaning to events in light of his or her own biography or experiences' (Corbin and Strauss, 2008).

A critical realist position within qualitative research presents an opportunity to consider human behaviours and the meanings that individuals and groups attribute to their everyday lives. From this position it was also important to consider the viewpoint that 'concepts and theories are constructed by researchers, out of stories that are constructed by research participants who are trying to explain and make sense out of their experiences, both to the researcher and themselves (Corbin and Strauss, 2008). While considered by many a useful philosophical and methodological framework for social science, critical realism acknowledges that 'human knowledge captures only a small part of a deeper and vaster reality' (Fletcher, 2016) and that there are likely to be a plethora of potential interpretations of the data of which one interpretation cannot be deemed to be more apt over others.

Whilst it is not feasible for the researcher to separate themselves from the research and analysis, the importance of research transparency remains at the forefront of this study. As the researcher it is has been important to consider what I might bring to the research context and to reflect on the ways in which this might affect the analysis. Having both worked and studied in the field of addictions, my interest into the perspective of those working with individuals who use substances has been informed by these experiences and it has been important to consider and reflect on these assumptions throughout the research process. With this in mind the reader can also view the study and its outcomes with respect to the researcher's background. This is discussed further in the final chapter (see sec. 4.4.8).

2.2 Thematic Analysis

The data was thematically analysed using six stages outlined by Braun and Clarke (2006):

2.2.1 Familiarising self with the data

The first stage of the analysis involved reading and re-reading the interview scripts in order to 'immerse' myself in the data to ensure a comprehensive knowledge of the 'depth and breadth' of the data. This stage facilitates preliminary themes to be conceptualised and I made brief notes of ideas and observations on the transcripts that were of potential interest (see appendix E).

2.2.2 Generating initial codes

This stage involved the production of initial codes from the data by coding each transcript manually. Coding the transcripts manually involved writing notes on the texts, indicating potential patterns or meaningful segments of the data (Tuckett, 2005). Braun and Clarke (2006) note a common criticism of the coding stage is that context can be lost and as such, I aimed to code inclusively and broadly.

2.2.3 Searching for themes

Once the data had been initially coded, this stage sought to re-focus the analysis at the broader level of themes. To facilitate the identification of themes and sub-themes theme mind maps were used to consider the relationship between codes and different levels of themes, which loosely collated codes together.

2.2.4 Reviewing themes

During this stage some themes identified in the previous stage were not supported adequately by the data, while other themes required re-configuring. For this stage I drew from Patton's (1990) dual criteria for reviewing themes – 'internal homogeneity' when themes should hang together meaningfully and 'external heterogeneity' where a theme should be distinct from others. Transcripts were re-read to examine validity of themes in relation to the data set and to further refine sub-themes and their relationships to the main themes.

2.2.5 Defining and naming themes

Once a more thematic map was established, each theme was further defined and a name selected to capture the essence of the data it contained. At this stage it was important to consider how each theme fitted into the broader narrative, in relation to research questions.

2.2.6 Producing the report

The final summary of the themes is outlined in the following chapter.

2.3 Ethical Considerations and Confidentiality

2.3.1 Ethical Approval

The University of East London's School of Psychology Ethics Committee gave ethical approval for the study in March 2018 (Appendix C).

2.3.2 Informed Consent

Providing participant information sheets, gaining informed consent and assuring confidentiality were carefully managed throughout the research. Participants were issued participants information sheets prior to consent being obtained to allow time for them to read the information and discuss the study with me (see appendix A). Once participants were satisfied with the information provided and stated that they wished to proceed, written consent was obtained (see appendix D). Participant's anonymity and right to withdraw from the study without disadvantage to themselves was emphasised.

2.3.3 Confidentiality

Confidentiality was highlighted both verbally and in written format using the participant information sheet (appendix A) prior to interview and again covered as part of the consent form (appendix D). All interviews and transcripts were anonymised and identifying features altered by the researcher who transcribed all interviews.

All information for the study was only accessed by the researcher and anonymised only data shared with supervisors. All data for the study including, transcripts, recordings, and consent forms were password protected and kept on a computer that required a password. Papers will be shredded and audio recordings deleted.

2.4 Materials

A standardised email/letter was used for those who expressed an interest in taking part in the study, introducing myself and the project (see appendix A). The information sheet and consent form were shared with the participant prior to the interview.

An interview schedule was used as a guide to conduct the semi-structured interviews and all interviews were audio recorded using a digital voice recorder.

2.4.1 Developing the interview schedule

The interview schedule was developed from a review of the literature, the research aims and objectives, my own professional experience and discussions with my supervisors who have conducted research in the area of substance misuse and psychology.

In order to yield a diverse range of responses from the participant on the topic areas the interview schedule covered a breadth of questions including but not limited to, direct questions '*Do you currently work with individuals with co existing mental health and substance misuse needs?*' indirect questions '*What role do* clinical *psychologists see themselves having in working with clients with co-existing substance misuse needs*' follow up questions '*Could you say a bit more about that?*' and interpreting questions '*When you say teams sometimes look to psychology to 'do something' is it fair to say that you feel there is an expectation that you should work psychologically with someone with co-existing substance misuse needs?*'.

After the first interview was conducted time was taken to reflect on the process and discussed with supervisors. This included a discussion around my interview style and further areas to probe in future interviews. This led to a

revised interview schedule (see Appendix B), which aimed to ensure areas of interest to the study were covered, while the use of prompts and follow up questions allowed participants to elaborate on their experiences and views which created space for greater breadth and depth of discussions which facilitated understandings.

The interview schedule was structured in a way, which sought to begin the interview by asking participants about their current role, which led to questions exploring their experiences and views of working with individuals with co-existing substance misuse needs and the role of psychology more broadly in this area. The semi structured nature of the interview schedule allowed me to both open up conversations about psychology's role in working with individuals who may have co-existing substance misuse needs, and flexibility to enable the participant to elaborate on their own experiences and perspectives of this work.

2.5 Participants

A total of 8 participants were recruited for the research. The inclusion criteria included that participants were currently practicing as a clinical psychologist and agreed to take part in an interview for the purpose of the study.

Clinical psychologists undergo a three-year professional doctoral training programme, which is accredited by the British Psychological Society and approved by the Health and Care Professions Council (HCPC). The programme is designed to ensure all clinical psychologists attain a series of overarching competencies to ensure that at the end of the programme trainees will be well prepared to work with a range of populations and across a diversity of settings.

Inclusion criteria were purposely kept broad to reflect the broad range of populations and diverse settings clinical psychologists work within. I was interested in clinical psychologists from a range of non-specialist settings and was not looking for 'experts' on substance misuse per se.   Seven participants were currently practicing within NHS services and one participant practiced

privately and had previously worked in the NHS for several years. Five participants were female and three were male.

Due to the study's aim of conducting in depth analysis of the data, a small sample was viewed as appropriate (Crouch & Mckenzie, 2006). I have not included a biography of the participants to ensure anonymity.

Table 1: *Interview data of interviewees*

Participant	Date of the interview	Length of the interview	Gender	Field
Clinician #1	31.10.18	0:37:00	Female	Early Intervention in Psychosis for Young Adults
Clinician #2	7.12.18	0:30:33	Male	Pain Management
Clinician #3	15.2.19	0:32:46	Male	Health Oncology
Clinician #4	16.3.19	0:36:06	Female	Health Oncology
Clinician #5	28.3.19	0:42:16	Female	Health Oncology
Clinician #6	5.4.19	0:33:47	Female	Adult Mental Health - Community
Clinician #7	14.4.19	0:34:24	Male	Health
Clinician #8	10.7.19	0:42:09	Female	Complex Care Adult Mental Health - Inpatient

2.6 Procedure

2.6.1 Recruitment

A number of strategies were used to recruit participants for the study. Recruitment efforts focused on professional platforms clinical psychologists were likely to access including, professional online forums, CPD events, network events, local and national professional events. Screening criteria included, practicing clinical psychologists working within healthcare services. The recruitment process emphasised that the project was not looking for 'experts' on substance misuse but interested in clinical psychologists' attitudes and perspectives towards working with individuals who use substances.

Initial contact was made through recruitment calls for the study on these various platforms, which introduced the project, outlining confidentiality and provided contact information for individuals who were interested in taking part. On receipt of an expression of interest, an email was sent with the information sheet and consent form attached and provided an opportunity for questions or queries to be addressed.

The response from recruitment calls varied; for instance, on a number of occasions having established contact in response to the call a number of difficulties ensued when following up contact. The most common issue was while some individuals expressed interest initially, a number subsequently decided not to take part due to limitations around time. This was despite it being made clear that interviews could take place face to face or via telephone, in or outside of work hours.

Recruitment benefited from snowballing effects, that when one person was found who fit the recruitment criteria they were then asked if they knew anyone

else who would also fit the study criteria. Recruitment also benefited from my connection within the psychology field as a trainee clinical psychologist.

2.6.2 Interviews

A total of 8 interviews were completed (6 interviews were conducted face-to-face and 2 by telephone). Face-to-face interviews were conducted at participants' places of work in meeting rooms that were pre-booked to maintain privacy. The interviews ranged between 30 minutes 0 seconds and 42 minutes and 16 seconds (mean = 36 minutes and 10 seconds). All interviews were audio recorded and transcribed verbatim by myself.

The interview schedule was used to guide questioning, while the semi-structured nature of the interview gave flexibility to the respondent to elaborate on their responses (Rapley, 2004). This provided a means to capture authentic accounts of subjective experiences (Rubin & Rubin, 1995) and meant I was able to probe new lines of inquiry that surfaced during the interview (Payne & Payne, 2008).

2.6.3 Transcription

All interviews were audio recorded and transcribed verbatim onto a word processor at the same time as data collection was being carried out. Each line of the transcript was double spaced to enable thoughts and themes to be noted and referenced.

Transcribing the data provided a valuable opportunity to familiarise myself with the data and emerging themes. While transcribing interviews soon after they were completed and while further data collection continued, meant that I was able to plan for exploration of areas of interest that emerged throughout the

interviewing period. When this happened, I was able to include further questions into the interview schedule to ask subsequent interviewees.

Once transcripts were completed, these were checked against the audio recordings for accuracy, which further enhanced my familiarity with the data.

2.6.4 Reliability and Validity

The criteria for assessing the 'trustworthiness' of quantitative research is arguably well established in the research literature and consideration for reliability, objectivity and validity are most widely used to assess the trustworthiness of quantitative data. There is some dispute with regards to the criteria used to measure facets like reliability and validity within qualitative research. While some question whether an individual interpretation can be objectively measured in terms of its 'trustworthiness', others claim there is a need to ensure the quality and integrity of qualitative findings within the research methodology field.

Guba and Lincoln (1981) argued that criteria used to measure facets including reliability and validity are not relevant for assessing qualitative inquiry because of the disparate ontological and epistemological assumptions. They proposed several criteria including, credibility, transferability, dependability, confirmability, reflexivity, transparency, triangulation and iterative process can be used:

Credibility refers to how 'valid' or truthful the data is and establishes how well research findings represent a participant's experiences. *Transferability* refers to the degree to which data can be extrapolated to other contexts or settings. *Dependability* refers to the 'stability of findings over time' (Bitsch, 2005). *Confirmability* refers to the degree to which research findings could be confirmed by other researchers. *Reflexivity* refers to the understanding of the

researcher being a part of the research process and as previously noted, as the researcher it is has been important to consider what I might bring to the research context and to reflect on the ways in which this might affect the analysis. *Transparency* refers to how 'visible' the study's methodological components are and how easily could someone replicate what the researcher has done. *Triangulation* refers to use of multiple methods of data collection from different sources to develop a comprehensive understanding of the phenomena being studied. Finally, *Iterative Process* refers to revisiting data throughout collection and analysis concurrently, as a means to continually engage with emerging insights and themes, which can be used to refine focus and lines of inquiry throughout data analysis. Each of these criteria will be evaluated in the discussion chapter (section 4.4).

Chapter 3   RESULTS

3.1 Overview

In this chapter, data from the research interviews that were analysed using TA are presented and discussed. Three over-arching themes were identified: 1. Professional and the Personal Self, 2. Organisations, Systems and Services, 3. Willingness to Treat.   Each of the themes were considered in relation to the others and sub themes served to both structure each theme and further the depth of the analysis (table 2).

Table 2: Interview data superordinate and sub themes

Superordinate Themes	Sub Themes
Professional and Personal Self	- The Professional and the Personal Perspective - The 'Risk Lens' - Confidence and Legitimacy
Organisations, Systems and Services	- Outcome Drivers - The Medication Paradox - Social and Ethical Responsibilities of Healthcare Services
Willingness to Treat	- Defining the Issues - Role and Remits

3.2 Professional and the Personal Self

3.2.1 The Professional and the Personal Perspective

The first main theme considers the ways in which participants conceptualise the personal and professional self when working with individuals with co-existing mental health and substance mis/use needs. This theme is explored through

three sub themes, 'Professional Desirability', 'Low Expectation of Self and Client' and 'Managing Feelings of Professional Inadequacy and Failure'. The themes highlight the role of identity, how aspects of therapy with this client group may influence its formation and development and how this in turn interacts with the clinical psychologist's sense of self.

3.2.1.1 *Professional desirability/actualisation*

A number of participants described a desire to be seen as 'competent' and 'able' in their professional role and identified markers of success in terms of their work.

> *'I have a sense that my role is to reduce the number, so there's a fiscal responsibility … I think that really is a measure of how well my efforts to help patients are working'* (Participant 2).

> '*If it goes well then it looks … it's great and if it goes not so well then it doesn't really matter because that person was never going to do that well out of therapy anyway'* (Participant 1).

While some participants identified ways in which they experienced a feeling of competency and of being positively regarded in their role, several participants described challenges to a sense of their professional self and of an awareness of a desire to be seen as a competent clinical psychologist.

All participants identified barriers to psychological work with individuals with co-existing needs including, non-attendance, intoxication, physical health difficulties and risk. The interviews revealed ways in which participants had come to view these as barriers or 'blocks' in being able to deliver psychological interventions. As a consequence, a number of participants spoke about how these factors, which came as a result of the substance use, meant that they felt unable or limited in being able to demonstrate their own skills and competency. The following extracts illustrate this theme of barriers to the work for both the

client and the participants and how certain behaviours "get in the way" of effective psychological interventions.

'I think that a lot of people who use substances tend to have quite chaotic lifestyles so things like not turning up for appointments can get in the way' (Participant 2).

'When it's at such a level, we're just not able to do stuff… then you know I've had to kind of stop… People can't be intoxicated during the sessions, it doesn't work' (Participant 1).

'It's really hard to deliver an intervention when somebody is like that' (Participant 3).

The interview data revealed ways in which participants wanted to be seen as doing a 'good job' and gave examples of how substance use, when present, can negatively impact on this. The remaining sub themes in this section explore in part, ways in which these experiences around the theme of professional actualisation can influence how clients' needs are understood.

3.2.1.2   *Low expectation of self and client*

All of the participants spoke about psychological work with individuals who present with co-existing substance use needs being perceived or to a certain extent somewhat expected to 'fail' or pose a challenge to the effectiveness of psychological interventions. There was some suggestion that a level of acceptance exists in the understanding that psychological intervention will be limited, or in some instances redundant within this client group.

'Fundamentally you never develop emotional tolerance, problem solving skills, you're always sort of drunk, things have gone away, or you've gone away…even if you suddenly stop drinking you probably couldn't handle any fear or negotiation or any sort of need to tolerate or wait' (Participant 5).

A total of six of the eight participant's spoke about a perceived 'chaos' substance use brings to the individual's life and their interactions with others, which in turn can bring challenges when attempting to plan treatment. Three of the six participants who described 'chaos' as a feature of the work with clients, viewed this as a somewhat inevitable consequence of substance use. This narrative alludes to a feeling of helplessness as a component of the work while, locating the experience of 'chaos' within the individual.

'If you've lived on drugs and drink, your life is going to be chaos' (Participant 5).

'I think people who tend to use a lot of substances tend to have quite chaotic lifestyles, you know like turning up to appointments and things… I certainly wouldn't give someone morning appointments' (Participant 1).

'I've had chats with people who work in addictions services and they will talk about the fact that people are generally poor at attending' (Participant 3).

This view of chaos and uncertainty that substance use can bring to psychological work could be seen to suggest clients can be viewed as being unpredictable and unreliable. It is possible that participants' expectations that clients would not attend appointments could be interpreted as them not being

able to successfully engage the client and negatively reflect on their level of professional competency. Alternatively for others responsibility may be placed on the client, without a sense of 'failure' in their own ability.

The idea that clients who use substances are less likely to attend appointments (or at least on time) highlighted issues of trust and honesty between therapist and client. Interview data indicated how these factors when considered in relation to expectations of the self and client, can contribute towards an early or pre-emptive negative view of the client, low expectation of viability of the therapeutic input and any subsequent outcome.

> *'Patients are reporting pain but their pain behaviour doesn't match, they don't look like they are in pain um and you start to get staff being sceptical and jaded with those patients'* (Participant 2).

> *'Once patients start coming in and saying that your know 'I'm in 10 out of 10 pain' but they don't look like they are in 10 out of 10 pain and staff stop believing them, you can't really hide that'* (Participant 3).

> *'I think that many patients have a fear of not being believed'* (Participant 6).

In contrast to these ideas, one participant described that holding low expectations and beliefs as to the feasibility and effectiveness of psychological input with this client group, can mean they do not feel they have to hold themselves professionally accountable in the same way if substance use wasn't present.

> *'I have wondered on a more personal level if one of the reasons why I like doing this work is because there are groups of people who are*

expected to not get great outcomes so anything that you do is a bonus
really and I think it probably takes a bit of pressure off ' (Participant 1).

The same participant spoke about exceptions to this perceived 'norm' and how these occasions can be experienced as a 'relief', and serve to motivate or reward the clinical psychologist for their efforts in a field where progress and 'recovery' are viewed as anomalies.

'You occasionally come across someone who is just really
motivated, really ready, they've got all the conditions, kind of
perfect and you need a bit of that .. you know in terms of variety
and not feeling like you're treading through treacle the whole time'
(Participant 1).

In summary, this sub theme aimed to consider participants' sense of expectation of themselves as the clinician, the clients and of the therapeutic viability when working with individuals who present with both mental health and substance misuse needs.

3.2.1.3 *Managing feelings of professional inadequacy and 'failure'*

The majority of participants highlighted the emotional challenges of working with individuals who present with both mental health and substance misuse needs. For two participants, witnessing physical deterioration or suffering as a consequence of the substance use was identified as a particular emotional challenge they faced, which could leave them feeling helpless in their role.

'It's sometimes emotionally difficult because I have watched a
couple of people really deteriorate in terms of their physical or
mental health and you sort of feel that you're watching this young

*person basically ruin their lives or kill themselves but like in a slow and chaotic way and that's really hard' (*Participant 1).

'Having to take a decision of you know you said you need help but actually I can't give it to you' (Participant 8).

'When you see someone whose life is getting worse that can be hard and maybe we just need to call this spade a spade, we're dealing with addiction here (Participant 2).

The interviews revealed some participants' views of how the substance in and of itself could be understood as the 'problem' and can be presented as being the reason why some clients were deemed to be unable, or unlikely to benefit from psychological interventions. This could suggest that if psychological interventions are being viewed as futile when substance use is present, this may leave the clinical psychologist with feelings of professional inadequacy and a sense of failure.

'You build an alliance with them, you want them to do well and then when they don't because of substances that's really hard, really really hard) (Participant 1).

'I think it's the only time I've had to end therapy earlier than we had initially contracted which was really difficult' (Participant 8).

A number of participant's spoke about acknowledging attempts they made to defend against or manage feelings of professional inadequacy when confronted with clients who were seen to be deteriorating in either their mental and/or

physical health. Two participants spoke about the role of supervision as being a space where they are able to explore feelings of inadequacy or failure. One of these participants identified that avoiding difficult topics or areas such as, substance use, where they may feel less knowledgeable and skilled in, can be used as a means to avoid difficult emotions that may be experienced when working with these clients.

'I do really value my supervision as a space to try and check in with stuff like this" (Participant 8).

'I try to check that I'm not avoiding things or just trying to stay with the subjects that I feel confident with so that I can come across as some 'wise therapist'. I try really hard not to occupy that position but that is not always an easy thing to do' (Participant 7).

All participants made reference to the emotional challenges psychological work with individuals with mental health and substance use needs can present. Many spoke about how a sense of failure can be experienced both in terms of feeling unable to meet the therapeutic needs of the client and in their view of themselves being a competent practitioner. There were some examples of how participants may attempt to manage these experiences including the use of supervision, avoidance and redirecting of the work to other services or professionals as illustrated above.

3.2.2   Development of the 'Risk Lens'

Seven out of eight participants spoke about experiences and perceptions related to ideas of risk associated with working with co-existing mental health and substance use presentations. Risk was considered and explained in a range of ways, which elicited two further sub themes, 'Dangerousness of substances and its management' and themes of 'Morality and ethical attitudes towards those who use substances'.

3.2.2.1   *'Dangerousness' of substance use and its management*

All participants spoke about risk in relation to the work with individuals with co-existing needs. For a number of these participants, risk was described in terms of the 'dangerousness' of the chemical composition a substance poses to the client's physical health.

> *'I've worked with people who are drinking an awful lot and actually even if I ..even if they said they wanted to cut down I couldn't do that, I'd need a doctor to sort all that stuff because it's dangerous isn't it?* (Participant 1).

For these participants, it appeared that they viewed themselves as being in a powerless position to manage this aspect of risk for the client and highlighted a need for medical colleagues involvement or guidance. Some participants seemed to suggest that the risk to an individual's physical health and wellbeing of clients can prevent them from being able to engage in psychological interventions and that until this risk is reduced or adequately managed psychological interventions are impractical.

> *'To go that long without cannabis would be quite difficult but we needed them to be able to come in for [cancer] treatment, I knew I couldn't do much about that side of things so the focus was on the palliative care consultant and she was able to get him onto a drug that mimicked the way that cannabis work on the body – like a substitute'* (Participant 3).

> *'I was concerned there might be… that he was quite paranoid and I wasn't sure if there was drug induced psychosis or if it was just*

an element of his anxiety and I asked him to be referred to a psychiatrist … and he kind of did do that and then sort of didn't follow through and then did come back and I did say I'm really sorry but um but I don't think it would be fair on you to do anymore work until we are able to have some sort of insight and guidance from a psychiatrist' (Participant 8).

Four out of eight participants spoke about viewing clients as being 'quick to anger' as a result of their substance use. None of the participants reported having experienced instances of physical or verbal aggression when working with this client group but there was a sense of the substance being a causal factor in someone's 'anger' and that this was out of the control of both the client and the participant. Anger understood as a result of something external to the client and possibly impervious to intervention could trigger feelings of fear and vulnerability in the clinical psychologist. Two participants identified a safe working environment as being something that should be protected against and a view that substance use and anger can threaten this.

'They're very quick to anger, it's very easy to set off anger and … even in people who don't normally have a temper' (Participant 2).

'Some of the cases that I've seen have had difficulties with anger management and then it's almost that you can see that the alcohol needs to be fully abstained from in order to come back because I think it brings up a lot of issues about safety in particular staff's safety' (Participant 3).

'I think one of the barriers is risk, like I couldn't go to their houses if I wanted to, it just wouldn't be safe enough for me to do that' (Participant 1).

'They [staff] might get a bit scared if they are acting strange'
(Participant 5).

While the ways in which risk was conceptualised differed among participants, the theme of risk was raised in all of the interviews. When asked about how risk can be best managed, a number of participants described how the use of psychological interventions can be limited when risk is considered to form a significant part of the clinical picture.

'It became apparent about the level of alcohol but largely the level of risk around her alcohol use … I was just really concerned about um her ability to manage what was happening in therapy, manage her relationship um and I took it to the team and we agreed that it wasn't safe to do an exploratory piece of work while she was using so much alcohol and being really risky um so it's the only time, I think it's the only time I've had to end therapy earlier than we had initially contracted which was really difficult' (Participant 8).

It appeared that early judgments, prior experiences and existing narratives around risk in those who present with both mental health and substance use needs could influence interactions with clients from the outset.

'When somebody arrives in clinic drunk or abusive I think that can put staff on edge and maybe be reluctant to work with them in the way they would with other patients' (Participant 4).

Most participants had some awareness of the physiological risk factors in substance use and there were indications that a lack of knowledge and

expertise around the management of these risks may affect how safe participants feel in the work with the person.

3.2.2.2   *Morality and ethical attitudes towards those who use substances*

A small number of participants considered the role and influence of moral and ethical issues related to working with clients with co-existing mental health and substance use needs.   The interview data revealed examples of how moral and ethical attitudes could be seen to influence negative attitudes and judgments of clients who present with substance use issues.

> '*People can almost be baffled that people might not be able to change the amount of thing consumed in order for them to be able to engage in treatment'* (Participant 3).

> *I think when you use the word addiction, what people think of is someone squatting behind a dumpster with a needle sticking out of their arm'* (Participant 2)

While a number of participants spoke about how views and attitudes can be influenced and guided by moral and ethical stances there was also indications of recent shifts in how substances are being viewed.   Three participants spoke about having experienced a change in how cannabis is viewed in services and there were several indications that cannabis is increasingly tolerated and viewed empathically when seen as a preferable means of coping or managing of symptoms.

> '*For him using cannabis would reduce his anxiety levels and so for us here it would be useful for him to almost have the benefit of cannabis because he was going to be an inpatient for about six weeks'* (Participant 3).

> *'I have a sense that many patients use cannabis as well but really that's kind of a supplement and sometimes for people who would rather not be using opioids or would like to be using less opioids they are trying to find other ways to cope …… some people use CBD oil which is all the rage at the moment so hopefully that is helpful'* (Participant 2).

Several participants positioned themselves as lacking knowledge and experience of working with substance use, which may be influenced in some way by their own moral and ethical viewpoints. One participant did disclose whether they identified themselves as a current or past user of substances and highlighted some ways in which this could influence their own attitudes and approach to the work. In this instance the participant described feeling that having not been an illicit drug user in some ways put them at a disadvantage when working with this client group, feeling unable to relate or empathise with the client's experiences.

> *'I've not ever been a drug user so from that place I'm quite sort of naïve um so I guess there's something about a sense of familiarity about what alcohol feels like and then my ability to sort of like, I don't know when someone is talking about it and their experience I guess there is more for me to try and sort of relate to'* (Participant 8).

This could also be understood as the participant positioning themself as being a 'law abiding' substance user by suggesting that they have only consumed alcohol, a legal substance also consumed by 29.2 million people in the UK (ONS, 2018). There may be underlying concerns for clinical psychologists in revealing any current or historical use of substances in view of their professional status and licenses to practice.

3.2.3 Confidence and Legitimacy

3.2.3.1 *Training and education in substance use issues*

All participants reported teaching on substance use issues formed a very minor part of their professional training programmes and all reported little, or no further formal training post qualification.

> 'I think I can remember one *(teaching session), now it might have been more but I can remember one and it must have come up in our module dealing with complexity, but that must have been an afternoon or a day max'* (Participant 4).

> *'I can definitely remember a couple of days training, you know the odd short seminar here or there … but not a lot of targeted specific training'* (Participant 3).

> *'I've never in all my years in clinical health, faculties, BPS, cancer networks there's never been that sort of event, you know with substance misuse during cancer treatment – never happens'* (Participant 6).

> *' I don't remember going on anything post qualification'* (participant 1).

A lack of training could be seen to significantly impact on a lack of knowledge and skills to work with mental health and substance use needs psychologically. Several participants spoke about substance use simply not being seen as a prevalent issue or concern within their field and how this could have implications for what clinical psychologists consider to be a training need. It could also

suggest that content and delivery of teaching syllabuses may influence how individuals with co-existing needs are conceptualised by clinical psychologists. This could have further implications on what questions are asked in psychological assessments, how difficulties are subsequently formulated, which in turn may be used to determine which therapeutic model or approach, if indeed any, are deemed appropriate.

> *'I'm sure that I could have gone through my whole of training and indeed my working life, if I'd have chosen a different specialty and very rarely come across substances and therefore rarely had to think about that issue'* (Participant 1).

One participant spoke about a perceived low prevalence of problematic substance use in their area of work and a missing factor for them not seeking or engaging in any further training.

> '*I've just avoided it like the plague, it just does not come up in clinical health … I wouldn't look for that, I wouldn't go really, frankly, you know there are a thousand things I need to learn, that's kind of not one of them'* (Participant 5).

Several participants stated that they would be interested in further training and spoke about training opportunities not being 'visible' or viewed as a crucial training need for clinical psychologists. A number of participants did express interest in attending further training in the future.

> *'It would be good as I've just had to find resources on my own to see what I need to do'* (Participant 2).

'I would certainly be interested in further training in that area… I don't think it comes up as much as I would expect in our roles' (Participant 4).

'Talking to you it does make me think you know that's something I should go back to' (Participant 8).

One participant highlighted that clinical psychologists are responsible for their own continuing professional development, which raises questions as to how decisions around what a clinical psychologist deems to be a training need for their own practice can have an influence on which difficulties are perceived as being pertinent to the clinical psychologist's role.

'That's a bias as a psychologist you are responsible for you own training is that you can sort of maybe not see the stuff and maybe the whole point of why you're not seeing it is because you need to do some training in it' (Participant 8).

This sub theme highlighted participants' perceptions of having a lack of knowledge and confidence in working with clients with additional substance use needs, which for some related to a lack of relevant training. Participants reported minimal teaching and focus on substance use issues within clinical training programmes, which arguably could influence how relevant further training in substance use issues is viewed by clinical psychologists. This could have further influence in what further training clinical psychologists choose to do following qualification.

3.2.3.2   *The Non Expert Expert Role*

Three participants spoke about being looked to, by other professionals for advice on difficulties with clients that present with substance use needs. The data revealed some of the challenges experienced by participants when they have felt they have been positioned as the 'expert' and how this can at times be at odds with how they may have come to view their own level of 'expertise' in this area.

> *'My expertise and my focus Is not on their drug taking so I don't have a kind of idea of the concepts, the methods, the knowledge, the techniques, the context. I don't know how one stops drinking – I just don't'* (Participant 5).

The participant's experience of being placed in an expert role with regards to addressing clients substance use needs but not viewing themselves in this role, highlights a disparity in opinion as to who is best placed to work with these clients; and this difference in views could lead to feelings of discontent within teams.

> *'Sometimes I would find people would be using alcohol to such an extent that they would find it really difficult to engage with psychological therapy, so it might be about communicating that in a way that patient's would find helpful and to staff who might be thinking 'well you're a psychologist so you can see them here' and I might have to explain why not'* (Participant 2).

> *'It's relatively easy when the person understands the role of the psychologist within that team, it's when it's not, then you're really having to explain what you're role is and that's when it can be difficult and cause tension'* (Participant 3).

While most felt that they were not best placed to work with clients who presented with substance use needs directly, all reported that they believed psychology had a role to play.

> *'There is more of a move towards consultation and supervision for psychologists, we have skills and training that perhaps others don't'* (Participant 1).

> '*We have a role to play not only with our patients directly but maybe more so with those involved in the care of those people'* (Participant 3).

> *'I think we have an important skill set to make sure services offer support and treatments for people affected by substance use issues, both directly in terms of clinical work but also training and supervision, and consultation, being able to formulate'* (Participant 4).

One participant spoke about service cuts to specialist services and how this may impact on the demand for mental health services to provide support with substance use difficulties. This could suggest that as specialist services are cut or lost altogether, local services and individuals with both mental health and substance use needs may increasingly turn to psychology for 'expert advice'.

> *'I think we have a role in leadership as this is an issue that effects a lot of people… those specialist services that are being cut have a wealth of knowledge and information that is being lost so we need to be a voice to state the need'* (Participant 4).

This theme highlighted participants' experiences and views on how clinical psychologists can often be placed in expert roles. There may be many factors, which influence this including, years of training, doctoral status, salary and leadership responsibilities and an assumption that clinical psychologists possess expert knowledge and skills in all areas of mental health.

Interviews revealed how these ideas can pose a challenge for clinical psychologists when they feel they have been positioned as the 'expert' in an area where they do not feel they possess adequate knowledge and skills but are being looked to for guidance and support.

3.3   Organisations, Systems and Services

This theme explores how organisations, systems and services can influence how individuals with mental health and substance use needs are conceptualised within the psychology profession. The theme comprises of three sub themes. The first, 'Outcome drivers', considers clinical psychologists' views of how systems designed to account for adherence to good clinical practice and measures of improvement in health and wellbeing operate within services that support individuals with both mental health and substance misuse needs. The second sub theme 'The Medication Paradox' examines how 'substances' are understood in terms of their strengths and limitations within mental health and substances use and explores how these views can differ within systems. The third sub theme 'Social and ethical responsibilities of healthcare services', examines clinical psychologists' views on social and ethical responsibilities of the services which support people with co-existing mental health and substance misuse needs and clinical psychologists positions within these systems.

3.3.1 Outcome Drivers

3.3.1.1 *Service accountability and favourable outcomes*

This theme explores participants' experiences of working within services and systems that use outcome measures as a means to demonstrate therapeutic effectiveness and change. Half of the participants interviewed spoke about having an awareness of the need for services they work within, to be able to demonstrate their clinical worth and how the pursuit of favourable outcomes can pose challenges for individual practitioners.

Two participants spoke about how clients with co-existing substance use needs can be seen to bring added complexity to a clinical case and suggested this can raise concerns within services as to how well these individuals can be best managed. There is a sense that these clients can become viewed as 'problematic' in terms of service delivery and outcome reports, which many services rely on for future funding and investment.

> *'I can understand why a number of psychological services might say no to that because it adds a level of chaos and complexity that is really hard to manage'* (Participant 1).

One participant spoke about how clients who present as 'complex' and who demonstrate minimal progress using existing patient reported outcome measures (PROMS) can be excluded from accessing services in an attempt to manage service pressures and meet service standard targets. There is a sense that services may see the presence of substance use as a barrier to change and consider this when making decisions around who is most likely to benefit from treatment and consequently how this will be reflected in outcome data.

'When you have big waiting lists you have to prioritise people that are most able to make use of the work, so it does get used as a bit of a way of excluding people, probably because I suspect that they are going to be people who are going to make less good outcome' (Participant 1).

There was also some evidence that there may be a level of acceptance and understanding of why this approach in managing waiting lists and service pressures it used currently. This could suggest that when co-existing substance use needs are present they can be viewed negatively by services that may be keen to move individuals through, or out of services with minimal disruption in the pursuit of positive outcomes demonstrating sufficient change within limited time periods.

'I suppose you've got to have a way haven't you of .. you know working out who's most likely to benefit and you know the substance stuff does come as something that's potentially going to get in the way' (Participant 5).

'We want people to flow through the system without too much delay and they don't want people to be discharged and then quickly readmitted as there are fines' (Participant 2).

Several participants identified service accountability as a factor when considering treatment options for individuals who present with co-existing substance use needs. There was a sense from some of the participant's interviews that the current climate within healthcare necessitates the need for services and the professionals that work within them to be able to clearly demonstrate clinical effectiveness as a means to justify on-going financial support and investment. This could subsequently influence the decisions

around who is most likely to benefit from psychological treatment and be able to demonstrate positive outcomes and those who are not. A lack of knowledge and understanding around substance use, and assumptions that its presence can bring chaos and uncertainty may influence clinical psychologists' views and decisions about who is most likely to benefit from psychological interventions.

3.3.1.2   *Narrowing of psychological approaches that may not produce favourable outcomes*

This sub theme conveys participants' descriptions of organisations, systems and services driven by the necessity to produce positive outcomes, which some participants suggest could lead to a narrowing of psychological approaches.

'Services aren't necessarily there to be able to support people for them to be able to access traditional psychology' (Participant 1).

'I'm not criticising CBT because I think it can be great for a lot of people but I think we need to acknowledge it's not suitable for everybody.. I think it's quite an important part of the psychologist's role to be able to offer that wider range of models, different approaches' (Participant 3).

'In our team we've got a CBT therapist and then there's me and um, I do think that there is something about being able to offer a wide range of models and not just CBT' (Participant 1).

Both of these participants' comments suggest a reliance on time-limited models that have well established outcome measures. Both participants also seem to suggest that as a result, a service's focus on the provision of psychology can become narrow and models that aren't able to demonstrate clear and credible

outcomes are not utilised. Participant 1's comment that '*in our team we've got a CBT therapist and then there's me*' could highlight a concern that clinical psychologists' range of skills and knowledge risk being reduced to one or two psychological models; and that this presents a need for clinical psychologists to differentiate their role and skills set from other therapists who are trained in single models. Interestingly, this participant makes the same differentiation again during the interview: '*so they might do that work first and then you know in preparation for the coming to see me or one of my colleagues in CBT'*.

Cognitive Behavioural Therapy may be viewed by some services as a means of being able to provide established, empirically informed outcome measures. Some participants highlight a concern that services are increasingly being held accountable against clinically credible and evidence based outcome measures which could lead to an over reliance on a few psychological models. The narrowing of psychological approaches within services could be seen to pose a threat to the clinical psychologist's role, that if services deem one model adequate enough, in being able to demonstrate favourable outcomes, this could leave other models and the professionals trained to deliver them surplus to service requirements.

This theme highlighted a view that the pursuit of demonstrating favourable outcomes in health services could restrict clinical psychologists' clinical practice to models, which may not be best suited to the clients that they are working with. This theme also highlights how the narrowing of psychological approaches could be seen as an attempt to demonstrate favourable outcomes which could limit our understandings of the interplay of systems and wider contexts in which difficulties, including substance misuse, may have developed.

3.3.2 The Medication Paradox

3.3.2.1   *Limitations of the medical model and the role of psychology*

Four participants spoke about the role of the medical model in working with individuals with co-existing mental health and substance use needs. Two participants highlighted the importance of medical approaches in working with individuals who may need pharmacological interventions to help manage the effects of physical addiction.

> *'I've worked with people who are drinking an awful lot and actually even if I, even if they said they wanted to cut down I couldn't do that, I'd need a doctor to sort all that stuff because it's dangerous isn't it?* (Participant 1).

> *'One of the consultants was able to get him onto a drug that almost mimicked the way that cannabis works on the body'* (Participant 3).

In these extracts participants highlight psychology's limitations in being about to manage the physiological aspects of substance use and the valuable role medical colleagues have in supporting individuals who use substances. These extracts highlight an area of the work with these clients, which rely on the medical model. In the above extract participant 1 spoke about not having the medical skills or training to manage the physiological aspects of substance use and the need for medical expertise and how this can 'get in the way' of the psychological work. This could suggest how it could be difficult to have both approaches and models working simultaneously.

Another participant describes how medical interventions, while they may aim to support individuals with substance use issues, can maintain or in some cases accelerate the harm caused by the substance use, which can pose challenges for clinical psychologists working with these clients.

> '*People can get medical grade diamorphine pretty easily um you know and for free*' (Participant 2).

> '*The programme that we're putting together is really seen as an alternative um allowing the doctors to turn off the taps a bit and restrict the prescribing – that really hasn't happened yet*' (Participant 2).

This participant suggests that psychologically informed programmes and approaches, which are offered in part, to help support medics to reduce the use of prescribed substances and to offer psychological interventions to clients with co-existing substance use needs can be hindered when access to these substances continue to be freely available.

Two Participants describe how they see difficulties arise when medical teams become concerned with a client's use of prescribed medications or the level of use is such that clients no longer experience the benefits they once had due to the development of tolerance to the substance.

> '*Maybe the GP says I'm not going to give you more than that, maybe it stops working after a while so they start coming to the day unit ……. they have been on the medication for a long time and are reluctant to reduce*' (Patient 2)

'I think when people are using this thing for a while they don't even consider it to be a drug' (Participant 3).

There was a sense that when the medical model has been exhausted a role opens up for psychology but that up until this point psychology may not have had that much involvement, possibly as a result of medications being effective and not deemed problematic by the client or others.

'So at the moment psychology is usually called in when the Doctors don't know what to say – 'oh we are having a problem, call the psychologist' (Participant 5).

'The Doctor comes in and says 'can we reduce your pain medication', the patient says 'no' and the Doctor gives them a lecture, that's not an effective strategy, so my role is to try and help that conversation go better' (Participant 2).

In these extracts participants depict the clinical psychologist as the 'peacemaker' called in when conflict arises between the medical team and client as a result medication celling effects or concerns of misuse of medications. These extracts imply medical interventions are currently seen as the first line of treatment in cases where there is evidence of substance misuse and to some extent psychology is called upon when this line of treatment fails in order to 'fix' the difficulty. There are also indications that psychological interventions at this stage were actively sought by other professions, which could suggest psychology can be seen by other professions as having a significant role in working with individuals with substance misuse needs.

3.3.2.2 *When do substances help and when do they hinder?*

The majority of participants spoke about the presence of substance use being viewed negatively and often, as an added complexity when working with someone who has mental health needs. However, a number of participants also gave examples of ways in which substance use could be perceived as being helpful in some way for the client.

> *'They're trying to find other ways to cope and some people use CBD oil which is all the rage at the moment so hopefully that's helpful'* (Participant 2).

> *'A patient recently who was smoking cannabis had managed to reduce their alcohol intake but could see the benefits for his cannabis use, for him cannabis would reduce his anxiety levels and so for us, here, it would be useful for him to almost have the benefit of cannabis because he was going to be an inpatient for 6 weeks. One of the consultants was able to get him onto a drug that almost mimicked the way that cannabis works on the body'* (Participant 3).

In this extract the participant acknowledges the benefits that the patient feels cannabis brings them in helping to manage feelings of anxiety. There is also recognition of a benefit that this could have in supporting this client to access treatment for other health difficulties. In this example, the benefits of a substance are recognised and validated by the clinical psychologist and medical consultant, so much so, that efforts are focused on replicating the physiological benefits described by the client through the use of a legal substance prescribed by the client's clinical team.

Some participants made reference to some drugs being seen as more acceptable or increasingly tolerated within healthcare services. There was some evidence of the ways in which this can be acknowledged in health services with the use of legal prescribed substances being used to simulate the physiological effects of the illicit substance being used by the client. This could suggest that while clinical psychologists may not want to be seen to endorse the use of substances, there is some acknowledgement as to ways in which the benefits of substances can be harnessed within the remit of healthcare policies and protocols.

On the whole, the presence of substance use when working with clients with mental health difficulties was mostly viewed as having a negative impact on the therapeutic work with clients. All participants said that they would work with clients who were also using substances but all described varying 'limits' or 'points' at which they felt they were no longer able to engage therapeutically with someone. Several staff gave examples of when they thought it would become too difficult to work with someone therapeutically, when the client was also using substances.

> *'I've had someone who has turned up and been clearly on something and I've just kind of stopped the session at that point'* (Participant 1).

> *'Functional drug addicts…I guess if you like they're more…people who are still using every day but they can kind of still function reasonably well even though they are still taking drugs or other substances'* (participant 7).

> *'If someone were finding it hard to fully engage in a therapeutic approach I guess I would be trying to figure out why that is but I*

think maybe I would have an inkling that it has to do with the fact that alcohol or drugs are being consumed at a certain … or a significant level' (Participant 3).

'I think that it's all about the degree…I think that if someone's substance use is to such a degree that they can't attend sessions or attending sessions under the influence or aren't able to engage in the psychological work (Participant 4).

Two participants spoke about a 'chicken and egg' dilemma when working with clients with mental health difficulties who also use substances, and how this can pose a challenge when seeking to work therapeutically.

'It's that chicken and egg thing isn't it? You know, that many people use substances as a way of coping with underlying psychological difficulties, anxiety, depression and trauma…so we can't expect someone to drop their coping strategies with supporting them' (Participant 4).

'There's always this kind of chicken and egg type debate you know… what is causing what? … so there's often a narrative around people self medicating to a certain extent - I think you know when they're using substances for that reason, … so is it covering up someone's psychological or emotional needs that could be potentially worked on or is it, or is it really exacerbating their problems because of it and maybe they need to stop using stuff erm.. before they can kind of do that psychological work (Participant 1).

Participants' descriptions within this sub theme convey an idea that if individuals can demonstrate a level of control of their substance use and continue to function adequately enough in order to engage in psychological work, the use may be 'permitted'. Although not explicitly stated, benefits of some substances were recognised. There is sense that these benefits lie on a spectrum of substance use and there was evidence of differing view as to what point substance use becomes less 'helpful' and more of a hindrance.

3.3.2 Social and ethical responsibilities of healthcare services

3.3.2.1 *Doors into and out of treatment*

Several participants spoke about how drug and alcohol services don't see themselves as a mental health service, and mental health services don't see themselves as drug and alcohol services. A number of participants suggested how this can leave limited opportunities for both difficulties to be addressed simultaneously.

> *'The drugs services aren't necessarily there to be able to support people for them to access traditional psychology. I think that's a big barrier…. I think they have the odd group or something … its all very much more medical so it's based on either substitute stuff like methadone or just basically going to see someone, keeping a diary, cutting down – that's about it really'* (participant 1).

> *'I think most of the time people who use substances are generally excluded from psychological services because they've usually been signposted towards drugs services first so they can stop using. It's that chicken and egg thing'* (Participant 4).

There was a sense that clients are typically referred to drug and alcohol services to address any substance use issues before engaging in psychological work. There was some suggestion that clients may find difficulty is accessing psychological interventions both while in drug and alcohol services and when attempting to re-enter mental health services following substance use work.

> *Drug services aren't necessarily there to support people to access traditional psychology services, I think that can be a big barrier for someone getting psychology input'* (Participant 1).

This participant suggests that drug and alcohol services may not view mental health difficulties or needs in the same way if they had been working within a mental health service. The participant talks about the work within drug and alcohol services being focused on the reduction of substance use '*keeping a diary, cutting down – that's about it really*' (Participant 1). In this sense the client may be seen as having successfully achieved their treatment goals and possibly may have developed adequate coping skills in the opinion of the drug and alcohol service and discharge is likely to follow. What this participant alludes to is that this work, while it may have supported someone to reduce or cease any substance use, may not have addressed any underlying psychological difficulties the client may have; who is then discharged nonetheless.

> '*I have had people who've had great outcomes from therapy and have done much better than anyone expected but who would never have been given a chance in traditional therapy services or who have been rejected on multiple occasions from traditional therapy services'* (Participant 1).

This extract suggests that individuals may be excluded or denied access to psychology services on more than one occasion. The participant also suggests that when people can access psychology they believe that they can benefit from psychological interventions – in spite of substance use that may be present, but that many will not meet service inclusion criteria from the outset.

A number of participants spoke about substance use not being 'the focus' of the service that they work in and in some instances the presence of substance use excluding an individual's access to a service.

> *'This is my understanding of the remit of this service…we don't see ourselves as the right service to be directly working on those issues'* (Participant 4).

> *'So having to say actually I can see why you would want this to be done but I think the person would find this really difficult at the moment, I think once you are able to explain that it's a timing thing as well as the person may benefit from being in another service and maybe ultimately coming back to our service'* (Participant 3).

> *'I can imagine if there was an illicit substance problem um.. we would probably want to refer out'* (Participant 2)

A few participants spoke about people being referred to other services or being excluded from psychology services, as a means managing service demands.

> *'When you have big waiting lists you have to prioritise people that are most able to make use of the work, so it does get used as a bit*

of a way of excluding people, probably because I suspect that they are going to be people who are going to make less good outcome' (Participant 1).

'Why teams do or don't is the degree we kind of lean into that or not, I don't, I don't go 'please tell me about people who have had drink or drugs problems' and then be like oh here's a caseload' (Participant 5).

These extracts suggest that clinical psychologists are aware that a significant proportion of clients present with co-existing substance use needs but may choose not to '*lean into it*' (Participant 6) for fear of an influx of clinical work in services that may already be managing long waiting lists.

This draws from ideas earlier in this chapter (see sec 3.3.1) that services may see the presence of substance use as a barrier to change and consider this when making decisions around who is most likely to benefit from treatment and consequently how this will be reflected in outcome data. This could be seen as services focusing on doing 'enough' but not taking more than their service remit currently indicates.

3.3.2.2   *Out of sight, out of mind*

All participants spoke about referring to specialist drug and alcohol services as an approach that they have, or would use when faced with a client who presents with substance use issues deemed to be out of their professional or service remit. What the interview data also revealed was how clients are often 'lost' or not seen again by the same person who referred them for support to address the substance use in the first instance. This could suggest that service links and working relationships between services do not exist or face significant

challenges in making any attempt at linking clients back in to the mental health services they were referred from.

'I had to signpost her to an alcohol agency to sort of work on that drug use and you know when she had managed to um either abstain or really limit it she could come back and think about the work again' (Participant 8).

'I don't think I've then seen a person after even to get a sense of what the intervention was, whether they benefitted, its maybe happened that because I've referred them to another service and then they go to continue in that service. I don't think I've ever had any people back and found out how the service was' (Participant 3).

A few participants also spoke about how requirements placed on clients to address substance use issues, can mean that clinical psychologists do not get regular opportunities to work with these issues. No participant highlighted this as a problem in terms of developing his or her own skills and competencies in working with substance use.

'I sort of think sometimes in psychological therapy do we put so many barriers in place that actually by the time they've achieved all this stuff they won't actually need therapy' (Participant 1).

'Alcohol is a difficulty that needs to be addressed first so they might be referred on, so that might be why I don't see people who are high consumers' (Participant 3).

These extracts could suggest that referring a client on, to address their substance use difficulties first, will reduce the level of complexity the case presents to the mental health service and the person will then be viewed as being in a position where they are able to engage in psychological therapy. What the interview data may also suggest is that poor working relationships or collaboration between mental health and substance use services can mean clients can be 'lost' when referred on to specialist services, with no clear routes back to the original referrer. There are examples of this even when there is an explicit hope that the work will enable the person to re-enter mental health services to work on what are perceived to be the underlying psychological issues.

3.4 Willingness to Treat

This theme explores the concept and role of 'willingness to treat' mental health and substance use needs simultaneously within services. Two sub themes are presented; the first 'Defining the issue' explores ways in which substance use is conceptualised as being 'problematic' by clinical psychologists and the services they work in. The second sub theme 'Role and remits' examines ways in which clinical psychologists can be seen or positioned as 'experts' and explores ways in which this may interact with how clinical psychologists view their own role within this area. This theme considers ways in which disparate views within these themes can influence how clients' needs are conceptualised and addressed when accessing non-specialist psychological services.

3.4.1 Defining the Issues

3.4.1.1 *When is substance use a 'problem' and for who?*

In all of the interviews participants spoke about ways in which substance use can be conceptualised as being a 'problem'. Participants gave examples of

how differing ideas of what constitutes 'problematic' substance use can vary between clients, clinical psychologists and services. A few participants gave examples of how clients have demonstrated a concern of how their substance use was being viewed.

'I think that when you use the word addiction what people think of is someone who is addicted to street drugs – squatting behind a dumpster with a needle sticking out of their arm … and that's not what's happening here …They're [Clients] *very keen to make a distinction between what they are doing and what an actual drug addict is doing even though chemically it's the same thing'* (Participant 2).

'Sometimes they're a bit sensitive about it because they might have been advised on several occasions before… but they'll still sort of strongly believe that's its really helpful' (Participant 1).

Both of these examples highlight how clients and professionals can hold different ideas as to what is deemed to be 'problematic' in terms of someone's substance use. There may be some suggestion that holding different views on when, how and at what point substance use becomes problematic may lead to difficulties in communication, which could have a detrimental impact on the therapeutic relationship.

None of the participants interviewed worked in specialist substance use services, and one participant noted that when individuals present at mental health services for support with a mental health need, they are not necessarily expecting to receive support for their substance use. This could also suggest that until the point of contact with mental health services that the client may not have even considered their use to be problematic, but can subsequently find themselves in services that view their use in this way.

'If they are still drinking and they come in and they are vague and they're unable, don't really want it, it's very different from people coming and saying 'I want your help' and then stopping…. they're really not asking for help, it's other people observing them thinking that the whole things a mess' (Participant 5).

'When I worked in a CMHT [Community Mental Health Team] *for example there was certainly more of a sense of we can't really see this person until they've stopped using'* (Participant 1).

A few participants spoke about how views on what is deemed to be problematic, in terms of someone's substance use, can not only vary between services, but also between the clinical psychologists who work within them.

'I'd be very interested to hear what psychologists generally say, would they actively seek that business or would they back off? … I think there would be a mixture' (Participant 6).

'I think in traditional psychotherapy services there's been a lot of emphasis on people not using substances before they start therapy and that's actually probably not realistic in my job in terms of the people that I work with so I … probably have a slightly different threshold in terms of taking people on and their substance use' (Participant 1).

These examples could indicate a possible disconnect between clients, services and the clinical psychologists that work within these systems when

conceptualising someone's use of substances. There is some suggestion that the way in which an individual's use of a substance is viewed by services and clinicians can have significant implications as to how soon someone is able to access mental health support.

Two participants' referred to the role of service and team structures when working with co-existing mental health and substance use needs, recognising a need for support and MDT working.

'The people who come and make it through usually have a couple of supporting players, someone who can handle that sort of complexity, brings them to appointments, gets their meds …… teams that might have things like psychiatry liaison or might have a CPN [Community Psychiatric Nurse] *or a kind of nursy-counsellor kind of person might feel a little bit more like 'ok we can deal with that'* (Participant 6).

'I'm really lucky because I work in an MDT where we all support each other and early interventions are comparatively well resourced compared to other services - some of my colleagues work who work in psychology services who you know pretty much are a lone therapist day in and day out might have that stuff available. So I feel comfortable with it' (Participant 1)

The participants highlight differences in experiences of teams and services views of how supported they may feel in working with this client group. They both refer to how feeling supported by colleagues in a service can influence how able or competent they view themselves. This could also influence how

much of a 'problem' the substance use is being viewed as '*might feel a little bit more like 'ok we can deal with that'* (Participant 6).

3.4.1.2   *Permissibility of substances*

Some participants described how substances could be viewed in terms of how permissible they are and ways in which this could influence how clinical psychologists conceptualise and treat individuals who have both mental health and substance use needs.

> *'They're being given a substance to try and manage that pain but that's the same thing that people use on the street, so they're very keen to make the distinction between what they are doing and what an actual drug addict is doing even though chemically it's the same thing'* (Participant 2).

This participant points out how substances could be viewed as more permissible when viewed as a pharmacological treatment administered by a healthcare professional. The participant seems to suggest that when viewed as a legal substance being used by an individual under these conditions there is a sense that the substance is 'less dangerous' when compared to an individual acquiring the same substance illegally. There is a suggestion that even if the substance was being used in the same way, the way in which the substance is obtained influences how 'permissible' is use is thought to be, which could have further implications for how the individuals presenting difficulties are understood.

A few participants spoke about client's use of cannabis and how this is now viewed within health services, possibly as a result of more recent shifts in legal and social attitudes.

'Maybe for some drugs more than others, maybe with things like cannabis I think sometimes people are not or maybe think that this might chill me out but then not appreciate that actually it might be worsening any anxiety difficulties they have, or it might reduce the anxiety but it might be having an impact on another kind of mental health condition… I think when people are using this thing for a while they don't even consider it to be a drug' (Participant 3).

*'I have a sense that many patients use cannabis as well but really that's kind of as a supplement… they're trying to find other ways to cope and some people use CBD oil which is all the rage at the moment so hopefully that's helpful**….** Honestly I don't think anyone is concerned about cannabis at all, I think that there is a sense that we are prescribing a lot of very powerful drugs and that so if somebody wants to vape with some CBD oil nobody really cares if somebody uses cannabis occasionally .. nobody cares'* (Participant 2).

This participant suggests that cannabis and one of the active ingredients (CBD) are used widely and as long as the persons use does not indicate a dependence, it no longer causes the same alarm or raise significant concerns among health professionals as it may have done so previously.

This sub theme illustrates a changing landscape around the permissibility of moderate and low level use of certain substances and highlights some of the challenges this can pose clinical psychologists when working with individuals with both mental health and substance misuse needs.

3.4.2 Roles and Remits

3.4.2.1 *The expert role (nobody wants)*

All participants indicated that they would, or have worked with both mental health and substance use needs. All participants also spoke about perceived limits to this area of work, in terms of how they viewed their own roles and professional remits.

Several participants spoke about ways in which clinical psychologists can be seen, or positioned as being the 'expert' within teams and services when clients present with difficulties deemed to be outside of the services' or other professions' remits. Two participants highlighted how this view of their role by other professionals within services contrasted with their own views of what they deemed to be their professional remit.

> *'We don't see ourselves as the right service to be working directly on those issues … but we certainly would be working with the team and that person to be thinking about other support'* (Participant 4).

> *'My expertise and my focus is on their cancer, not on their drug taking'* (Participant 7).

> *'I've had people look to me for guidance around that and tried to have chats with me …I mean it's relatively easy when the person understands the role of the psychologist within that team – it's when they don't that you're really having to explain what your role is'* (Participant 3).

There were a number of suggestions that substance use within mental health services can be viewed as being a 'specialist' area and that clients who present with this co-existing need may be better placed within specialist services.

'People are generally excluded from psychological services anyway you know like specific psychological services because they're usually signposted towards drugs service' (Participant 1).

'There are alcohol liaison workers … so they can be contacted and come in' (Participant 4).

Several participants spoke about not having received sufficient training around substance use issues which could be seen as contributing to a sense that clinical psychologists do not feel able to take up the expert position on working with individuals with co-existing needs.

'I completed my training program probably 15 years ago, so it just wasn't part of the training then …. I can't imagine anyone doing clinical work now who wouldn't need to have training' (Participant 2).

'I could have gone through the whole of training and working life and very rarely come across substances and therefore not have to think about that issue' (Participant 1).

There is some suggestion that a lack of teaching on substance use within psychology training curricula could influence how clinical psychologists perceive their role and area of expertise as they move into qualified posts within health

services. One idea could be that if substance use teaching and/or training requirements to undertake a certain amount of clinical cases with present with substance use needs are not embedded within curricula, and seen as more of an 'add on' or 'extra' it might suggest it does not form part of the mainstream work remit for clinical psychologists.

I think because I've never worked within specialist substance misuse services I don't feel that my skills are as good as they could be' (Participant 4).

'We're not trained in this area, don't know enough' (Participant 4).

All participants identified a role for psychology in working with both mental health and substance use difficulties. A number of participants described ways, which they can be placed in 'expert ' roles within their services and teams and described experiences of how others may assume clinical psychologists will, or feel able to undertake this work. A number of participants spoke about challenges of managing others expectations or perceived abilities when faced with an area of psychology they may feel they 'don't know enough' about.

3.4.4.2   *When to refer?*

A number of participants highlighted ways in which services view care provision remits to be within either mental health or substance use, with very few examples of participants experiencing services encompassing both of these needs. There was a sense that services were seen to push back against clients who presented with additional complexities that were not considered to be within the remits of the service, and as a result clients can find themselves not 'fitting' neatly into any service.

> *'Yes substance use services have a role to play, but other people and other services probably have a role in that as well'* (Participant 1).

Several participants described thoughts on when it may be deemed appropriate to refer onto substance use services. This suggests that for some participants there is a threshold or point at which it is thought a client's needs would be better served in another service. What the interview data also revealed is that this 'point' can vary significantly between professionals and services. Two participants suggest that the type of substance use can influence decisions on referrals to another service.

> *'If there was an illicit substance problem we would probably want to refer out'* (Participant 2).

> *'The advice we have had from psychiatry has been it's probably best to keep someone in sort of manage it in house as much as possible but I don't know if they would say the same thing if someone was using cocaine or meth'* (Participant 2).

These extracts highlight factors such as the legal status or possibly the perceived 'dangerousness' of the substance being viewed as a reason for referring a client on to another service.

For another participant the level of use and evidence of a client being addicted to a substance was identified as a factor that would influence the decision for onward referral. Clinical psychologists not being medically trained and able to support individuals with the physiological impact of those substances, which require medical supervision, may also influence this.

If it's more addiction then maybe the role is much more about trying to explore the difficulty and trying to engage them in agreeing to a referral to another service' (Participant 3).

'Even if they said they wanted to cut down I couldn't do that, I'd need a doctor to sort all that stuff out because it's dangerous isn't it to um.. at a certain level, so you need other agencies' (Participant 1).

Two participants spoke about how they felt they were able to support individuals within the service that they worked in, which meant that they did not necessarily look to other services.

'I mean I'm really lucky because I work in an MDT where we all support each other and are relatively well resourced compared to other services …. they might not have that stuff available' (Participant 1).

'I'm just thinking of a case I'm working with where they are linked in with the alcohol services within the hospital and they have a CNS there so we link in and coordinate that support, I think if I was at a different hospital and there wasn't that connection I think that would be much harder, you would be more isolated' (Participant 4).

For other participants they did not view either themselves or the service they work within as being in a position to support an individual with co-existing substance use needs but made some suggestions that it was felt to be in the client's best interest to address the substance use in the first instance.

'It's a timing thing as well the person may benefit from being in another service or ultimately coming back to our service' (Participant 3).

'There was certainly more of a sense of we can't really see this person until they've stopped using' (Participant 1).

'I had to signpost her to an alcohol agency to sort of work on that drug use and you know when she had managed to um either abstain or really limit it she could come back and think about the work again' (Participant 8).

The interview data revealed inconsistences and a lack of agreement within and between services of where clients who present with both mental health and substance use needs might be best supported. A number of participants identified services with MDTs being better placed to manage both presenting needs, and that when services do not have access to this resource referrals to drugs and alcohol services are more likely to be sought. A number of participants did highlight their hope that clients accessing support for substance use would enable them to make better use of psychological therapy in the future.

Chapter 4   SUMMARY AND CONCLUSIONS

4.1 Overview

In this chapter, key research findings are summarised and implications for findings are considered in relation to clinical psychology. Lastly, a critical evaluation and final reflections are presented.

4.2 Summary of Findings

This study sought to explore clinical psychologist's attitudes and perspectives towards working with individuals who present with both mental health and substance use needs. The research set out to gain a better understanding of the following research questions: i) What are clinical psychologists' experiences of working with individuals with co-existing mental health and substance use needs? ii) How do clinical psychologists conceptualise the needs of these individuals? iii) What role does psychology play in supporting individuals with co-existing mental health and substance use needs? The main themes and some of the interconnections between them will be discussed in relation to relevant literature below.

4.2.1 Personal and Professional Self

The theme of the 'Professional and Personal Self' contained several interrelated themes, which explored how the clinical psychologist's view of their professional sense of self can influence how individuals with co-existing mental health and substance use needs are conceptualised.

Professional and Personal Perspective

Professional Desirability - Participants highlighted the importance of being clinically competent to undertake psychological work with clients with co-

existing needs and expressed a desire to be seen as such by colleagues, teams and the services that they work in. There was some evidence of existing assumptions that professional competence in relation to psychological work is equated with positive outcomes, hence if outcomes are viewed negatively this may be viewed as a reflection of the clinical psychologist's level of competence (Devlin & Appleby, 2010). Diveck et al. (2005) proposed an innate desire to acquire and exercise competence and that this becomes part of the self-concept, both in how one comes to view the self and part of what others esteem for. Maslow's (1962) theories around self-actualisation and the 'desire for self fulfilment' discuss individual motivations for 'esteem needs' which include, achievement, mastery, self respect and respect from others. Maslow's later work purported that these aspects of self-actualisation can also be sought and realised within work settings (Maslow,1970a).

This study found that the presence of substance use as part of the clinical presentation, could pose a challenge for clinical psychologists in non-specialist services. Participants identified several factors that were perceived as barriers to psychological treatment and as a consequence the possible attainment of positive outcomes including, non-attendance, intoxication, physical health difficulties and risk issues. These barriers to treatment have been associated with poor outcomes in this client group (Todd et al, 2002; Palmer et al, 2009; Lloyd, 2012).

This theme drew attention to participants' desire to be able to demonstrate competence for both the clients, themselves and to others. One suggestion could be that a perceived reluctance to undertake work with individuals who present with substance use needs is an attempt to avoid feelings of incompetence.

Low expectation of self and client - The study found that a number of participants viewed individuals who present with substance use needs in mental

health services as being less likely to benefit from psychological interventions within non-specialist services. In some instances this appeared to be related to pre-existing ideas that this client group brought added complexity and 'chaos', not experienced by participants when substance use was not present. This lends some support to research, which describes lowest regard for this client group being found in clinicians who do not work in specialist addiction settings (Gilchrist et al. 2011 pg 1121). Research has also highlighted ways in which this can lead to avoidant approaches in the delivery of treatment to patients with substance use needs compared to other patients (Gilchrist et al. 2011; Van Boekel, 2013; Rao et al. 2009). Other studies have demonstrated how individual's decisions, behaviour and performance can be influenced by their beliefs about how well they will do on an activity or task (Atkinson 1957; Eccles et al 1983; Wigfield, 1994; Wigfield & Eccles, 1992). This could also illustrate how pre-existing negative beliefs about the self and client can influence diagnosis and treatment of mental health and substance use needs.

Managing feelings of professional inadequacy and 'failure' - This theme also highlighted emotional challenges experienced by the participants when working with individuals who present with both mental health and substance misuse needs. Participants conveyed ways in which a sense of failure can be experienced both in terms of feeling they are unable to meet the therapeutic needs of the client and in their view of themselves being a competent practitioner. Consideration of the interconnected subthemes of, professional desirability, low expectation of self and client, and feelings of professional inadequacy and failure illustrate the multi-faceted ways in which clinical psychologists self evaluation within the context of working with mental health and substance use can influence how clients' needs and the clinical psychologist's role within this may be conceptualised.

Development of the 'Risk Lens'

This theme was evident in all of the participants' interviews and highlighted how ideas and responses to risk around mental health and substance use can vary between clinicians and services.

Dangerousness - Several participants spoke about a view that anger and aggression can be result of an individual's substance use. There is a body of research which suggests health professionals generally have lower regard and feelings of dissatisfaction when working with this client group (Ford et al., 2008; Gilchrist et al., 2011; McLaughlin et al., 2006,;Rao et al., 2009). This was sometimes explained by the perception of health professionals that these patients are potentially violent, which may cause feelings of frustration, resentment and powerlessness among professionals (Deans and Soar, 2005; Ford, 2011; Adams et al., 2000).

There has been a wealth of literature about risk aversion in health settings and considerable attention in health services is focused on minimising risk (Giddens, 1990; Sheard, 2011). This could suggest there are implications for clients who are seen as presenting a 'risk' in some way when seeking treatment for mental health and substance use needs. This finding supports Peckover and Chidlaw's (2007) research indicating that a health professional's sense of risk and vulnerability can restrict practice in terms of time spent and engagement with the client. There is an established body of research, which reports higher levels of anger and violence among substance abusers, compared to the general population (Pickard et al, 2013; Grisso et al. 2000; Clancy, 1997; Reilly et al. 2000). Peckover and Chidlaw indicated that discourses of risk, mental health and substance use could lead to risk being prioritised even though psychological treatment for this client group is valued. Similarly, 'zero-tolerance' responses have been reported to lead to 'rigid attitudes, poor tolerance and loss of important skills for managing violence' (Middleby-Clements & Grenyer, 2007). Ford (2011) highlights an important caution, that it is neither practical, nor fair to ask health professionals to amend their practices, without first providing safe working environments.

Morality and ethical attitudes towards those who use substances - The findings of the study highlighted varying degrees of social acceptance of substance use. It could be argued that moderate or low level use o legal and indeed some illegal substances is more socially accepted in western societies, this study highlighted participant awareness of the existing health and social burden of substance use. Existing research has demonstrated how factors including, attribution beliefs, knowledge of and experience of mental health and substance use can influence the formation of stigmatising attitudes of health professionals towards people with substance use problems. It is also widely recognised how these attitudes can negatively impact on therapeutic alliance and delivery of healthcare (Livingston et al, 2011; Henderson et al, 2014)

This study provided examples of participant awareness that clients with mental health and substance use needs can experience negative attitudes from healthcare staff and services. However, a number of participants felt that there was greater acceptance of these patients among the psychology profession. This was in part supported by Gilchrist et al's (2011) findings from a European multi-centre study of staff regard towards working with substance users which found clinical psychologists and social workers to have higher regard towards working with this client group. This study also highlighted that research into regard towards working with substance users, outside of nursing professions is lacking. This sub theme highlighted how moral and ethical attitudes around mental health and substance use can influence clinical psychologists' interactions with clients and the systems they are a part of.

Confidence and Legitimacy

Training and education – This theme illustrates a perceived lack of knowledge and training in substance use issues for clinical psychologists. All participants spoke about feeing that they had received minimal teaching around these issues as part of their professional training programmes. These findings stand in line with research conducted by the British Psychological Society's Faculty of Addictions (2014) which found that half of all clinical training courses offer one

day or less throughout the teaching programme, and that specialty placements are sparse. This is despite several policy reports and guidelines prioritising psychological aspects of substance misuse treatment (Scottish Government, 2008, 2012; NICE, 2011). Research suggests that this is a view shared more widely among health professionals and that, in general, health professionals feel that they lack specific knowledge and skills in caring for this particular patient group (Deans and Soar, 2005; Giannetti et al., 2002; McGillion et al. 2000; McLaughlin et al. 2006).

While findings highlighted participants perceived lack of knowledge, skills and training in this area, it also revealed that nearly all participants would be interested in undertaking additional training in working with individuals with mental health and substance use needs. Participants expressed hopes that this would enable them to feel better equipped to work therapeutically with these clients. This could have implications for increasing access to psychological treatment for this client group. Research has also found that training for staff can lead to reductions in negative attitudes towards substance users, regardless of their current work setting i.e. specialist vs. non-specialist (Howard and Holmshaw, 2010).

The 'Experts Non Expert' role – This sub theme highlighted the fact that once qualified, clinical psychologists become responsible for identifying their own training needs. A lack of attention and teaching on substance use issues in pre-qualification training could be seen as a failure to prepare clinical psychologists for working with substance users in healthcare settings (Foster et al. 2011; Billingham, 1999). This study found that while participants did not view themselves as being 'experts' in this specific area of mental health, there were a number of examples of this perception being at odds with other health professionals and clinical teams understanding of the clinical psychologist role. A number of participants spoke about teams looking to psychology for support and guidance when working with individuals with co-existing mental health and substance use needs. A number of participants highlighted psychologist

'expertise' lying in the psychological formulation of a client's difficulties in the context of their substance use which draw from theory, research and clinical experience (Johnstone, 2017). While participants viewed this as a positive contribution to teams working with individuals with mental health and substance use needs, research and evaluation of formulation as an intervention in teams and services is limited (Cole, Wood & Spendelow, 2015).

These findings could suggest that a lack of teaching and training on substance use issues in professional training programmes, may influence how clinical psychologists view their role and 'expertise' in this area upon qualification. This in turn could have further implications regarding the nature of questions asked in psychological assessments, how difficulties are subsequently formulated and could ultimately determine which services clients are able to access. This could present an important area for future research in supporting clinical psychologists in working with clients who have co-existing mental health and substance use needs.

4.2.2 Organisation, Systems and Services

Outcome Drivers

Service accountability and outcomes – The sub themes '*service accountability*' and '*narrowing of psychological approaches*' highlighted ways in which participants work with individuals with co-existing mental health and substances use needs, can be influenced and guided by the systems and structures they work within. Participants spoke about how individuals with co-existing needs often do not 'fit' service remits and specifications, and this can contribute to these individuals being viewed as 'complex' or presenting with difficulties deemed to be outside of the service remit.

Participant views of individuals not 'fitting' existing service structures also appeared to be related to the requirement of services to evidence their clinical

effectiveness through the use of standardised patient reported outcome measures. There was a sense that clients who were viewed as not 'fitting' with the specification of a service and who were predicted to produce 'poor' outcomes on measures, could be denied access to psychological services on this basis. Another possible factor is the mounting concern for services that are under increasing pressure, to produce favourable outcomes to demonstrate clinical effectiveness and in turn to secure future funding and investment.

The study found that outcome drivers are used to support decision making around assessment and treatment, which is described as one of a number of benefits reported in the literature (Whipple and Lambert, 2011). It also highlighted ways in which the use of outcome measures can influence clinician's decisions around accepting referrals from the outset. The findings also indicate ways in which outcome measures can generate information that can disadvantage clients or limit access to services (de Jong et al. 2012; Moran et al. 2012). One participant's suggestion that outcome measures can be used as a means to limit access to services may be a reflection of current service pressures, to meet treatment/outcome targets and secure funding.

Narrowing of psychological approaches – This sub-theme highlighted how being held increasingly accountable, against clinically credible and evidence based outcome measures, could lead services to draw from a limited number of psychological models. Moran (2012) suggests that while a number of benefits have been identified for the use of PROMS in health services, they may not adequately reflect the decision-making challenges clinicians face on the frontline of services. Moran also posits that standardised questions can be experienced as a 'potential burden' to health practitioners, and may raise anxieties by both client and clinician about their use to limit service provision.

The perceived need to be able to demonstrate clinical effectiveness through the use of such measures could have implications for the use of psychological

models within services. There was some suggestion that services focus on the provision of psychology can become narrower and psychological models that aren't able to demonstrate clear and credible outcomes are used less in practice. Some participants highlighted an increased use of CBT approaches, highlighting how the short term, structured nature of treatment makes it particularly attractive to services and amenable to empirical investigation (Anderson et al. 2007; Norcoss et al 2005).

This theme highlighted a view that in the pursuit of favourable outcomes in health services, this could inadvertently be contributing to clinical psychologists feeling increasingly restricted in their use of psychological approaches. This narrowing of psychological approaches within services could be seen to pose a threat to the clinical psychologist's role, in that, if services deem one model adequate enough in being able to demonstrate favourable outcomes, this could leave other models and the professionals trained to deliver them surplus to service requirements.

Social and ethical responsibilities of healthcare services

Doors into and out of treatment – Findings suggest that the simultaneous treatment of mental health and substance use continues to present a challenge to healthcare professionals and services. While there is guidance that recommends integrated care for co-existing mental health and substance use difficulties (NICE, 2007; 2010; 2011), this study highlighted examples of how these co-existing needs continue to be viewed and treated independently of each other. A number of participants spoke about how the service they work in do not see themselves as a service that provides substance use support, leaving limited opportunities for both difficulties to be addressed simultaneously. These findings are in keeping with research that highlights how organisational structures, processes and support of health professionals working with this client group can impact on the care individuals with co-existing needs receive (Van Boekel et al. 2013; Albery et al., 2003; Curtis and Harrison, 2001; Ford et al., 2008)

Out of sight, out of mind - It is not uncommon for individuals to be excluded from mental health services because of co-occurring alcohol or drug use. These same individuals may have also experienced exclusion from substance misuse services due to the severity of their mental illness and can find themselves 'stuck' between these systems, not meeting either services' criteria. This study highlighted examples of how clients referred to substance use services for needs deemed to be out of the clinical psychologist or service remit can become 'lost', or not seen again by the same clinical psychologist who referred them for support to address the substance use in the first instance. While this could be seen as an attempt to reduce the level of 'complexity' as understood by mental health services, the study showed that there is often a lack of continuity of care between mental health and substance use services. The need to establish positive working relationships and a collaborative approach to supporting individuals with co-existing mental health and substance use needs is widely recognised in the literature (Maslin et al, 2001; Abou-Saleh, 2004; Mojtabai, 2005)

The Medication Paradox

Limitations of the medical model and the role of psychology – The findings highlighted examples of participant perceived limitations in working with individuals with substance use needs. The study revealed a number of ways in which clinical psychologists can experience feelings of helplessness when considering the physiological aspects of a persons substance use. Dasgupta and colleagues (2018) suggest that a historical reliance, or over use of pharmacological interventions in healthcare services and the pursuit of 'quick fixes' for complex physical and mental health needs has run its course and contemporary literature has pointed to an imminent prescription public health crisis (Dhalla et al. 2011; Weisberg et al, 2014; Humphreys et al, 2017). The study suggests that limitations of the medical model within mental health and substance use are being more widely acknowledged and may have a subsequent impact on clinical psychologists, as healthcare providers seek alternative approaches.

When do substances help and when do they hinder – While the study's findings highlighted predominately negative views of substance use in the context of working psychologically, there were acknowledgements of the potential benefits of substance use in some instances.

Mullar and Schuman (2011) highlight that the vast majority of research focuses on seeking to understand and eliminate substance mis/use. They propose that for some substance users, the use can be understood as a means to achieve personal goals and present a process whereby the consumption of a substance enables an individual to alter their mental state, which can subsequently allow for better performance and goal achievement. The study found examples drawing from an idea that while some forms of substance use undoubtedly cause harm to the individual and society, other forms can induce positive emotions which can support a person to 'cope' or 'adapt' to situations which may allow the individual to gain greater benefits in other ways (Nesse and Berridge, 1997). This study illustrated examples of this in practice including the use of pharmalogical interventions in the management of anxiety for patients needing to access cancer treatments i.e. extended inpatient stays/invasive procedures. In this research there was evidence that perceptions and attitudes towards a persons use of a substance can be influenced significantly by the context in which it is being used or administered. This in turn could have further implications for how individual need is conceptualised by clinical psychologists within non-specialist settings.

4.2.3 Willingness to Treat

This theme brings together key aspects of the two previous themes. The study highlighted how disparate views and understandings of the needs of individuals with co-existing mental health and substance use needs, both within and between services can impact on how, where and who is able to access psychological treatments. The theme explored the concept and role of

'willingness to treat' among clinical psychologists in treating both needs simultaneously.

<u>*Defining the issues*</u>

When is substance use a 'problem' and for who? - Definitions of addiction and what is considered to be 'problematic' use of substances have never been more hotly contested (Fraser et al. 2017). There were indications that working with individuals who use substances in a way not viewed as being problematic for the client, can present a conflict for clinical psychologist in how the client's difficulties are conceptualised. For many participants validating client's experiences of the benefits of the substance use that they reported, and in some instances experiencing and witnessing these benefits for themselves, formed a key aspect of the psychological work. The study found examples of how this view can trigger conflicting ideas within the clinical psychologist i.e. as a healthcare professional not wanting to be seen to endorse or condone the use of substances. These examples highlight the role clinical psychologists can have in maintaining existing dominant narratives around substance use being largely viewed as 'problematic', which can subsequently limit alternative discourses around the potential benefits and usefulness of substance use for some individuals.

Permissibility of substances – The study found that views of how permissible substances are considered to be could vary significantly among clinical psychologists. This is reflective of the literature which highlights how legal drugs are seen to be embedded within western capitalism and while there is greater acceptability in the use of certain substances i.e. alcohol, cigarettes, caffeine, the same cannot be said for all substances (Evans et al. 2001; Gianetti et al. 2002; Fraser et al. 2017). The study found examples of clinical psychologists and services using 'spectrums' of substance use and that some substances and uses were deemed to be more permissible than others. The study revealed the ambiguous nature of what clinical psychologists and services consider being 'acceptable' or 'workable' when considering how appropriate

someone may be for psychological treatment. This suggests that clients seeking support for both mental health and substance use needs can face a healthcare 'lottery' in how each substance is viewed in terms of its 'permissibility' and how 'problematic' the use of the substance is for the client, clinical psychologist and the service.

The study found that the majority of participants held positive views on treatment interventions for substance use and how this in turn, could benefit a person wanting to access psychological treatments, but there were mixed views as to whether specialist services were better placed to address this need in the first instance.   This is supported by Pinikahana's (2002) research in which mental health professionals reported disagreement on statements about the permissiveness of drug and alcohol issues. In the current study, several participants suggested that in order to benefit from psychological treatment, the person would be advised to address the substance use need first. This supports research, which has posited that how one difficulty is conceptualised can influence the course and treatment of the other (Evans & Sullivan, 2001). This study highlighted how the concept of how 'permissible' a substance is viewed as, can play an important role in how co-existing difficulties can be conceptualised by clinical psychologists. The study also found that this could have further implications for how, and where someone is able to access psychology.

Role and Remits

The expert role – The study highlighted a consensus view that there is a role for clinical psychologists in supporting individuals who present with co-existing mental health and substance use needs in non-specialist settings. The study illustrated ways in which clinical psychologists believed that they are in fact, well placed to provide psychosocial interventions for this client group. Findings also highlighted participants' views that clinical psychologists training in a range of psychological models can make valuable contributions to the comprehensive and coherent understanding of an individual's needs.

Johnstone (2018) proposed formulation as the core skill of the psychology profession and the current study found a number of examples in which psychological formulation of a person's difficulties was considered to be a somewhat unique contribution of psychology in this area. These psychologically informed summaries of a person's difficulties have also been seen as having considerable influence over subsequent decisions around prioritising issues and problems, selecting and planning of interventions (DCP, 2011). Redhead and Colleagues (2014) reported that this can be experienced by the client as increasing understanding and trust between the individual and clinician.   Conversely, they also noted how clients can experience formulation as imposing a view with which they disagree and may ultimately serve to guide where or where not the person received support (Johnstone, 2013a).

As previously stated, the study found that participants did not feel that they necessarily perceived themselves to have sufficient expertise, knowledge and skills within the area of substance use. While participants may have seen their formulation skills as a unique contribution to the field, this could in turn lead to a bias in how an individual's difficulties are conceptualised if clinical psychologists do not see themselves as part of the solution to the difficulties presented.

When to refer - The study found most participants believed substance use needs were more likely to be better met within specialist services. This supports McLaughlin et al's (2006) study, which found health professionals to be of the opinion that the care for this client group should be undertaken by specialist services. McLaughlin's study went on to conclude that most of the health and social care professionals that took part in the study appeared '*unprepared and unwilling to meet the challenge of caring for illicit drug users'*. Peckover and Childlaw (2007) similarly suggest that clients who misuse substances can be subject to a reductionist approach in their health care provision. Current clinical guidelines recommend that existing services should seek to adapt to meet clients co-existing needs (NICE, 2011).

The current study highlighted a number of participants who did not consider themselves to be in the position to offer psychological support to people who presented with co-occurring substance use needs. Participants did however report that individuals presenting with co-existing needs are likely to benefit from psychological input, but that any substance use should be addressed first to ensure that they are able to benefit from psychological input. Findings suggest that a lack of training, knowledge and 'expertise' could mean there is a low threshold that clinical psychologists feel able to work with within their roles, and even at the point of referral and initial assessment, clinical psychologists can feel 'out of their depth' and look to specialist services to deliver treatment.

This theme highlights how a lack of knowledge and training on substance use in clinical psychologists can mean clients presenting with these difficulties can be swiftly moved through and out of services that do not see themselves as 'substance use' services. This study indicates that increased training opportunities and support within services for clinical psychologists to work with this client group could improve access to psychology and promote an increased willingness to take up the challenge of working with both mental health and substance use needs.

4.3 Implications

This study sought to explore clinical psychologist's attitudes and perspectives towards working with individuals who are living with mental health and substance use needs within non-specialist services.   Clinical, service and research implications of the study's finding for clinical psychology are discussed below.

4.3.1 Personal and Professional Self

The study found how a lack of focus and teaching on substance use issues within professional training courses has contributed to some clinical psychologists perceived lack of competence in working with clients who present with these co-occurring needs. Furthermore, a lack of focus or consideration of the psychological needs of these clients within training courses could influence how clinical psychologists see their role and value in working with this client group. This not only impacts on the clinical psychologist's sense of the professional self when faced with substance use needs within their clinical practice, but can subsequently impact on individuals' access to psychological treatments. The study found that the majority of participants would have appreciated greater amounts of teaching on their training courses around this issue, as substance use issues are something they had all experienced at some point in their careers. These findings suggest that professional training courses should review the existing curricula around substance use and psychology, and look towards including a requirement for trainee clinical psychologists to evidence experience and competency in working with substance use needs. This could bring greater focus to the role and implications for clinical psychologists working with individuals with co-existing needs could promote greater engagement with clinical psychologists upon qualification. Greater engagement with this area of health could also enhance familiarity with substance use issues, which has been associated with more positive attitudes among healthcare professionals and can further self-efficacy of clinical psychologists in working with these clients (Brener et al. 2007; Ding et al, 2005).

4.3.2 Organisation, Systems and Services

The study highlighted a number of challenges substance use issues can present for non-specialist services. Services designed to support individuals with mental health needs may not see substance use as a need they are designed or indeed feel able to address, and the study found examples of how service outcome measures can reflect this. The study found that while outcome measures could be a valuable tool for services that are facing increasing

pressure to demonstrate clinical effectiveness and good practice, they can also disadvantage clients with co-existing substance use needs by limiting access to psychological services. The study highlighted a number of examples where clients accessing psychological services who were identified as having a substance use need deemed to be outside of the non specialist service care remit, were subsequently referred on to specialist services to address this need in the first instance. The study did not find examples of clients referred to specialist services to address substance use issues in the first instance, re-entering services to access the psychological input they had originally sought.

As science practitioners, clinical psychologists could play a key role in reviewing the suitability and inclusivity of outcome and evaluation measures currently used within non-specialist services. In addition to this, identifying substance use as an issue for individuals who are accessing non-specialist services for psychological support presents an opportunity for services to review how existing care provision is meeting these needs and identify ways in which clinical psychologists can be supported to work with these individuals within 'non-specialist' services.

4.3.3 Willingness to Treat: A need for congruency

The findings illustrated disparate views between and within psychology services as to roles and remits of clinical psychologists in substance use issues outside of specialist services. A key implication is that mental health services and substance use services can view each other as the service best placed to address the individuals needs, which can give rise to a disconnect between services, potentially limiting access to treatment from either service. Clarifying clinical psychologist roles and remits in collaboration with local substance use services could help to identify and close any service 'gaps' where a client could find themselves not fitting either service. Increased collaboration between clinical psychologists and substance use services could also provide more opportunities to share skills and knowledge of mental health and substance use, enhancing clinical competence, which could serve to motivate clinical

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psychologists to take up the opportunities and enhance a willingness to work with this client group.

At the time of writing, this was the first qualitative study which sought to explore clinical psychologists' experiences and perspectives of working with individuals who present with co-occurring mental health and substance use needs.

Existing research has previously explored and compared healthcare professionals regard towards working with individuals with co existing needs more broadly. This study provided a unique opportunity to advance our current understanding of clinical psychologists more specifically, in this under researched area using a qualitative design.

While existing research has established clear associations between substance use and mental health, this study further highlighted how clinical psychologists are likely to face addiction in their clinical work across a diverse range of populations and non-specialist services. Despite the high likelihood of clinical psychologists encountering co-existing needs of clients, this study revealed how a paucity of teaching and training around substance use needs for clinical psychologists may have a significant impact on how clinical psychologists perceive their clinical competence in this area. This study revealed how this may further impact of clinical psychologists willingness to work with this population and ultimately, individuals access to psychological treatments.

4.3.4 Limitations

The paucity of research on the perspectives and attitudes of clinical psychologists in working with co existing needs has proved challenging when drawing comparisons with previous studies.

This research relied on verbal communication for the purpose of the study interviews. While attempts were made to ensure all participants were put at ease during the course of the interviews, there may have been some implications for the data obtained using a face-to-face approach to explore areas of participant's practice which they may have felt less confident in. I was conscious of how participants might have experienced being interviewed about an area of their practice that they may not have felt to be their most 'competent' area by a trainee in the same profession. A mixed method approach, which uses written/online questionnaires that do not rely on face-to-face contact, may have yielded different responses and further enriched the data.

While the inclusion criteria for participants was kept broad to reflect the range of populations and diverse settings that clinical psychologists work within, a larger sample or a focus on a particular setting could highlight any existing nuances of the experiences of clinical psychologists specific to the clinical setting /context. On reflection, it may also have been helpful to have additional information on participants with regards to the number of years post qualification.

Finally, while this study benefited from the flexibility that thematic analysis offers I was mindful of how this flexibility can also lead to inconsistencies when developing themes. Furthermore, a notable limitation of this approach when compared to other methods is that it does not allow the researcher to make claims about language use (Braun and Clarke, 2006).

4.3.5 Future Research

This research found that all participants felt that they lacked adequate knowledge, skills and experience in working with co-existing mental health and substance use needs. This supported research by the BPS (2014), which found substance use teaching and specialist placements to be scarce among professional training programmes. Future research examining teaching on

mental health and co-existing substance use issues could help to identify ways to address this neglected area of teaching within professional training programmes. It could also be helpful to evaluate any impact increased teaching on substance use and the role psychology may have on clinical psychologists' sense of competency and whether this results in more clinical psychologists working with individuals who present with these needs in non-specialist services.

This research involved clinical psychologists from a range of health settings including, adult mental health, early interventions for psychosis and clinical health. Increased attention to the needs of individuals with co-occurring needs and the use of psychological approaches in specific areas of health could highlight nuances of the experiences of both clients and clinical psychologists in different health settings.

4.4 Critical Evaluation

This research was evaluated using a set of quality criteria, which draws on Guba and Lincoln's (1981) principles of trustworthiness and credibility.

4.4.1 Credibility

Credibility refers to how 'truthful' or valid interview data is and how well it represents participants' experiences. While I undertook all data analysis, given the importance of this point, research supervisors were consulted after data collection, which served to strengthen the analysis and ensure integrity of any analytic interpretations. Subsequently, I have endeavoured to promote the credibility of this research through grounding the analysis in the substantial and multiple data extracts and linking it to relevant literature to demonstrate analytic interpretations.

4.4.2 Transferability

Transferability refers to the degree to which data can be extrapolated to other contexts or settings. This research sought to explore clinical psychologist's experiences and perspectives of working with individuals who present with co-occurring mental health and substance use needs. While the focus of the study was that of the clinical psychologists' experiences and perspective, participants interviewed worked across a range of health service settings including adult mental health, oncology, pain, early interventions and young adults and interview questions and subsequent analyses were found to translate well across these different contexts and addresses the much wider and diverse concept of the role of psychology in co-occurring mental health and substance use needs.

4.4.3 Dependability

Bitcsch (2005) referred to dependability as the 'stability of findings over time' and recommended researchers undertake an 'audit trail' at each stage of the research process to ensure transparency. Reasons as to how and why decisions were made at each stage of the research process were documented throughout and are captured in the methodology chapter (see chapter 2), which also details analytic steps that were taken. I have also included annotated extracts of raw data and thematic maps to demonstrate the development of themes and promote transparency of the research path (Appendix E and F).

4.4.4 Confirmability

Confirmability refers to the degree to which research findings could be confirmed by other researchers and concerns the aspect of neutrality (Lincoln & Guba, 1985). To ensure that analytic interpretation remained grounded in the data and not influenced by my own experiences and viewpoints it has been important to consider what I might bring to the research context. Throughout the research process I discussed my developing analysis and subsequent

findings with my supervisors and these discussions helped me to reflect on the ways in which my own experiences and perspective could influence the analytic processes and findings. I discuss this in greater detail later in this chapter (see sec 4.4.8).

4.4.5 Transparency

Transparency refers to how 'visible' the study's methodological components are and how easily could someone replicate what the researcher has done. I have endeavoured to demonstrate transparency throughout the research process, including the initial ethical application and approval (appendix C), detailing methodology and analytic steps taken in Chapter 2, including the interview schedule (appendix B) and extracts of annotated raw data (appendix E) and presenting research findings and linking it to relevant literature to demonstrate analytic interpretations.

4.4.6 Triangulation

Triangulation aims to enhance the process of qualitative research by using different data sources, investigators and methods of data collection (Lincoln & Guba, 1985). While I did not ask any other researchers to analyse the data, I did consult with my supervisors throughout the research process, sharing extracts of the data, discussed the analytical steps I worked through and interpretation decisions. While the data collection method for all participants was obtained by semi-structured interviews, participants worked across a range of settings enhancing triangulation of the data.

4.4.7 Iterative Process

Iterative process refers to revisiting data throughout collection and analysis concurrently, as a means to continually engage with emerging insights and themes, which can be used to refine focus and lines of inquiry throughout data analysis. During data collection, consultation with my supervisors provided a space to reflect and revisit aspects of the interview process to ensure that any

new lines of inquiry were incorporated in future interviews, creating space for greater breadth and depth of discussions.

4.4.8 Reflexivity

Reflexivity is the process, which encourages the critical self-reflection of the researcher in order to maintain objectivity and to transcend the differences that may exist in terms of culture, power or class (Grbich, 1999).

This research was influenced by my prior experience of both working in addiction services as an assistant psychologist and my current status of trainee clinical psychologist. Working within addiction services was a positive experience for me, I enjoyed working with people who used substances and both witnessed and felt a part of a service that sought to improve the care and support for this vulnerable group. While in this role I also witnessed and experienced for myself some of the challenges individuals who use substances and the professional who work with them can experience when seeking psychological input. My later roles within mental health services meant I gained experience of the 'other side', working within mental health services with long waiting lists, witnessing clinical psychologists concerns of 'coping' with additional complexities in patients in already under resourced services when individuals with co-existing needs were referred to the service.

While I shared my observations and experiences within services that I went on to work in, and was at times allocated patients with substance use needs because of my experience and background in addictions, I felt I lacked the skills and confidence to make any significant difference. With this in mind I have tried to remain conscious of the assumptions that I bring with me to this research.

I have tried to remain conscious throughout this process of my position, that of a trainee clinical psychologist undertaking research as part of this doctorate which could potentially influence future practice. Throughout the recruitment and interview process I reflected on my position as a final year trainee clinical psychologist and researcher. I considered how participants might have experienced being interviewed about an area of their practice that they may not have felt to be their most 'competent' area by a trainee in the same profession. One participant commented at the end of the interview that they had felt 'nervous' and joked about how clinical psychologists aren't normally the ones in the 'hot seat'. I made an effort to try and ensure participants did not feel pressured in anyway to talk to me and reiterated that interviews could stop at any point in the process. While I tried to situate myself firmly in a researcher role, participants were also aware that the research formed part of my doctoral training which they had themselves been through and I may have been viewed more as a peer, which may have influenced how comfortable they felt in being able to talk about their own practice.

During the analysis I was mindful of my own assumptions that clinical psychologists who work in non-specialist settings, would find working with individuals with co-existing substance use needs challenging and that they may feel less confident in this work, compared to when substance use is not identified. I identified this as a potential challenge from the outset of this research and, therefore, drew on supervision throughout, to carefully review and reflect on my own experiences, preferences and perspectives in view of the research process. In addition to supervision, I also found it helpful to continuously revisit the data and used mind maps to help me to look for alternative perspectives.

This research has proved to be a valuable learning experience. Listening to clinical psychologist's experiences and perspectives of working with individuals with substance use has helped me to appreciate their needs. This process has helped me to develop my research skills but has also prompted be to think

about my own future role as a clinical psychologist and the varied demands this role can bring. I hope to take what I have learnt to consider the different needs of colleagues, services and clients when working with co-occurring substance use needs.

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Chapter 6: APPENDICES

Appendix A: Participant Information Sheet

PARTICIPANT INVITATION LETTER

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Who am I?

I am a Post Graduate student in the School of Psychology at the University of East London and am studying for a Professional Doctorate in Clinical Psychology. As part of my studies I am conducting the research you are being invited to participate in.

What is the research?

I am conducting research into Psychologists' attitudes and perspectives towards working with individuals who use substance.

The School of Psychology Research Ethics Committee has approved my research. This means that my research follows the standard of research ethics set by the British Psychological Society.

Why have you been asked to participate?

You have been invited to participate in my research as someone who fits the kind of people I am looking for to help me explore my research topic. I am looking to interview Psychologists currently working within Mental Health Services.

I emphasise that I am not looking for 'experts' on the topic I am studying. You will not be judged or personally analysed in any way and you will be treated with respect.

You are quite free to decide whether or not to participate and should not feel coerced.

What will your participation involve?

If you agree to participate you will be asked to meet with the researcher and engage with a number of questions related to working with individuals who use substances e.g. '*what do you see as psychology's role when working with individuals with coexisting mental health and substance use difficulties?*'

Interviews will be conducted at a mutually convenient time and location for you and the researcher. Telephone/video calls may also be used where required. Interviews will be audio recorded and last approximately 60 minutes.

I will not be able to pay you for participating in my research but your participation would be very valuable in helping to develop knowledge and understanding of my research topic

Your taking part will be safe and confidential

Your privacy and safety will be respected at all times.

Interviews will be recorded on a digital recording device and password protected. Information will be stored securely for the period of time necessary for transcription and destroyed thereafter.

Participants will not be identified by the data collected, on any written material resulting from the data collected, or in any write up of the research.

Participants do not have to answer all questions asked of them and can stop their participation at any time.

What will happen to the information that you provide?

All the information you provide for the purposes of the study will be anonymised and stored securely on password protected devices.

The results obtained from the research will be incorporated into a doctoral thesis that will be submitted to the university of East London.

The thesis may be published in an academic journal in the future, however any identifiable data about you will not be included in any report or publication.

What if you want to withdraw?

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. However, if you withdraw I would reserve the right to use material that you provide up until the point of my analysis of the data.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Hannah Rose u1622897@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Dr John Turner, School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: j.j.d.turner@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: m.finn@uel.ac.uk)

Appendix B: Interview Schedule

Interview Schedule

The following provides a guide to the areas to be covered within the semi structured interview. This will be partly guided by the participant's responses and prompts may be used, as outlined.

Introduction

- Review consent, confidentiality and right to withdraw procedures.

Interview Questions

- What is your current role?
- Do you currently work with individuals who have both mental health and substance use/misuse needs?
- What has been your experience working with individuals with mental health and substance use needs?
- Are there difficulties when working with these individual's?
- How does this compare to working with individuals who do not use/misuse substances?
- What have been your experiences of barriers to psychological treatment for these individuals?
- What do you see as psychology's role when working with mental health and coexisting substance use/misuse?
- How could psychology build its role in this work?

Debrief

- Questions
- Transcript (is the participant happy for the interview to be fully transcribed? Any part they would like to be omitted?
- Issue contact details

Prompts

- Could you say a bit more about that?
- Could you tell me more?
- What do you mean?
- What was that like for you?
- How do you feel about that?
- How does that make you feel?
- Could you give an example?

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION
For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

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REVIEWER: Laura Mcgrath

SUPERVISOR: **John Turner**

STUDENT: Hannah Rose

Course: Professional Doctorate in Clinical Psychology

Title of proposed study: Psychological Treatment for Individuals with Co-Occurring Mental Health and Substance Misuse Needs: A Qualitative Study From the Psychologists Perspective

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application

will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY

(Please indicate the decision according to one of the 3 options above)

APPROVED with MINOR

Minor amendments required *(for reviewer)*:

Best practice to provide some options for support to all participants, not make this dependent on contacting the researcher. Distress is unlikely but would recommend a short debrief to give out to participants thanking them for participation, re-providing contact details, and providing some recommendations for support. As it's a professional group, maybe find a professional support network rather than a full on mental health one, eg Samaritans.

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *Hannah Rose*

Student number: U1822897

Date: 14/10/2018

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES / NO

Please request resubmission with an adequate risk assessment

If the proposed research could expose the <u>researcher</u> to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐   HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐   MEDIUM (Please approve but with appropriate recommendations)

☐   **LOW X**

Reviewer comments in relation to researcher risk (if any).

Reviewer *(Typed name to act as signature)*: Laura McGrath

Date: 13/3/2018

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE:

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

Appendix D: Participant Consent Form

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

Psychological Treatment for Individuals with Co-Occurring Mental Health and Substance Misuse Needs: A Qualitative Study From the Psychologist's Perspective

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study that has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data after analysis of the data has begun.

Participant's Name (BLOCK CAPITALS)

……………………………………………………………………………………

Participant's Signature

…………………………………………………………………………………..

Researcher's Name (BLOCK CAPITALS)

…………………………………………………………………………………..

Researcher's Signature

……………………………………………………………………………………

Date: …………………..………

What has been your experience of working with individuals who have

both mental health and substance use needs?

There's always this kind of chicken and egg type debate you know, what..

what is causing what really...um.. so there's often a narrative around

people self-medicating to a certain extent and I think you know are they

using substances for that reason and therefore it's kind of um.. so is it

covering up someone's psychological or emotional needs that could be

potentially worked on or is it. or is it you know that it is really

exacerbating their problems because of it and maybe they need to stop

using the stuff um... before that we can do that kind of psychological

work. I guess I've come across those standpoints really.. In terms of

other psychologists and things that I've worked with.. So I think in a

traditional psychotherapy service there's been a lot of emphasis on erm..

People not using substances before they start therapy and that's actually

probably not realistic in my job in terms of the people that I work with so

um.. I probably have a slightly different threshold um.. in terms of taking

people on and their substance use really.. but I do have to put some kind

of ground rules in, in the sense of you know ...um.. saying that people

can't be intoxicated during the sessions .. um.. so they've got to come

sort of clean.

And I guess you know ... there have been issues where using is becoming

a certain level which is just not, we're just not able to do stuff then you

know.. and I've had to stop. so with certain people you know postpone

working with people um.. because of that really.

Appendix F: Examples of Thematic Maps

Professional and Personal Perspective

- Psychology often sees more 'complex' cases
- Low expectation of self /impact of work
- Challenge to 'Competent practitioner' role

Professional and Personal Self

Development of a risk lens

- Perceived 'dangerousness' of substances/people who use them
- Negative narratives around sub use i.e. poor attenders, difficult to engage, unreliable
- Moralised behaviour

Confidence and Legitimacy

- Low confidence/self doubt
- Limited substance use training pre/post qualification
- Viewed/positioned as the 'expert' by other professions/clients

Outcome Drivers

- Increasing pressure/demand to evidence clinical effectiveness
- Measures/models, preference for clear/demonstrateable outcomes
- Limits range/scope of psychological approaches, which could be better suited?

Organisations, Systems and Services

Medication Paradox

- Medical model – limitations of medical model, prescribing, detox
- Role of medical model in substance use prescribing how to challenge, fear of rupturing professional relationships

Social/Ethical responsibilities

- 'Off loading' to other service
- Services/professionals seeing each other as being best placed to treat
- Reduction in services –being asked to widen net of who they will treat

Defining the Issues

- What is deemed to be 'problematic' substance use, who is it a problem for?
- Acknowledging substance may have beneficial factor for SU, how to hold this in mind within a service/society that discourages sub use
- Not wanting to be seen to endorse use of substances – social/professional desirability

Willingness to Treat

Roles and Remits

- Substance use identified, viewed as 'complex'/outside of service inclusion criteria/professional remit
- Referred to different service/professional. Develops coping skills - No longer deemed 'complex' or warrants psychological input Discharged/added to waiting lists
- Psychological needs unmet
- Relapse/sub use/MH - Complexities increase
- Referred to psychology
- Cycle repeats