Navigating the chaos: A grounded theory study of seeking psychological therapy amongst people who use alcohol

Madeleine Wickers

A thesis submitted for the Professional Doctorate in Clinical Psychology

School of Health and Social Care

University of Essex

April 2025

Acknowledgements

This study was made possible by the participants who shared their stories. Thank you for allowing me to see the unfiltered and nuanced experiences of living with both mental health difficulties and addiction. I would like to thank each of you for your openness, candour and courage to speak about the challenges you have faced. I would also like to thank the organisations that supported me with recruiting for interviews and taking a chance on this project in the first place. I hope that the dissemination of this study can have some impact on the provision of psychological support for your service users.

I would like to thank my supervisor, Dr John Day, for your continuous enthusiasm for the study over the past two years; your encouragement and academic support has been invaluable to me.

To my former line manager Graeme Hodgkinson during the drug and alcohol service days - thank you for tolerating my never-ending questions about 'the sector' and your detailed explanations of all things policy-related.

Lastly, thank you to my partner Matt, for your unwavering patience throughout this process and your willingness to lend a listening ear when I have needed it most.

Contents

Abstract

Background: People who use alcohol (PWUA) experience a higher rate of psychological problems including depression, anxiety and post-traumatic stress disorder (PTSD). Despite clinical recommendations for psychological therapy as first-line treatment, psychological support for PWUA in the United Kingdom (UK) remains fragmented and inconsistent. Provision is often split between specialist community substance use services and National Health Service (NHS) mental health services. Broader research into the UK healthcare system has shown PWUA struggle to access appropriate services for support with both general health and alcohol addiction. More specific research into PWUA's experience of pathways into psychological therapy is limited.

Aim: This study addresses this gap in the literature and explores the experiences of attempts to access psychological therapies from the perspective of PWUA.

Method: 15 PWUA were recruited mainly from community substance use services and addiction support groups across South East England. Semi-structured interviews were conducted with participants who identified as trying to negotiate both alcohol addiction and a mental health problem. A Constructivist Grounded Theory approach guided the data collection and analysis with a focus on the principles of constant comparison.

Findings: A theoretical model was constructed, integrating the themes of chaos, negative self-image, embodied experiences such as relapse, and an increasing sense of self-reliance. The process by which PWUA remain stuck in a chaotic system, as well as the alternative pathways sought out of chaos, are presented in the model.

Conclusion: This study draws attention to the difficulties PWUA experience when attempting to navigate routes into mental health treatment as well as the need for integrated, consistent and accommodating pathways to support chronically excluded PWUA into appropriate psychological treatment. Findings are discussed in relation to existing research; implications for clinical practice are considered, especially regarding the provision of NHS services as opposed to third sector organisations.

Chapter One: Introduction

1.1 Chapter overview

This study examines the experiences of people who use alcohol (PWUA) as they navigate the psychological treatment pathway in an attempt to access talking therapy. Chapter One first provides an overview of the relationship between alcohol use and mental health issues. It then describes the complex and often contested definitions of both addiction and recovery, giving a brief history of the differing schools of thought and competing conceptualisations of addiction. The chapter then explores the segregation of mental health and addiction services within a UK healthcare policy context. More specifically, it presents the impact that this has had on treatment options for those struggling with substance use issues, and in particular alcohol addiction. Recent changes to NHS Talking Therapies (previously known as Improving Access to Psychological Therapies [IAPT]) in the context of inclusion and exclusion criteria for PWUA are considered. A review of the current literature is then provided, in the form of a meta-ethnography. The chapter concludes with a presentation of both the rationale and aims of the study.

1.2 Alcohol and health

Alcohol addiction accounts for approximately 5.3% of the global burden of disease and three million deaths each year worldwide (World Health Organisation [WHO], 2022). The Office for National Statistics (ONS, 2025) reported that alcohol-related deaths in the UK were at a record high in 2023 with 10,473 reportedly due to heavy drinking. The co-occurrence of both alcohol addiction and psychological problems is well-established within

the literature. In the UK, 71% of PWUA were reported to have a mental health need in 2023 (Office for Health Improvement & Disparities, [OHID] 2023a). Research has also shown alcohol addiction is strongly associated with higher rates of both anxiety and depression (Lai et al., 2015; Puddephatt et al., 2022).

More specifically, a causal relationship between increased alcohol use and the development of mental health issues such as anxiety, depression and PTSD has been documented (Connery et al., 2020; Debell et al., 2014; Jané-Llopis & Matytsina, 2006; Klanecky et al., 2016; WHO, 2022). Conversely, psychological problems and exposure to traumatic life events, especially those occurring in childhood, are now recognised to increase the likelihood of developing an alcohol addiction, including physical dependency (Ford et al., 2007; Khoury et al., 2010; ; Maté, 2018; Moustafa et al., 2021). Recently, the Dame Carol Black independent review of drugs in England reported that trauma and mental ill-health are the "drivers and accompaniment of much addiction" (Black, 2021).

The term "dual diagnoses", referring to the presence of both a substance use disorder and psychological illness, is now well-established in the literature (Guest & Holland, 2011; Hall & Farrell, 1997). In a UK healthcare context, this term only refers to those with a diagnosed serious mental illness (SMI). The term has been criticised as problematic and even pejorative, with critics arguing that addiction and mental health issues should instead be viewed as "co-occurring conditions", "co-existing difficulties" (Guest & Holland, 2011) rather than "separate problems for a 'dual diagnosis'" (Black, 2021). Furthermore, the term does not account for those with undiagnosed or common mental disorders (CMDs), defined by the Department of Health and Social Care as psychological problems such as anxiety, depression and phobias (DHSC, 2020).

1.3 The history and conceptualisation of addiction and recovery

1.3.1 Addiction

The concept of addiction remains notoriously elusive, with attempts at definitions often failing to grasp the complexity and richness of the process (Albanese & Shaffer, 2012; Fisher, 2022; Shaffer, 1997; Shaffer 1999; Shaffer & Albanese, 2005; Weegman, 2017). Throughout history, addiction has been conceptualised under two competing frameworks: the disease versus the morality model (Frank & Nagel, 2017; Pickard, 2020). Prior to the early twentieth century, the term addiction related to an admirable sense of passion, from the Latin to *assign to*, rather than a pathological disorder (Maté, 2018). The now-dominant disease, or neurobiological, model emerged over the twentieth century, with roots in the birth of Alcoholics Anonymous (AA) in the 1930s (Morris et al., 2023a). Addiction is understood as a "chronic, relapsing neurobiological disease characterised by compulsive use despite negative consequences" (National Institute of Drug Abuse [NIDA], 2020; Pickard, 2020, p. 37). The brain is thus "hijacked" by substances that enhance surges of dopamine through neurotransmitters, creating an artificially increased sense of pleasure, activating the brain's reward processing system and alleviating negative emotional states such as anxiety, stress and emotional pain (National Institute of Alcohol Abuse and Alcoholism [NIAAA], 2023). In this way, compulsion overrules choice, with addicted individuals continuing to ingest substances despite no longer deriving pleasure from use.

The neurobiological model helped to counter the previously dominant morality model of addiction whereby individuals are seen to have a choice whether or not to be addicted, and

those who engage in substance (mis)use viewed to lack willpower and self-control (Frank & Nagel, 2017; Pickard, 2020). Neurobiological models, therefore, were understood to de-moralise addiction (Frank & Nagel, 2017) and remain prominent globally, considering NIDA's (2020) statement of addiction as a "brain disorder". For some, the neurobiological model reduces stigma by allowing the individual to believe they are victim to a disease. For 12 Step recovery programmes such as AA, the outsourcing of the causes of addiction allows individuals to hand over responsibility to a higher power (AA, 2001). It has since been argued, however, that the neurobiological model may in fact reinforce questions of morality rather than reduce them, considering that disease itself is stigmatised and difficult to rid oneself of (Frank & Nagel, 2017). Viewing addiction in an isolated biological form under the dominant disease model could lead to pessimism and a sense of hopelessness – substance users may consider themselves passive victims of a disease outside of their control. Addiction becomes viewed as something to be "got rid of" rather than something to be "worked with" (Fisher, 2022).

Neurobiological models are also criticised for their reductionist nature, notwithstanding questions relating to why some people become addicted while others do not (Fisher, 2022; Frank & Nagel, 2017; Maté, 2018). While all addictions have a biological dimension, given the altered physiological state in the brain, there are myriad complex factors involved which tend to be overlooked (Maté, 2018; Teesson et al., 2011). Towards the latter half of the twentieth century, there was a rise in psychological theories of addiction, including behavioural models, for example, as well as studies relating to individual differences including the "addictive personality" (Teesson et al., 2011). More recently, socio-cultural explanations, such as environmental factors which make addiction more likely, have been explored (Fisher, 2022; Maté, 2018; Teesson et al., 2011). The more recent backlash to the

disease model has started to reframe the individualised moral burden of addiction into something of a complex interaction between human beings and their social and political environments (Maté, 2018). Links between environmental impacts of early years trauma on brain development and the subsequent likelihood of developing an addiction have been well-researched, with traumatic childhood experiences now understood to impact on key biological functions of the brain (Fisher, 2022, Maté, 2018).

1.3.1.1 Diagnostic criteria: alcohol use disorder (AUD)

Clinically diagnosing addiction remains equally contested. Addiction itself is rarely defined, but terms such as abuse, dependence and disorder have been used interchangeably over time (Rosenthal & Faris, 2019). The 11th Edition International Classification of Diseases (ICD-11) uses the umbrella term "disorders due to use of alcohol" (WHO, 2022). Within this category, there are differentiations between varying degrees of alcohol use. "Harmful use" is defined as "a pattern of alcohol use that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others" (WHO, 2022). In the UK, the National Institute for Health and Care Excellence (NICE) uses the terms "alcohol misuse" and "alcohol use disorder" (AUD) interchangeably, covering a spectrum of varying severity from harmful to dependent drinking (NICE, 2014). In comparison, the 5th Edition Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association [APA], 2013) only relatively recently combined the previously separate terms "abuse" and "dependence" into a spectrum of AUD in 2013 (Rosenthal & Faris, 2019), defining AUD as "a problematic pattern of alcohol use leading to clinically significant impairment or distress". The DSM-5 definition uses 11 criteria grouped into four primary categories: physical dependence, risky use, social problems, and impaired control. Diagnoses

range from mild (meeting two to three criteria), moderate (four to five criteria), or severe (six to eleven criteria) (APA, 2013).

The diagnostic category of AUD has also been criticised as one which overlooks the "complex and heterogeneous nature of alcohol problems" (Morris et al., 2023a). Public versus professional narratives relating to AUD also tend to differ greatly, with public conceptions continually embedded in the stigmatising and othering notions of "alcoholism" and "disorder", favouring reductionism under the umbrella of a clinical "disease model" narrative, which has dominated discourse over the twentieth century and heavily burdens the individual as biologically problematic (Morris et al., 2023a).

1.3.1.2 Terminology used in the current study

Considering the complexity associated with the concept, definition and diagnosis of addiction, the current study employs the term "people who use alcohol" which is recommended by the Society for the Study of Addiction (SSA) (2022) as appropriate "person-first" terminology to refer to alcohol addiction whilst avoiding stigmatising language in research. Whilst of course the majority of people who consume alcohol would not identify themselves as having an addiction, the current study intends the term PWUA to describe those who self-identify as having an "addiction" to alcohol or consume alcohol in a "harmful" or "problematic" way, rather than "general population" level drinkers. The term PWUA also accounts for the many participants and readers who may be unlikely to have clinically-diagnosed AUD, but nonetheless self-identify as having "problematic" or "harmful" alcohol use, as defined by the individual themselves. Therefore, PWUA as a term accommodates an individual's self-identification in terms of addiction, whilst acknowledging

that alcohol use – in terms of the presence of an addiction or AUD - is difficult to define solely through presence or absence of diagnostic criteria.

This is in line with the current movement towards understanding addiction as broad and deeply heterogeneous, rather than existing upon a single continuum of biological disease, representing a person's entire identity (Maté, 2018; Morris et al., 2023a). The term PWUA also aims to avoid the stigmatising and reductionist notions of "alcoholic" or "addict". The use of acronyms has also been deemed stigmatising in some literature (SSA, 2022). While the current study acknowledges and agrees with this perspective, it is required to adhere to a restrictive word limit. It therefore continues to use the acronym PWUA for practical purposes.

1.3.2 Recovery

Like addiction, recovery is conceptually blurry and difficult to define, especially considering the natural ebbs and flows that occur during its process (Davidson & White, 2007; El-Guebaly, 2012; White, 2007). A systematic review of the literature on the concept of recovery demonstrates the contested nature of the term, with various bodies producing and re-producing loose definitions (El-Guebaly, 2012). The UK Clinical Guidelines for Alcohol Treatment (OHID, 2023) define recovery as "a process of building up positive benefits that can help the person to sustain abstinence (or moderate drinking where appropriate) and to develop broader wellbeing and a life that is meaningful to them". Alternatively, APA (2018) defines recovery as "a state of ongoing sobriety following long-term substance abuse" which has been criticised for overlooking the chronic (but expected) cycles of relapse and re-entry into treatment and recovery which can last for decades, if not life (El-Guebaly, 2012).

Recovery as simply “sober” alludes to a status of “fixed”, “healed” and “cured” which are common terms within 12 Step approaches, supporting PWUA towards total sobriety and the notion of becoming a “better person” (El-Guebaly, 2012). Such ideas are problematic in themselves and can in fact further stigmatise the already denigrated addicted person within society. Within the field of healthcare, even the “fully recovered” person holds marginalised status when compared to other biomedical fields such as “cancer survivor” (El-Guebaly, 2012). Furthermore, non-abstinent recovery stories, especially those of lived experience, are rare in the field of addiction (Morris et al., 2023a). Fisher (2022) also argues that abstinence should not be the sole goal of treatment, describing addiction as “profoundly ordinary: a way of being with the pleasures and pains of life, and just one manifestation of the central human task of working with suffering” (p. 300). Neale et al. (2015) explored service users’ views of recovery measures in UK treatment providers, finding weaknesses in views of recovery as “cure” and preferences for recovery to speak to notions of “coping”.

In the UK, the heavy impact of social, cultural and economic factors on the root causes of addiction (such as poverty and trauma) contrast starkly with the provision of care when it comes to supporting those with addictions– such as adequate rehabilitation and detoxification programmes (Sebatindira, 2023). It is argued that soberness and recovery are a way of fitting into a capitalist norm, ensuring all individuals contribute to and function productively within society. Sebatindira (2023) suggests that society’s reluctance to provide support to somebody who is not yet sober or “recovered”, or even somebody who is still “committed to failure” in the eyes of the state demonstrates that supporting those with addictions is still a radical concept. As it stands, provision of addiction treatment and decisions over who has access to help speaks volumes as to society’s views on who is, or is

not, worthy of treatment (Sebatindira, 2023). Arguably, this is an example of the heavy burden of morality that is laid upon recovery being the desired end goal and one which all people with addictions should be aiming for.

1.4 Addiction and mental health services: The UK healthcare context

1.4.1 Addiction treatment in the UK

In the UK, the DHSC introduced a four-tiered system in 2006 in order to treat addiction. Tier one treatment is delivered by healthcare professionals (HCPs) in primary care settings which includes interventions such as alcohol use screening and onward referral, whilst tier two services are provided by HCPs with some training in substance use, offering extended brief interventions such as harm reduction. Those with more serious substance use issues are seen by tier three services, which provide structured support from specially trained HCPs. Tier four provides rehabilitation and detoxification inpatient services staffed by highly specialised HCPs (Murray et al., 2012).

For those with clinically-recognised AUD, treatment is centred upon community services providing outpatient detoxification and psychosocial interventions, alongside residential services providing structured rehabilitation programmes as well as inpatient detoxification, whereby PWUA can be supported to safely withdraw from physical alcohol dependence (Rose et al., 2011). Rehabilitation and detoxification programmes in England, however, are underfunded and remain notoriously difficult to access (Black, 2021; Jackson et al., 2024) often with long delays for inpatient treatment, triggering stress and feelings of isolation for those on the waiting list (Neale et al., 2024).

1.4.2 Segregation of mental health and addiction services

Considering the well-known links between alcohol addiction and mental health problems, it is concerning to note the chronic issue of segregation between the substance use and mental health sectors in the UK. This has drawn significant attention since the 2012 Health and Social Care Act (HSCA) transferred commissioning responsibilities for drug and alcohol services from the NHS to local authorities (King's Fund, 2021; NHS England, 2016; Poulter et al., 2021; Roberts et al., 2020). Substance use services are "currently being delivered to patients by a fragmented patchwork of largely non-NHS providers" (Poulter et al., 2021, p. 4) including third sector or quasi-autonomous non-governmental organisations. 65% of specialist community services are now provided by third sector or private agencies, compared with 90% provided by the NHS prior to 2012 (Roberts et al., 2020).

This transition contributed to the divide between mental health and addiction services, with siloed funding and commissioning no longer providing incentives for joined-up working (Black, 2021). There is a chronic lack of coordination across services as a result, making integrated support for those with co-occurring conditions a practical challenge. HCPs have also become broadly specialised within fields of health which goes against the concept of integrated service provision (Murray et al., 2012). Even the term "dual diagnosis" itself arguably contributes to the complexity and fragmentation of substance use and mental health issues in terms of treatment provision (Guest & Holland, 2011; Holland, 1998), viewing the two as separate diagnoses requiring separate treatment from separate services (Black, 2021).

1.4.2.1 Impact of segregation on PWUA

A meta-analysis conducted into the association between mental health problems and alcohol use concluded a strong need for alcohol and psychological problems to be "treated in parallel" (Puddephatt et al., 2022, p. 1570); in the UK, however, the lack of service integration has drawn heavy criticism, becoming a well-documented issue in public health policy over the last decade. Numerous reports have highlighted the risk of exclusion that people with addictions face from mental health support as a result of the long-standing divide between services (Black 2021; King's Fund, 2021; NHS England, 2016; PHE, 2017; Recovery Partnership, 2015). Providing specialist, rather than integrated, services leaves people risk of falling through the gaps between treatment providers, or facing rejection from mental health services due to strict referral criteria surrounding addiction. The Five Year Forward View for Mental Health report (NHS England, 2016, p. 23) highlighted similar concerns, stating "referral pathways have become more complex and many people with mental health and substance misuse problems no longer receive planned, holistic care". Those with addictions and co-occurring mental health problems often find themselves frequently passed between various providers, which risks service drop-outs and treatment incompletion (Black, 2021; King's Fund, 2021; Powell, 2006) and places the onus on individuals to manage and coordinate their own care (Jackson et al., 2024; May et al., 2014). Reports have suggested that people with addictions are regularly excluded from mental health support until they have resolved their addiction issues, whilst simultaneously excluded from substance use services until they have addressed their mental health problems (Black, 2021; Jackson et al., 2024; Montgomery et al., 2023; Roberts et al., 2020).

The state of substance use service provision itself has also been criticised as fragmented following the 2012 HSCA (King's Fund, 2021; Black, 2021; Poulter et al., 2021).

In 2021, Public Health England (PHE) (now OHID), reported 82% of dependent PWUA are not accessing any substance use treatment (Alcohol Change, 2018). The complexity of the funding and commissioning process inadvertently affects pathways into services as well as the quality and range of treatment options (Gilburt et al., 2015). Alcohol-related hospital admissions have been significantly increasing in England, leaving the NHS to regularly provide unplanned and non-specialist hospital detoxification out of necessity (Poulter et al., 2021). Until recently, spending cuts to local substance misuse services resulted in fewer service users accessing and completing treatment (Roscoe et al., 2022) as well as the closure of numerous specialist inpatient units and increasing pressures on acute hospital services (Phillips et al., 2021). In 2021, however, it should be noted that increased funding was allocated to both new and existing detoxification services in the UK, following an independent review into the significant financial under-provision of services (Neale et al., 2024). What little psychological support is provided within substance use services often refers to motivational interviewing or keywork sessions rather than psychological therapy with an accredited therapist (Black, 2021; Jackson et al., 2024). Psychosocial interventions that are currently offered are limited and delivery is "substandard, frequently amounting to little more than a chat with a drug worker" (Black, 2021, p. 34). Furthermore, there are a shortage of training posts in addiction psychiatry due to funding cuts. The impact of such cuts have been cited as fewer specialists within addiction services, meaning that non-specialist doctors, such as those in A&E departments, often take the lead in supporting those with addictions, without the necessary expertise (British Medical Association [BMA], 2024).

1.4.3 NHS Talking Therapies and clinical therapeutic guidelines

Psychological support for common mental disorders (CMDs) is, at present, provided largely by NHS Talking Therapies. The service provides therapeutic interventions for depression and anxiety as well as other CMDs such as PTSD, as outlined in NHS England's Community Mental Health Framework (2019). While NICE provides clinical treatment guidelines for people with "co-existing severe mental illness and substance misuse" (NICE, 2016), at present there are no equivalent guidelines for those with co-occurring CMDs and addiction issues. Recommendations are based on specific presentations alone, such as treatment for anxiety or depression (NICE, 2014a; 2022); separate guidelines offer treatment recommendations for PWUA (NICE, 2014). Psychological, or talking, therapies such as cognitive behavioural therapy (CBT) are acknowledged to be highly effective in treating alcohol use disorders (NICE, 2014; OHID, 2023). Despite this evidence, NICE (2014) recommendations for supporting PWUA therapeutically is to offer CBT or other behavioural therapies with a focus on "alcohol related problems", rather than offering specific psychological interventions for trauma, anxiety or depression, for example.

A "Positive Practice" report, published by NHS Talking Therapies in 2012, recognised the possibility of "substantial clinical gains to be made" in working with those with addictions, given "there is no evidence that substance misuse *per se* makes the usual psychological therapies ineffective" (IAPT, 2012, p. 1). From 2018, NHS Talking Therapies set out that drug and/or alcohol use should not be an automatic exclusion criterion from treatment as long as one's use does not interfere with session attendance or engagement and that people with addictions should be in treatment with a local substance use service simultaneously to receiving therapy (NHS England, 2024). Guidance also suggests, however, that services should be flexible in their approach to engaging those with addictions, such as tolerating some missed sessions and working jointly with substance use services to provide

treatment (NHS England, 2024). In practice, however, it has been found that PWUA are often excluded from accessing psychological support in the UK due to their alcohol use, informed that sobriety is a requirement before being accepted into therapy services (Jackson et al., 2024; Montgomery et al., 2023). Studies have also shown that while PWUA perceive their addictions to be intrinsically linked to their mental health problems, this is seldom recognised by healthcare services (Jackson et al., 2024; Lawrence-Jones, 2010).

1.4.4 Integrating the addiction and mental health sectors

Davidson and White (2007) argue that integration between the addiction and mental health sectors is "sorely needed and long overdue" especially considering "mental illnesses and addictions co-occur within the same person as frequently as they exist independently of one another" (Davidson & White, 2007, p. 110). A meta-analysis conducted by Drake et al. (2004) also demonstrated the benefits of an integrated care system for people with co-occurring addiction and mental health issues, especially in terms of engagement and motivation for recovery. The need for better integrated services to tackle the exclusion of people with addictions from mental health services has been emphasised in UK health policy research over the past decade. The "Better Care for People with Co-Occurring Mental Health and Alcohol/Drug Use Conditions" report (PHE, 2017) recommended addiction treatment and support to be delivered in mainstream services rather than specific substance use services. They presented a "no wrong door" policy whereby "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" while "treatment for any of the co-occurring conditions is available through every contact point" (PHE, 2017, p. 9).

Similarly, the DHSC (2017) published its Clinical Guidelines on Drug Misuse and Dependence, recommending there be "no wrong door through which to enter services (whether based on levels of alcohol and/or drug dependence or on presence or absence of specific diagnoses of mental illness), even if subsequently this sometimes leads to referral for alternative pathways of care" (p. 232). The most recent NHS Long Term Plan (NHS, 2019) also set out plans to integrate primary and community health services to support those with mental health and substance use issues through a multidisciplinary service model.

Despite a focus on illicit drug use, the Dame Black (2021) report called for NHS mental health services and substance use providers to ensure that "individuals do not fall between the cracks" (Black, 2021) and that investment should be directed into mental health provision for this underserved group. In response to the report, NHS England (2024) published a '10-year Strategic Plan for the Drug and Alcohol Treatment and Recovery Workforce' outlining a movement towards employing qualified psychotherapists and psychologists within substance use services, as well as clearer referral pathways to be made available to HCPs. Viewing addiction as a trauma response was also highlighted. Another recent government report detailing a "10-year Drugs Plan to Cut Crime and Save Lives" (Department for Department for Levelling Up, Housing & Communities, 2022) recommended the employment of psychologists within substance use services. Furthermore, the recent Lord Darzi Independent Review into the NHS in England (Darzi, 2024) also called for simplified and integrated NHS service models to incorporate mental health, primary and community care, especially considering the surge in waiting times for mental health treatment at present.

1.5 Alternative therapeutic approaches to working with addiction

Bowen et al. (2024) discuss potential benefits of alternative therapeutic approaches, such as Dialectical Behavioural Therapy (DBT), considering the prevalence of emotional dysregulation in co-occurring PTSD and substance use disorders, for example. Besides, with the exception of CBT, therapies are very difficult to access through the NHS, despite evidence suggesting their effectiveness amongst this population (BMA, 2024). While CBT and other behavioural therapies are recommended by NICE guidelines for the treatment of both alcohol addiction and CMDs, much has been written about the psychoanalytic stance to working with addiction (Weegman, 2017; Reed, 2002; Rodriguez de la Siera, 2000). Such approaches, however, are yet to be clinically recommended by NICE guidelines and therefore are not incorporated into NHS treatment provision. Psychoanalytic therapies are argued to be some of the few approaches that hope to rehumanise the "disorder" of addiction (Weegman, 2017). The therapist works to identify patterns of emotional dysregulation within patients, understanding addiction as a means of self-medication and as a way of coping and an ongoing battle with accumulated life adversity, such as childhood trauma (Weegmann, 2017).

Reed (2002) discusses the drug as a "container" referring to Bion's (1963) concept of the dynamic relationship between container and contained. The purpose of psychotherapy for those experiencing addiction is to transfer the role of the container from the drug to the therapist. Those in active addiction can be understood as maintaining death on the periphery of their lives. This "dance with death" becomes a form of comfort, knowing that a numb state of mind is never far away and that alcohol can offer a swift exit from a world that has often become "deadened" by trauma in the form of neglect or abuse (Reed, 2002). Psychodynamic theories allude to the notion that addiction can cause people to only experience a sense of aliveness when in extremeness, walking a fine line between life and death.

1.6 Marginalisation from healthcare services

1.6.1 Stigma surrounding addiction

Efforts have been made to understand the rationale behind the segregation of mental health and addiction treatment, but also of addiction from mainstream healthcare over time. In the US, Davidson and White (2007) note that both fields of addiction and mental health have a "dark past" (p. 110) in which those suffering with addiction or mental health problems occupy "a common place of disgrace in society" (p. 111), often excluded from or given ineffective treatment. In the UK however, whilst mental health services remain largely under NHS provision, addiction has become even further marginalised (Poulter et al., 2021). Research has found stigma to play an important role in this denigration. One systematic review (Schomerus et al., 2011) found that when compared to non-substance related mental health disorders, people with alcohol dependence were less often regarded as having a mental health issue, and instead more commonly held responsible for their condition. They were also more likely to be subject to social rejection and negative emotions from the public, as well as being at risk of more general structural discrimination. Olsen et al. (2003) summarised six studies across the UK, US and Australia, concluding that respondents from the general public believed PWUA should receive less priority when it came to healthcare.

Similar reviews have been conducted into staff perceptions of people with addictions, revealing that longstanding stigmatised views can contribute to lower levels of care (Caszalis et al., 2023) as well as reduced levels of empathy (Van Boekal et al.,2013). Marginalisation within therapeutic contexts is also prevalent. People with addictions are regularly dismissed by therapists, often deemed "unmanageable" and passed over to organisations, such as

substance use services, that quite often will find themselves overwhelmed by the challenges of working with this client group without qualified psychologists or psychotherapists (Rodriguez de la Siera, 2002). HCPs working in addiction services often perceive addiction as having no way out, their organisations becoming an endless revolving door to those who attempt recovery, relapse and return (Weegmann, 2017).

Views around addiction being a "self-inflicted condition" reflect society's longstanding prejudice towards people with addictions (Weegmann & Cohen, 2002). There exists, to an extent, a fascination with addiction due to it being placed outside of the law and society as a dumping ground for our own psychological projections of "badness" (Reed, 2002). Language also has a powerful impact on policy and social attitudes; referring to people as "alcoholics", "drunks" or "addicts" contributes to the stigma around PWUA (Fisher, 2022). The use of language to describe recovery is laden with stigma – words such as "clean" are in direct opposition to the "dirty addict" (Weegmann, 2017). Even across recovery models such as AA, narratives surrounding the stigmatisation of alcoholism prevail (Morris et al., 2023a). Patterns of substance use "entail a process of social degradation and exclusion, a process described in classic AA terminology as ending in 'the drinker hitting rock bottom'" (Room, 2005, p. 147). AA recommends that in order to begin recovery "the delusion that we are like other people… has to be smashed" (Alcoholics Anonymous, 2001, p. 30) encouraging PWUA to distance themselves from those around them who are "normal" in comparison (Morris et al., 2023a).

Room (2005) identifies three sources of marginalisation when it comes to substance use: that of social exclusion, such as being ousted from family and friends; that of social agencies which draw attention to the most "problematic" of users and enhance exclusion; and

that of the national and local policy decisions such as the criminal justice system or health policy, which contribute to further marginalisation. Operating at a deeper level is the ongoing stigmatisation faced by PWUA, enhanced by a sense of moralisation and an existence outside the norms of society. Substance use is heavily moralised; using drugs or alcohol crosses the boundary between social inclusion and exclusion (Room, 2005). Problem drinking, in this sense, lies in stark opposition to ideas of self-control, health and moderation (Peele, 1987).

Crawford's (1980) notion of "healthism" takes this notion further, exploring the "elitist moralising about what are believed to be unhealthy coping behaviours" (Crawford, 1980, p. 385). The concept of "healthism" also indicates the extent to which the onus of maintaining good health is often placed upon the individual, taking responsibility away from institutional or structural systems. It implies that good health should be something one strives towards, performing individualised acts of self-care, for example, to achieve a status of healthy conformity. Both the problems of poor health and the solutions are therefore the responsibility of the individual, serving to de-politicise health. Conceptualising alcohol addiction as an individually located disease overlooks the roles of social, environmental and commercial determinants of health as well as public health policies in providing opportunities for recovery (Morris et al., 2023a). This was notable in the Review of Drugs report (Black, 2021) which highlighted the prominent role of societal factors such as homelessness and unemployment on increasing levels of addiction. Viewing addiction as a social, rather than individual, issue has been discussed within critiques of capitalist, or free-market, literature (Alexander, 2012). The inherently social nature of addiction involves critical examination of the wider role of the state including living conditions such as poverty and experiences of the social care system (Sebatindira, 2023).

1.6.2 Epistemic injustice

Notions of blame and responsibility placed upon an individual can be thought about within a context of epistemic injustice. The notion of epistemic injustice (Fricker, 2007) explores the wrongdoing of somebody in their capacity as epistemic subject, or "knower". Epistemic injustice can occur in two ways – that of testimonial injustice, whereby those with lived experience are not believed because of their status in society, and that of hermeneutical injustice, whereby societal structures make even the individual with lived experience struggle to comprehend or communicate the injustice they are subject to. This concept has been applied to both mental health studies, namely in relation to psychiatry and the difficulty subjects can face in expressing experiences (Crichton et al., 2017; Drożdżowicz, 2021), and more recently to the realm of addiction, namely that of drug addiction (Shevchenko & Zhavoronkov, 2025). It is argued that for people who use drugs, epistemic injustice exists temporally – such as misalignments between the expectations of time-keeping and treatment timelines from healthcare systems compared with those of people with addictions (Shevchenko & Zhavoronkov, 2025). Struggling to attend morning appointments, due to physical challenges associated with drug use, for example, contributed to the mismatch between health systems' expectations on service users and the reality of drug use. Similarly, the onus placed on an individual to collect methadone prescriptions three times per day is an example of unrealistic time-budgeting expectations placed on the individual. Service users may struggle to articulate reasons for missed appointments, or express needs related to help-seeking adjustments, often accepting individual-level blame.

Although writing specifically about the experience of people who inject drugs, Harris (2020) describes the embodied violence experienced by those excluded from mainstream

healthcare, an experience which can also be applied to stigmatised substance users (such as PWUA) more broadly. Delays to care-seeking, for example, are often put down to individual cognitive decisions and lack of personal responsibility (Harris, 2020). The cultural norms instilled by the "right" and "wrong" ways of doing healthcare (Harris, 2020) contribute to both the segregation of substance use services from other mainstream healthcare providers, and a sense of self-protection whereby PWUA may feel alienated and deterred from seeking support for psychological issues.

However, the purpose and role that comes with injecting drugs is vital amongst many people who use drugs, helping them to cope with the challenges associated with being chronically excluded from healthcare and society in general. Despite the physical pain of injecting, the process of sourcing and using heroin provides a cyclical and rhythmic pattern to the day, creating order out of what at first might appear to be out of control and chaotic lives. Heroin use also has the capacity to numb; seemingly self-destructive acts such as delays to care-seeking can, on the contrary, represent meaningful and protective acts of self-care in terms of avoiding hospital treatment for risk of not being able to use heroin whilst admitted, risking withdrawal. Refusing to seek healthcare also provided a sense of agency within what was experienced as hostile and rejecting healthcare system (Harris, 2020).

1.6.3 PWUA and barriers to accessing healthcare services: current research

Despite the high rate of both psychological and physical health concerns amongst this population, people with addictions tend to be less likely to access healthcare services (Connery et al., 2020; Francia et al., 2022; Hoover et al., 2021; Jackson et al., 2024; May et al., 2019; Priester et al., 2016; Probst et al., 2015). This is partly a result of the chronic

marginalisation of people with addictions from healthcare services but also due to the stigma and shame surrounding addiction which are both recognised as common barriers to accessing care (Connery et al., 2020; Francia et al., 2022; Room, 2005; Sawer et al., 2020). Shame and stigma can also contribute to delayed treatment-seeking (Hoover et al., 2021; May et al., 2019).

While there is no existing systematic review into PWUA's experiences of either psychological or general healthcare services in the UK, some broader, international reviews of the experiences of PWUA have been conducted relating to experiences of healthcare services. One systematic review explored the qualitative barriers to AUD treatment for PWUA (May et al., 2021). It found shame, stigma, lack of perception regarding individuals' needs for treatment and a fear of giving up drinking to be among the key barriers to accessing healthcare. One study of six countries in northern Europe (not including the UK) found shame and stigma to be one of the biggest barriers to PWUA diagnosed with AUD in primary care seeking specialist treatment (Probst et al., 2015). Systematic reviews into the experiences of people with addictions more generally have found structural barriers to accessing mental health and substance use treatment to be a chronic issue globally (Priester et al., 2016). Another review similarly found that people with addictions and mental health problems regularly attend accident and emergency (A&E) departments due to a lack of alternative community resources (Li et al., 2022).

The following section will provide a systematic overview of the current literature relating to PWUA experiences of healthcare services from a UK context.

1.7 Systematic literature review: A meta-ethnographic approach

A systematic literature review was conducted to identify current qualitative research related to the experiences of PWUA in accessing psychological therapies in the UK. Given the lack of studies relating to psychological provision specifically, the search criteria were expanded to include experiences of UK healthcare services. For the purpose of this review, psychological and healthcare services refer to a wide range of NHS and third sector settings including: psychological therapy services, substance use services, inpatient treatment settings, A&E departments, GP surgeries and specialised outpatient clinics.

A meta-ethnographic approach, first offered by Noblit and Hare (1988), provides an interpretative account that is suitable for synthesising qualitative data. Meta-ethnography is particularly useful as a means of understanding patient experiences of healthcare (Britten et al., 2002). Noblit and Hare's (1988) seven-phase process holistically organises data in order that it can be used or translated across multiple studies (Priestly & McPherson, 2016). Meta-ethnography was deemed appropriate for the current literature review not only because of its appropriacy to healthcare research, but because it culminates in the development of a line of argument, or theoretical model, which can then help to inform or guide the broader research into PWUA within this study. The seven phase process put forward by Noblit and Hare (1988) was closely followed for this research. The process involved: getting started; deciding what is relevant to the initial research interest; reading the studies; determining how the studies are related; translating the studies into one another; synthesising translations; expressing the synthesis (Noblit & Hare, 1988).

The current meta-ethnography ensures rigour by primarily following Noblit and Hare's (1998) seven phase approach. It also incorporates recent guidance from the eMERGe

framework for reporting meta-ethnographies (France et al., 2019) (Appendix N). Further methods for ensuring rigour were through the use of the Critical Appraisal Skills Programme UK (CASP) (2018), a PRISMA flow chart (Paige et al., 2021) to systematically select articles, and lastly a SPIDER table to focus the search strategy. All guidelines carry systematic guidance; the study reflects on the limitations of carrying out an independent systematic review at the end of the chapter.

1.7.1 Article selection

In order to select the relevant articles, a systematic search was carried out on 5th August 2025 using four databases: APA Psycinfo, APA Psycharticles, MEDLINE Ultimate and CINAHL Ultimate. Search terms are demonstrated in Table 1. Given the large number of results gleaned from the initial searches, the specific criteria were adjusted in order to narrow down the results to relevant papers. The researcher discussed the search strategy with her supervisor and agreed to limit results according to specific criteria, in adherence with eMERGe guidelines (France et al., 2019). This was to ensure the search minimised the amount of irrelevant studies included. Search terms were limited to abstract-only and results filtered to include 'Peer reviewed' and 'UK' studies only. The results were also limited to studies published from 2010 onwards. This year was chosen due to the 2010 publication of the 'Healthy Lives Healthy People' NHS Long Term Plan (NHS, 2010) which determined public health policy across this decade. Research prior to this was considered likely to provide outdated examples of healthcare experiences.

France et al. (2019) also recommend reducing bias by reviewing and screening studies for inclusion with a second researcher. The researcher discussed screening criteria with her

supervisor and submitted her initial search results and inclusion strategy for formal review before proceeding. Studies were included if they met the following criteria: 1) participants were PWUA with experience of accessing healthcare services, 2) studies were conducted within the UK, 3) studies were peer reviewed. Studies were excluded if: 1) they focussed solely on healthcare experiences from other people's perspectives (such as HCPs) 2) they focussed solely on the COVID-19 pandemic, 3) they explored pharmacological treatment programmes for alcohol use, 4) they used quantitative methodologies or mixed methods, 5) studies conducted prior to 2010 were excluded in order to provide up-to-date experiences of healthcare.

A subsequent process of article exclusion then took place by reading the abstracts of the remaining 55 articles. Some studies were excluded due to either irrelevant research focus or other disqualifying factors detailed in Figure 1. Specific search strategy and exclusion categories are also outlined in the PRISMA flow diagram. Ten studies were selected for inclusion (Dorey et al., 2021; Gilburt et al., 2015; Haighton et al., 2016; Jackson et al., 2024; Montgomery et al., 2023; Naughton et al., 2013; Parkman et al., 2017a; Parkman et al., 2017b; Roberts et al., 2020; Roper et al., 2013).

Figure 1 illustrates a PRISMA flow diagram (Moher et al., 2009; Page et al., 2021) which indicated the various phases of the search strategy. The SPIDER framework (Cooke et al., 2012) was employed in order to define the search strategy as well as to guide topics of interest (Table 2). It should be noted that the search criteria for PWUA was difficult to define. The intended study sample was people who use alcohol in a "harmful" or "problematic" way, or consider themselves to have an "addiction" to alcohol. However different studies employ a wide variety of terminologies, concepts and definitions when it comes to identifying this

population. The researcher therefore considered the following study populations to appropriately meet the systematic review's population of interest: people who self-identify as using alcohol at a "harmful" or "problematic" level, including those who self-identify as having an alcohol addiction, people with clinically diagnosed AUD, people who identify as being alcohol dependent, people identified by researchers as having "harmful" or "problematic" alcohol use (such as those who do not consider themselves to drink to a "harmful" or "problematic" level but repeatedly attend A&E visits for alcohol-related reasons), and people with dual diagnoses (alcohol rather than drug use). The SPIDER table (Table 2) employed simplified terminology (people who use alcohol at a "harmful" or "problematic" level, or identify as having an alcohol "addiction") to encompass this range of definitions for PWUA whilst simultaneously excluding study samples of adults who drink alcohol at a "general population" level, i.e. drinking that is not considered "problematic" or "harmful".

Table 1

Table showing search terms employed.

Search number	Search terms
1.	alcohol or people who drink alcohol or people who drink or alcohol-related or drinker* or alcohol user* or people with alcohol addiction* or alcoholic* or dual diagnos* alcohol dependen* or AUD or alcohol use disorder* or alcohol-use disorder or problem drinker* or alcoholic* or people who use alcohol
2.	healthcare or health care or care service* or service prov* or hospital* or health service* or health facilit* or medical care or medical service* or hospital* or emergency department* or accident and emergency or A and E or A&E or ED or mental health service* or psychological service* or therapy service* or therapeutic service* or counselling service* or IAPT or talking therap* or psychiatric service* psychological treatment* or treatment or pathway

3.	experience* or access* or service prov* or availability or treatment barrier* or treatment need* or treatment seeking or experience* or treatment-seeking or navigat*
4.	UK or United Kingdom or London or England or Britain or British
5.	qualitative or interview* or focus group

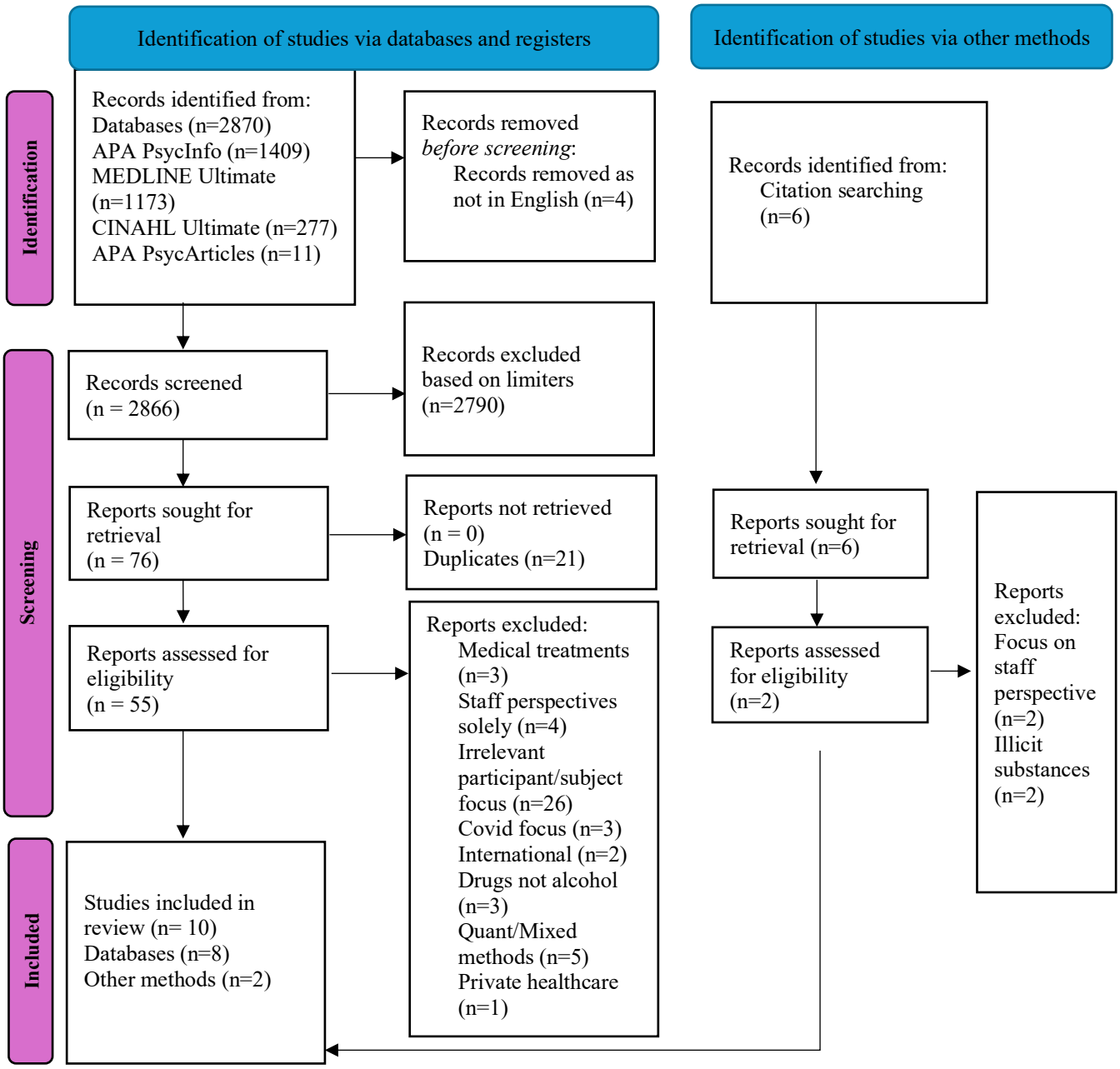
Table 2

SPIDER criteria for study eligibility and inclusion (Cooke et al*., 2012).*

Criteria	**Definition**
Sample	People who use alcohol in a "harmful", or "problematic" way, or consider themselves to have an "addiction" to alcohol. This excludes adults who drink alcohol at a "general population" level, i.e. drinking that is not considered "problematic" or "harmful".
Phenomenon of interest	Experiences of UK healthcare services
Design	Interviews, focus groups
Evaluation	Views, experiences
Research type	Qualitative

Figure 1

PRISMA flow diagram of search process (Page et al.*, 2021).*



1.7.2 Quality assessment

In order to assess quality, the primary researcher conducted an analysis following the CASP (Appendix D). The results demonstrated varying levels of quality across the studies;

while CASP does not offer a formal scoring system, the researcher decided that studies which met eight out of ten criteria were deemed to be of high quality, while studies that met four to seven out of ten criteria were deemed medium quality. Studies below four were deemed low quality and would justify exclusion from the meta-ethnography. Using this scoring system, the current meta-ethnography found that two studies scored “medium” (Montgomery et al., 2013; Roper et al., 2012) and eight scored “high” (Dorey et al., 2021; Gilburt et al, 2015; Haighton et al., 2016; Jackson et al., 2024; Naughton et al., 2013; Roberts et al., 2020; Parkman et al., 2017a; Parkman et al., 2017b;).

The majority of studies laid out a clear rationale for research including sample selection and research design, however some were less clear regarding the rationale for the research design. The inclusion of both staff and service users’ opinions within two studies (Roberts et al., 2020; Montgomery et al., 2013) somewhat reduced the richness of analysis and discussion of PWUA’s experiences, especially considering the discussion did not separate out the responses to specific themes in order to allow for direct comparison during the results and discussion. Similarly, the rationale behind the use of individual interviews and focus groups as methods of data collection was explored in the methods section but then not expanded upon within the discussion of Haighton et al.’s (2016) study. Further reflection regarding the process of using focus groups amongst this demographic could have been beneficial. One study (Haighton et al., 2016) met the SPIDER search term criteria of ‘alcohol dependence’ as the population being interviewed, however it also included participants who drank alcohol to a level not deemed ‘problematic’. Following discussion with her supervisor, it was agreed that including the study made the systematic review more rigorous than omitting it.

The majority of papers referred to a discussion of ethical considerations, apart from Roper et al. (2012). Ethical discussion was also minimal in Montgomery et al. (2013) and only alluded to ethical approval granted. However, despite the majority of papers interviewing those who may have been under the influence of alcohol, issues of consent and capacity that are crucial when interviewing this population were only alluded to in Jackson et al. (2024) and Parkman et al. (2017a; 2017b). Dorey et al. (2021) did not interview those under the influence but gave a thorough discussion of ethical considerations in general. Only two papers discussed the participant-researcher relationship (Jackson et al., 2024; Roberts et al., 2020) and the way in which this could impact on the quality of interviews. One study provided vague recruitment criteria and also employed the use of breathalysers to ensure sobriety prior to interviews (Roper et al., 2012). This is questionable ethically given the research appeared to recruit those with current alcohol addictions.

While some meta-syntheses rigorously assess for quality, others find CASP to be overly rigorous in its approach (Priestly & McPherson, 2016). Despite certain shortcomings in specific papers, however, for the purpose of this meta-ethnography it was assumed that all ten studies met the SPIDER criteria, were peer-reviewed, and provided an acceptable standard of both valuable and rich information, and in-depth analyses, justifying their inclusion in the meta-ethnography. This also aligned with practical restrictions given the limited number of journal articles in this area of the literature. Table 3 provides an overview of the key features of the studies included in this meta-ethnography.

Table 3

Table showing key features of studies.

Author and location	Participants	Study setting	Study aim	Study population	Methodology	Key findings
Dorey et al. *(2021)*	n=24	Inpatient hospital detoxification services in the UK.	PWUA's experience of specialist nurse interventions within hospital detox programmes.	Patients who had undergone alcohol detoxification within the past month.	Semi-structured interviews.	Specialist nurses provide critical support to those in hospital detox as well as follow-up support which improves recovery.
Gilburt et al. *(2015)*	n=20	Community alcohol treatment services in London.	Service users' perspectives on navigating the alcohol treatment pathway.	Individuals seeking help for alcohol dependence.	Semi-structured interviews.	Motivation and self-efficacy is required to navigate alcohol treatment in London.
Haighton et al. *(2016)*	n=51	One charity and two community alcohol treatment services in Northeast England.	Exploring experiences of PWUA seeking treatment for alcohol-related health issues in mid-later life.	Recovering dependent drinkers, 'sensible' drinkers, dependent drinkers, people who currently consume alcohol.	Semi-structured interviews and focus groups.	PWUA in mid-later life tended to be more isolated and covert in drinking habits. Better aftercare is required along with enhanced role of the GP.
Jackson et al. *(2024)*	n=39	Voluntary and community sector organisations in Cumbria.	Experiences of formal care provision for PWUA and depression.	People with current or recent experience of co-occurring heavy alcohol use and depression.	Semi-structured interviews.	Treatment is required that acknowledges PWUA's socioeconomic context and need for relational support.
Montgomery et al. *(2023)*	n=10	One primary care and two secondary care alcohol	Experience of PWUA and staff of alcohol treatment	People with alcohol dependence.	Semi-structured interviews.	Barriers to timely and appropriate treatment for PWUA include

		treatment services in Liverpool.	units (ATUs) in relation to service provision and help-seeking behaviours.			lack of mental health support, stigma and complex treatment pathways.
Naughton et al. *(2013)*	n=19	Housing organisations and alcohol treatment services in Southwest England.	Understanding the delay in PWUA seeking treatment.	'Problem drinkers'.	Semi-structured interviews.	Motivations for seeking treatment were around psychosocial, health and situational problems rather than a desire to stop drinking.
Parkman et al. *(2017a)*	n= 30	Six A&E departments in London.	PWUA who frequently attend A&E's views of substance use services.	People who frequently attend A&E for alcohol-related reasons.	Semi-structured interviews.	PWUA cited a need for mental health and social care support rather than help for drinking; these needs often go unmet in substance use services.
Parkman et al. *(2017b)*	n=30	Six A&E departments in London.	PWUA's experiences of A&E departments.	People who frequently attend A&E for alcohol-related reasons.	Semi-structured interviews.	A&E departments provided immediate, accessible and sympathetic care to PWUA compared to limited community resources.
Roberts et al. *(2020)*	n=18	Four community alcohol treatment services in England.	Service users, providers and commissioners' perspectives on access to specialist community treatment in England.	People with diagnosed alcohol dependence.	Focus groups.	Stigma, shame, guilt, combined with lack of integration with mental health services create barriers to alcohol treatment.

Roper et al. *(2013)*	n=30	ATU in Northwest England	Experiences of PWUA in decisions to seek inpatient treatment.	People currently seeking treatment from an ATU.	Semi-structured interviews.	Decisions to seek treatment are not gradual and often result from 'mirroring events' which trigger changes in self-identity. Initial acceptance of self as 'alcoholic' supports movement towards perceptions of self as agent of change.

1.7.3 Determining how the studies are related

Recurring and shared themes were identified following a detailed examination of the ten selected journals. Following Atkins et al. (2008), a table was created in order to ease the process of identification and organisation of key emergent themes, as well as to facilitate cross-comparison. Table 4 is a tabulated example of one study to illustrate the process involved in reviewing the themes and concepts within the study. The final row provides a single explanation in order to summarise the key theory within the paper, termed a 'second-order interpretation' (Britten et al., 2002).

Table 4

Sample of tabulated study details and key concepts.

Methods and concepts	Roper et al. (2012)
Key study details	
Purpose	To understand the process by which PWUA decide to seek treatment with an NHS ATU.
Setting	North West England
Sample	30 PWUA
Data collection	Qualitative interviews
Key concepts	
Ambivalence to change	Process of seeking treatment is not gradual and unlikely to occur without a push factor.
Sense of shame	Shame and stigma prevents PWUA from seeking treatment.
Pivotal moments	Participants underwent 'mirroring events' e.g. sudden hospital admission or relationship breakdown.
Shifting identities	Problem recognition, self-reflection and change and change can result from such events, providing a window of opportunity for engagement with services.
Feeling seen	PWUA require support with building new self-identities following crisis points.
Explanation (second order interpretation)	PWUA require support navigating new self-identities in order to overcome stigma. Services must assist with supporting PWUA away from self-perceptions as 'problem drinkers' towards a those of 'responsible', 'engaged' and 'action-taking'.

1.7.4 Translating the studies into one another

Once the summary tables (Table 4) were completed for each study, the key themes that emerged from the studies were then analysed across all papers, a process of translating the studies into one another (Noblit & Hare, 1988; Britten et al., 2002). Recurrent themes were reduced and nine key concepts were identified: Ambivalence to change, Sense of shame, Anticipating poor treatment, Uncertain pathways, Going it alone, Pivotal moments, Shifting identities, Going the extra mile, and Feeling seen. The main concepts were then

consolidated into one overarching table (Table 5). This provides a cross-comparison of the studies according to key concepts.

Table 5

Cross comparison of studies by concept.

Concepts	Dorey et al. (2021)	Gilburt et al. (2015)	Haighton et al. (2016)	Jackson et al. (2024)	Montgomery et al. (2023)	Naughton et al. (2013)	Parkman et al. (2017a)	Parkman et al. (2017b)	Roberts et al. (2020)	Roper et al. (2013)
Ambivalence to change		*	*	*	*	*	*		*	*
Sense of shame	*	*	*	*	*	*			*	*
Anticipating poor treatment	*	*	*	*	*	*	*	*	*	
Uncertain pathways	*	*	*	*	*	*	*	*	*	*
Going it alone	*	*	*	*	*		*	*	*	
Pivotal moments	*	*	*	*		*		*	*	*
Shifting identities	*	*			*	*				*
Going the extra mile	*	*	*	*	*	*	*	*	*	
Feeling seen	*			*	*	*	*	*	*	*

1.7.5 Synthesising the translations

The meta-ethnography followed Atkins et al. (2008) who recommend viewing the tabulated study details from each paper next to one another in order to aid direct comparison. Second order interpretations were then developed (Britten et al. 2002). At this stage, four broader categories were then developed: Inner conflict, Perception of a hostile healthcare service, Accepting addiction, and Bridging the gap between addiction and health (Figure 2). A thorough examination of the studies' relevant second-order interpretations aided the development of the key concepts and categories, which linked together and uncovered a third-order analysis, effectively producing a line-of-argument woven throughout all ten studies (Figure 3).

Figure 2

Summary of key concepts and synthesised categories.

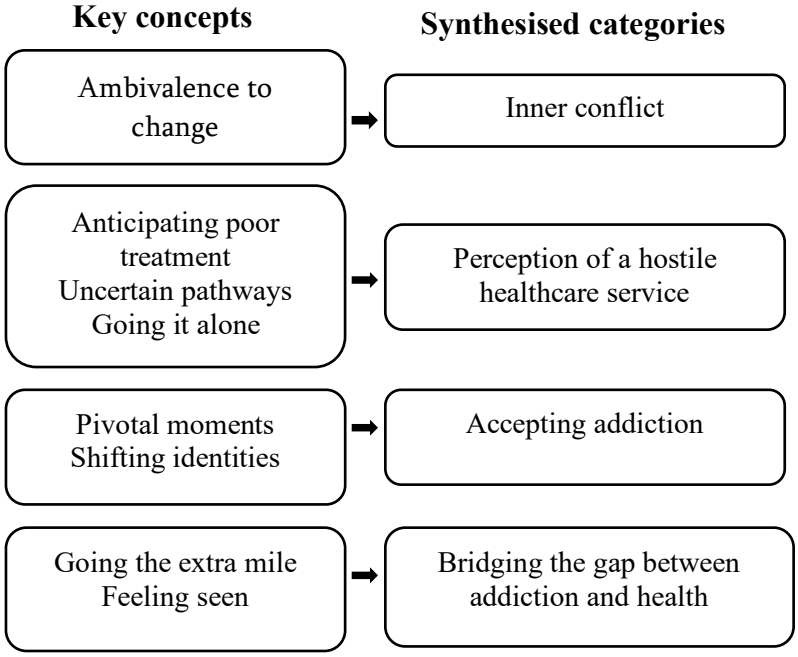
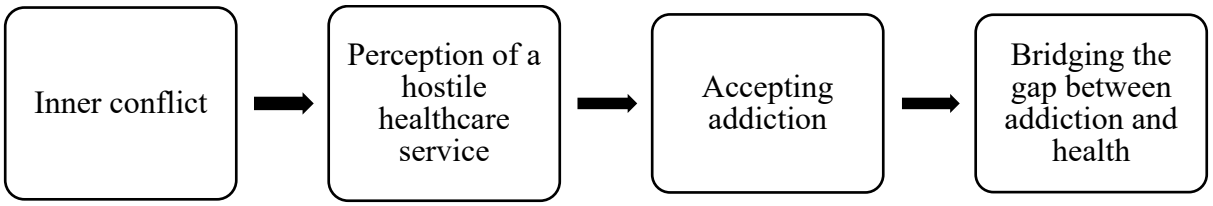


Figure 3

Line-of-argument: progressive stages of PWUA's experiences of healthcare.



1.7.6 Results

1.7.6.1 Inner conflict.

Ambivalence to change. Across most studies, the sense of ambivalence towards both help-seeking and changing one's alcohol intake were amongst the leading experiences of PWUA. Many participants expressed a belief that their alcohol use was not problematic, or a belief that help was not needed, which led them to delay, or avoid, engaging with appropriate services (Naughton et al., 2013; Montgomery et al., 2023; Parkman et al., 2017a; Roberts et al., 2020). Parkman et al. (2017a) noted that A&E attendances amongst PWUA were unlikely to be centred upon a desire for support with drinking; participants in fact demonstrated a lack of interest in, or an unawareness of the need for, getting any form of specialist help and instead sought psychosocial support. An ambivalent attitude towards making changes and taking the first step towards recovery was also determined by the general level of functioning in other areas of their life. It was noted by Naughton et al. (2013) that without problems arising in other areas of their lives due to drinking, PWUA would refuse to "realise, acknowledge or accept" (p. 300) a need for intervention.

Sense of shame. Co-existing with ambivalence was an enduring sense of shame that had become internalised within participants, meaning they were fearful of reaching out for help. Internalised stigma, guilt and embarrassment (Gilburt et al., 2015; Haighton et al., 2016; Jackson et al., 2024; Roberts et al., 2020; Roper et al., 2013;) were reported by participants across all studies as being a barrier to help-seeking when it came to a range of healthcare services, creating a sense of inner conflict about needing help but often being too ashamed to ask for it. PWUA regularly cited not wanting to self-identify as an "alcoholic" leading to hesitations in approaching healthcare services generally (Montgomery et al., 2023). Avoiding the truth to oneself and others often created a vicious cycle, leading to increased alcohol intake. Naughton et al. (2013, p. 300) reported that for PWUA, "hiding their drinking from friends and family brought on feelings of shame and guilt and alcohol was used to deal with those feelings".

1.7.6.2 Perception of a hostile healthcare service.

Anticipating poor treatment. The perception of healthcare services as hostile came up in most studies (Gilburt et al., 2015; Haighton et al., 2016; Jackson et al., 2024; Montgomery et al., 2023; Naughton et al., 2013;). Although some studies (Parkman et al., 2017a; 2017b) reflected an overall positive perception of healthcare services with the occasional poor experience, others reported a clear lack of faith in services. PWUA reported services' inability to "recognise their distress or acknowledge their social context" (Jackson et al., 2024, p 272). Some PWUA had views of GPs "not wanting to treat drinkers, or did not see drinking as a 'legitimate' illness to trouble a doctor with" (Haighton et al., 2016, p 8). Additionally, seeking support from a GP would require "admitting to being 'drunk all the time', or having an alcohol problem" (Haighton et al., 2016, p. 8). A common thread that

wove through the studies was that the continued fear of judgement or hostility from services fuelled PWUA's sense of low self-esteem (Gilburt et al, 2015).

Uncertain pathways. Pathways into various healthcare services were often cited as complex, with no clear route into alcohol treatment specifically or other healthcare support more broadly (Dorey et al., 2021; Gilburt et al., 2015; Jackson et al, 2024; Montgomery et al., 2023; Naughton et al., 2013; Roberts et al., 2020; Roper et al., 2013). Services tended to be siloed, with the separation between mental health and alcohol support services named as a particularly frustrating divide amongst many participants. Attempting to move from substance use into mental health services was cited as feeling like a "brick wall" (Roberts et al., 2020, p. 4) while Naughton et al. (2013) described the treatment seeking pathway as "complex and iterative" (p. 302). Services were often experienced as separate entities entirely (Jackson et al., 2024). Parkman et al. (2017a) found PWUA would regularly end up attending A&E departments in order to receive care for psychosocial problems such as housing and financial concerns for which they were unable or uncertain how to access elsewhere. PWUA were also drawn to A&E because of the sympathetic response from staff and the ease of being seen promptly and under one roof (Parkman et al., 2017b).

The complex nature of services was a key deterrent for PWUA in seeking healthcare support, demotivating PWUA to access help (Gilburt et al., 2015). Participants were regularly caught between services, particularly substance use and mental health, with abstinence often cited as a barrier to gaining psychological therapies (Dorey et al., 2021; Montgomery et al., 2023). Gilburt et al. (2015, p. 448) found "a lack of role definition and role boundaries in services, overlap in treatment provision and poor service integration" often left PWUA

confused and unclear about which service or individual was their main point of contact when it came to alcohol support.

Going it alone. Multiple studies concluded that PWUA regularly felt as though they had been left to navigate the healthcare system on their own without support (Dorey et al., 2021; Gilburt et al., 2015; Haighton et al., 2016; Jackson et al., 2024; Montgomery et al., 2023; Parkman et al., 2017a; Parkman et al., 2017b). Putting the responsibility on the service user was a common theme across some studies, with individuals citing that they were often made to feel they were to blame for their alcohol use and depression and should therefore be taking responsibility for getting well (Jackson et al., 2024). This was experienced as an expectation for self-efficacy and motivation on the individual (Gilburt et al., 2015). Both Parkman et al. (2017a) and Parkman et al. (2017b) reported PWUA regularly find themselves lacking in wider psychosocial support that often led them to approach A&E departments instead. Those who did receive inpatient or intensive treatment would regularly finish inpatient detoxification programmes with little to no follow up in order to help them maintain abstinence (Haighton et al., 2016). The focus on personal responsibility to navigate the healthcare system exacerbated a sense of feeling uncared for, heightening what were often already low levels of self-worth amongst service users (Jackson et al., 2024).

1.7.6.3 Accepting addiction.

Pivotal moments. Moments of clarity, or "mirroring events" (Roper et al., 2013) defined the specific moments in PWUA's lives that propelled them into help-seeking. This was commonly defined as reaching a crisis point whereby PWUA might become hospitalised or come face-to-face with other statutory services, forcing participants to confront their

alcohol addiction head on. For many it was also an opportunistic moment for healthcare services to engage them in treatment. A similar notion was recognised across a range of studies (Gilburt et al., 2015; Haighton et al., 2016; Jackson et al., 2024; Naughton et al., 2013; Parkman et al., 2017b). Contrary to the long-standing narrative that change in drinking habits is a gradual process over time, numerous studies reported key moments where PWUA might feel out of control, during which they would decide to urgently seek help. Such moments were often the result of factors such as health scares or significant life events such as relationship breakdowns or involvement with police or social services (Gilburt et al., 2015). Parkman et al. (2017b) recognised that significant physical injury was often a moment that propelled PWUA into help-seeking from A&E departments.

Shifting identities. Sudden shifts in self-identity following such pivotal moments contributed to a process of self-acceptance that was critical in PWUA's experience of help-seeking (Dorey et al., 2021; Gilburt et al., 2015; Montgomery et al. 2023; Naughton et al., 2013; Roper et al., 2013). Viewing oneself as an "alcoholic" or "problem drinker" because of a crisis point created a shift in self-view which was challenging, yet also a point of hope in terms of getting much-needed healthcare support. These moments proved critical in terms of how services responded to PWUA; engaging people in services at this time were seen as opportune moments to initiate change. A fine balance needed to be struck between a sense of both "agency and passivity" (Roper et al., 2013, p. 485). In this sense, a combined identity was deemed most helpful, whereby PWUA could take responsibility for their drinking but also be helped to acknowledge that the addiction was often out of one's control. Such identities allowed PWUA to view themselves as "agents of change" (Roper et al., 2013). Other studies also highlighted the importance of developing a new self-narrative, in order to facilitate engagement with services. It was highlighted that "for many, overall, it was a

facilitation of self-reflection, to develop a deeper personal understanding of an individual narrative, which proved key" (Gilburt et al., 2015, p. 447).

1.7.6.4 Bridging the gap between addiction and health.

Going the extra mile. PWUA described that the complexity of services could be counteracted by joined-up working between healthcare providers, as well as by services which took a holistic approach to treatment (Haighton et al., Montgomery et al., 2023; Roberts et al., 2020). This included recognising the wide and varying needs of service users which extended beyond that of just alcohol use. Participants "without exception… spoke about wanting to resolve life disruption rather than wanting to stop drinking *per se*" (Naughton et al., 2013, p. 299), pointing to the need for a psychosocial approach to healthcare amongst this demographic. A&E attendances by PWUA were, on the whole, related largely to mental health needs, physical healthcare emergencies or a desire for psychosocial support (Parkman et al., 2017a; 2017b). PWUA found A&E departments more likely to be able to meet these needs in a timely manner, citing A&E staff as going the extra mile by providing follow up phone calls post discharge, for example (Parkman et al., 2017b).

On occasion, PWUA had been able to access primary care which, against the odds, "acknowledged explicitly their relationship between alcohol use and depression" (Jackson et al., 2024, p. 274). Despite this, in general the responses received by PWUA tended to be those with a heavy focus on alcohol as the problem. GPs were experienced by PWUA as dismissive of health concerns, citing alcohol use as the cause of most health issues (Haighton et al., 2016).

Feeling seen. Being met, assessed and triaged holistically, and tailoring treatment to individual needs, were regularly cited as facilitators of better engagement with healthcare services (Dorey et al., 2021; Jackson et al., 2024; Montgomery et al., 2023; Naughton et al., 2013; Parkman et al., 2017a; Parkman et al., 2017b; Roberts et al., 2020; Roper et al., 2013). Despite this role, follow-up care from the point of discharge was often found to be lacking, requiring PWUA to continue treatment pathways on their own. Being seen in A&E was a generally positive experience for PWUA, being treated compassionately and fairly by staff and having a guaranteed, timely intervention (Parkman et al., 2017b). These settings felt safe and were reported to be staffed by people who knew PWUA as individuals, including their medical and social histories (Parkman et al., 2017b). PWUA's perception of specialist substance use services were mixed, but services that offered holistic support were deemed more valuable, for example those that accounted for PWUA's wider psychosocial needs beyond that of addiction support (Parkman et al., 2017a). Peer support or mutual aid within services was also cited as a positive, with "contact with clients at the clinic… validating their own experiences and helping them build a more positive view of themselves" (Roper et al., 2013, p. 484).

1.7.7 Line-of-argument synthesis

The current meta-ethnography uncovered a line of argument that details various stages in which PWUA approach and engage with healthcare services. This often begins with an initial stage of inner conflict, fraught with ambivalence towards healthcare services and an inner sense of shame. The act of approaching a healthcare service was often clouded by prior experiences of hostility, or concern regarding the confusion of services available; participants often felt left on their own to attempt to engage with services. The role of stigma and shame

is entangled with that of ambivalence, as the more people were disinclined to reach out owing to internalised shame, they were simultaneously unconciously strengthening a belief that they did not need help and that they were able to cope on their own.

Committing to engaging with services often required a step towards self-acceptance, which came about during pivotal shifts in self-identity, often at crisis point. Maintaining engagement with services required a bridging of the gap between the broad range of healthcare services, as well as compassionate and person-centred care that went beyond that of standard alcohol-treatment such as inpatient detoxification. Going above and beyond by providing psychosocial support alongside alcohol treatment, was deemed essential across all the studies. Being treated as a person, feeling seen, and having staff who recognised the need for wraparound care, was a highly valued outcome for PWUA and a contributor to more sustainable engagement with services.

1.7.8 Discussion

This meta-ethnography synthesised current research into PWUA's experiences of healthcare services in the UK. The line of argument reveals a four-stage process in which initially, internalised stigma and shame alongside an inherent ambivalence to seek help and change prevents PWUA from approaching healthcare services. The role of stigma and shame is entangled with that of ambivalence, as the more people were disinclined to reach out due to internalised shame, they were simultaneously strengthening a belief that they did not need help, effectively able to cope on their own. This aligns with numerous studies across the global North which have found that stigma and shame prevented people with substance use disorders from seeking treatment (Connery et al., 2020; Francia et al., 2022; Hoover et al.,

2021; May et al., 2019; Room, 2005; Sawer et al., 2020). This extended to a lack of acknowledgement that there was a problem in the first place (Cunningham et al., 1993; Hingson et al., 1982; Oleski et al., 2010; Wagner et al., 2017; Motta-Ochoa et al., 2017).

The meta-ethnography also demonstrated that when participants did reach out to services on occasion, they often experienced healthcare services as hostile, complex and fragmented. Not knowing where to go for support and being left to manage care independently seemed to put PWUA off seeking treatment and often caused them to remain isolated and avoidant of further help-seeking in future. Divisions between mental health and addiction services specifically were regularly reported by participants across the studies and were often referenced along with the lack of joined up care and complexity of referral pathways. This was apparent not only in mental health versus addiction services, but also across inpatient and community detoxification pathways, with many referencing little to no follow-up or after care once they had been discharged. Such issues also existed across broader inpatient versus community services, including primary versus secondary healthcare settings.

Interestingly, participants' first experiences of significant engagement with alcohol treatment services specifically could be triggered by a pivotal moment whereby PWUA found themselves at crisis point. These "mirroring events" (Roper et al., 2013) would allow PWUA to see themselves in a different light, contributing to a shift in self-identity. While it was confronting to be faced with the reality of having an "alcohol problem", for many it was also an opportunistic moment for healthcare services to engage them in treatment. At this point, supporting PWUA with a transition to a new, and more hopeful, identity was required to facilitate a sense of agency in the process of recovery. Despite this, the reality was that staff

sometimes continued to treat service users as “alcoholics”, rather than providing a much-needed holistic approach to their healthcare. Going above and beyond, and providing psychosocial support alongside support for PWUA’s alcohol use, was deemed essential across all the studies, as was a desire for joined-up working between services. PWUA regularly approached healthcare settings for support with housing or financial difficulties such as access to benefits. Being treated by compassionate staff who recognised the need for psychosocial support that goes above and beyond straightforward medical care was noted in multiple studies and implied the critical and transformative role that HCPs can play in supporting PWUA into services.

1.7.8.1 Limitations

One limitation to note is that the researcher did not preregister the review. This is because it was not part of the University doctoral thesis guidelines. However, the research acknowledges that not preregistering may result in potential bias in terms of the literature search. In line with France et al., (2019), the researcher made an effort to avoid bias by discussing search strategy and article screening processes with the secondary researcher (supervisor) and submitting the systematic review for formal feedback. Despite this limitation, it should be noted that reflexivity is an integral part of qualitative research, which can also be perceived as a strength rather than a weakness.

1.8 Rationale for current thesis

There is a small, but growing, body of research into PWUA and their experiences of UK healthcare services more broadly, as well as some studies exploring reasons why PWUA decide to seek treatment for alcohol addiction (Orford et al., 2006; Roper et al., 2013).

However, it is surprising to note that there are no current studies that explore the experiences of PWUA when it comes to the psychological services treatment pathway specifically. Conducting the meta-ethnography therefore highlighted a stark gap in the literature relating to PWUA's experiences of psychological services and provided a rationale for conducting the current empirical study.

Furthermore, the meta-ethnography highlighted the various barriers, both systemic and individual, that exist when it comes to PWUA's experience of attempting to access healthcare services in the UK. The studies suggest that perceptions of a hostile healthcare system, such as the uncertain pathways into treatment and the sense that PWUA needed to act independently to seek help, might prevent help-seeking amongst this population. Similarly, PWUA's expectation of poor treatment or sense of stigma and shame meant that participants often avoided help-seeking in the first place. The results of the meta-ethnography therefore provided further rationale for the current empirical study; considering the lack of qualitative research into PWUA's experience of psychological services, it was deemed appropriate to conduct a study to specifically explore PWUA's experiences within this healthcare setting.

The studies also demonstrate the rich and valuable data that qualitative research methods contribute to healthcare research. For example, important policy implications relating to A&E attendances are raised in two studies (Parkman et al., 2017a; Parkman et al., 2017b). The current empirical study hopes to offer similarly valuable clinical implications relating to psychological healthcare policy, whilst also comparing and contrasting psychological healthcare provisions with that of other UK healthcare contexts.

This meta-ethnography has further illustrated the gaps in service provision between mental health and addiction services in particular, as well as the critical need for support for PWUA that is holistic rather than siloed into specialised areas of treatment. Given the flurry of recent healthcare policy reports in the UK recognising that "people with mental health problems and co-occurring substance use problems can face barriers to accessing mental health support" (NHS England, 2020, p. 20), the current study aims to address this gap highlighted by the systematic review and provide detailed exploration into the experiences of PWUA as they navigate the psychological therapy treatment pathway in the UK.

1.9 Chapter Summary

This chapter has provided a broad overview of the history of alcohol addiction and mental health as well as the growing segregation between services over time. A systematic literature review in the form of a meta-ethnography was conducted in order to assess current research into the experiences of PWUA accessing healthcare services. The literature review confirmed that there is no current qualitative research into PWUA experiences of accessing psychological therapy in the UK. This chapter has provided a rationale for the current study, both in terms of the gap in the literature as well as its aims to inform future clinical practice given the current challenges facing service provision.

Chapter Two: Methodology

2.1 Chapter overview

This chapter discusses the ontological and epistemological positionality of the researcher. It then describes the research design of the project and explains and justifies the

rationale behind the selection of constructivist grounded theory (CGT) as a qualitative research method. It will present the main principles of grounded theory (GT), along with a description of the foundations of the method as well as the different approaches through which GT has been adapted. The chapter will then describe the research process, including participant selection and recruitment, methods of data collection and process of data analysis. The chapter will conclude with a discussion on ethical considerations as well as suggestions for research dissemination.

2.2 Rationale for choosing qualitative methodology

Qualitative research, as opposed to quantitative, is normally derived from a relativist framework, and is congruent with interpretivist-constructionist philosophies (Creswell, 2003; Willig, 2018). It is concerned with gaining rich and detailed understanding of people's lived experiences (Coolican, 2009) and suggests that meanings are formed through conversations and interactions with others (Creswell, 2003). Qualitative methods seek to understand how meaning is assigned to experience as well as how people form interpretations of the social world (Polgar & Thomas, 2013). Qualitative research is concerned with questions such as 'how', 'what' and 'why' within specific contexts (Denzin & Lincoln, 1998).

Qualitative methodology was considered appropriate for the current study for a variety of reasons. Firstly, the aim of the study is to examine and understand the psychological, practical and embodied experiences of PWUA when attempting to access psychological therapy. This is a complex phenomenon and is based on subjective experiences as well as PWUA's individual understandings of the world around them. Qualitative methodology is understood to be an appropriate methodology to gather detailed data relating

to subjective experiences (Pope & Mays, 1995). Secondly, qualitative research methods shed light on the complexity of health-related experiences and practices as well as taking into account the epistemological assumptions that underlie health-related knowledge (Malson, 2010). Thirdly, this study relies on transcribed data from one-to-one interviews conducted with PWUA. Qualitative methods are particularly useful for understanding participant experiences and gathering rich descriptions (Barker et al., 2015); exploring the detailed knowledges from PWUA themselves using qualitative methodology can provide crucial insight into lived experiences for service providers, commissioners and health policy-makers (Neale et al., 2015). Finally, a qualitative methodology aligns with the researcher's personal philosophical positioning, as outlined in the next section.

2.3 Philosophical positioning

Ontologies are beliefs about what constitutes reality and can vary from realism to relativism when it comes to interpreting the nature of the social world and how it is produced (Giaocomini, 2010). Establishing either a realist or relativist stance is important both in the data collection process and in the analytic stages of research (Willig, 2012). Realism assumes that an external reality exists and therefore can be known. Collecting data from a realist perspective in qualitive research involves taking participant accounts as an objective "truth" (Giaocomini, 2010) that exists independently of people's perceptions and constructions (Fletcher, 1996; Phillips, 1987). At the other end of the spectrum, a relativist perspective abandons claims of truth. "Realities" are understood as subjective and do not exist beyond an individual's own thoughts and experiences (Willig, 2012).

From an ontological starting point, an epistemological viewpoint can then be developed, which refers to assumptions regarding the theory of knowledge (Willig, 2012). In this sense, "epistemologies (how we must find out) flow necessarily from ontological beliefs (what we want to find out about)" (Giaocomini, 2010, p. 131). Epistemological standpoints are concerned with both the means and the extent to which knowledge can be acquired and are understood to exist along a continuum between positivism and interpretivism (Crotty, 1988). Positivist approaches understand knowledge as measurable; researchers are neutral and therefore do not affect or distort what is studied (Coolican, 2009; Willig, 2018). Positivist approaches are centred upon objectivity; researchers aim to uncover causal explanations about an external and "knowable world" (Charmaz, 2014, p. 5).

Interpretivist ontologies are grounded in relativism, viewing knowledge as co-constructed between researcher and participant. Constructionism is just one of several interpretivist, or postmodern, paradigms which emphasises individuals' constructions of the world through relational and social interactions (Williamson, 2006). Knowledge is co-constructed between participant and researcher as people explain and describe their worlds, creating subjective meaning (Banister et al., 1994; Coolican, 2009). From this stance, the perception of the researcher provides an equally important account of a shared social world (Willig, 2012). This has subtle differences to other interpretivist paradigms such as social constructionism which emphasises the importance of specific cultural and social contexts (Young & Collin, 2004) and to constructivism, which emphasises individual cognitive processes.

As Willig (2012) suggests, researchers should be reflexive and confront the multiple identities that "represent the fluid self in the research setting" (Guba & Lincoln, 2005, p.

210). Researchers require self-awareness regarding their own epistemological and ontological positioning as well as the practical considerations of the project (Banister et al., 1994). In this study, the researcher adopts a relativist ontological standpoint, maintaining a belief in the existence of multiple subjective "truths". Epistemologically, the researcher is aligned with a social constructionist standpoint, understanding knowledge to be co-produced between participant and researcher, through careful and attentive conversations with participants and detailed exploration of the processes and experiences that define their worlds (Charmaz, 2014). In this way, "a social constructionist approach to grounded theory allows us to address *why* questions while preserving the complexity of social life" (Charmaz, 2008, p. 397). The researcher also understands knowledge to be embedded within a social context, as well as influenced by individual cognitive processes from participants' personal experiences.

2.4 Rationale for choosing grounded theory

Within the field of psychological research, there are a range of qualitative research methods that are commonly used, alongside varying approaches to analysing qualitative data (Denzin & Lincoln, 1998). Within psychology, methods of qualitative inquiry commonly include thematic analysis (TA), interpretative phenomenological analysis (IPA), discourse analysis (DA) and grounded theory (GT).

GT was deemed most appropriate for this research because of its unique approach of moving beyond description into explanation and theory generation (Charmaz, 2017). GT has been recognised as a useful methodology for understanding health-related processes or journeys through social phenomena (Charmaz & Henwood, 2017); GT also provides a systematic approach to data analysis, with theoretical concepts remaining detailed and closely

connected to the data itself (Charmaz, 2017). Given the extent of complexity in current policy regarding addiction and mental health service provision, gaining context-specific and detailed insights into PWUA experiences of this social phenomenon makes it best suited to GT methodology. GT will be explored in more detail in the next section of this chapter.

Braun and Clarke (2006) developed TA to interpret patterns of meaning within qualitative data (Terry et al., 2017), adopting a flexible approach to analysis whilst recognising the subjectivity of the researcher (Braun & Clarke, 2006; Terry et al., 2017). However, TA has been criticised for being too broad a research method and therefore lacking distinction from other qualitative approaches (Terry et al., 2017). Similarly, TA tends to identify and describe themes rather than exploring process, providing explanation and developing theory – all of which are critical to GT (Charmaz, 2017). This project will be focusing on a specific phenomenon to craft a theory, hence a broad approach to analysis would have been insufficient.

DA focuses on linguistics and its power to shape meanings, identities and relationships through social, political and psychological characteristics (Arribas-Ayllon & Walkerdine, 2017). Meaning is understood to be created through a shared and mutually agreed use of languages, as well as the context through which it is shared. Compared to GT, however, DA is often criticised as conflating both realism and relativism in its approach. This project seeks to develop theory from data through a constructionist lens, lending itself to a relativist approach to analysis, and similarly the focus of this project draws on experience of the social world of participants, with less attention paid to linguistics. DA was therefore not selected as a research method.

IPA aims to understand the lived experiences of participants relating to a particular phenomenon, and to examine, interpret and find patterns of meaning across experiences (Eatough & Smith, 2017). Despite sharing similarities with GT in terms of a distinct focus on how participants make sense of their social worlds, IPA remains largely descriptive in its approach, compared with GT's aim to explain process and develop theory. This project seeks to generate theory to explain PWUA's experiences, therefore a descriptive approach was thought to be inappropriate.

2.5 Grounded theory: development of grounded theory

GT was initially developed by Glaser and Strauss (1967), making a case for qualitative research to rival quantitative as a systematic and inductive method of inquiry (Charmaz, 2000). GT follows a process of systematic data collection and analysis, aiming to uncover phenomenological processes such as behaviours and social relationships, studying such phenomena in the environments in which they take place (Glaser & Strauss, 1967). In this way, the aim was to bring scientific rigour into qualitative research, moving beyond descriptive studies towards "explanatory theoretical frameworks" (Charmaz, 2014, p. 8). Originally, GT aimed to uncover a theory which explained a basic social process (Lever, 2013). Glaser and Strauss (1967) advocated for a process of "developing theories from research grounded in data" as opposed to deducing hypotheses from pre-existing theory (Charmaz, 2014, p. 4). The theories developed from the data are understood as hypotheses to be further tested or researched in the future (Glaser & Strauss, 1967) and laid the groundwork for qualitative research to be seen as a credible methodology (Charmaz, 2014). For Glaser and Strauss (1967), a "finished grounded theory explains the studied process in new theoretical terms" (Charmaz, 2014, p. 7). As first-generation GT theorists, Glaser and Strauss

(1967) prompted a move away from deductive positivism yet continued to adopt a positivist view of an objective "discovery" of theory, representing what has come to be known as traditional GT (Charmaz, 2014).

In the following years, Glaser and Strauss differed and later diverged in their approach to GT; Glaser continued to be influenced by positivism and empiricism, whilst Strauss proposed a symbolic interactionism approach, understanding humans to be active agents in their own worlds, creating structure through engaging in social processes (Charmaz, 2000; Chun Tie et al., 2019). Strauss and Corbin went on to develop an independent strand of GT known as evolved or interpretivist GT (Strauss & Corbin, 1990; Levers, 2013), highlighting the importance of multiple realties and context in theory development. Their approach also acknowledged the role that researchers play in the interpretation of data, but nevertheless remained grounded in a relativist pragmatist position (Charmaz, 2000).

A second generation of GT theorists later emerged, moving away from positivism and proposing a post-modernist approach to GT. Theorists such as Bowers and Schatzman (2009), Byrant (2002) and Clarke (2005) acknowledged the value of GT guidelines but began to lean towards combining GT with more flexible assumptions and approaches. Charmaz (2006) developed the constructivist approach to GT (CGT), positing that both research and theory are not discovered, but are instead constructed (Charmaz, 2006; 2014). CGT adopts a "middle ground between postmodernism and positivism" (Charmaz, 2000, p. 510). While the approach is firmly grounded in social constructionist epistemology (Charmaz, 2008; Byrant, 2002) and assumes multiple social realities, it does not overlook "the existence of an obdurate, real world that may be interpreted in multiple ways" (Charmaz, 2008, p. 410). Within CGT, theory is thought to be constructed by the researcher who views the world

"through their own particular lens" (Chun Tie et al., 2019, p. 3). Charmaz (2014) emphasises that experiences are co-constructed through the interaction between participant and researcher, providing a subjective interpretation of the world, not merely a construction of it.

Certain differences in traditional versus CGT are notable, such as the use of focussed coding in CGT which allows for a more interpretative approach to the coding process. In CGT, researchers are also encouraged to take a "deeply reflexive stance" termed methodological self-consciousness, which encourages researchers to "scrutinize their data, actions, and nascent analyses" (Charmaz, 2017, p. 3). This encourages the researcher to pay close attention to her own individual response to the process of information gathering and data analysis (Charmaz, 2017). Charmaz views traditional GT as a useful set of principles that can be used as flexible guidelines for research.

2.6 Grounded theory: techniques and application

Some methodological techniques remain consistent across all strands of GT, despite their differing philosophical frameworks. These include coding, memo writing, constant comparison, concurrent data collection and analysis, theoretical sampling and theoretical sensitivity. A brief explanation of the various techniques will be explained below.

CGT is an iterative rather than linear approach meaning that data is concurrently collected and analysed throughout the research process. In this way, the researcher continually refers back and forth between the stages of data collection and analysis, refining categories along the way (Charmaz & Henwood, 2017). The recurrent nature of the GT approach allows for the processes of theoretical sampling as well as constant comparison.

Theoretical sampling is a "defining property" of CGT (Charmaz, 2000, p. 519). Throughout the process of collecting and analysing data, it is likely that gaps emerge within nascent theories, whereby further data might be required. Using theoretical sampling, the researcher seeks to sample specific issues to gain a deeper understanding of emergent theories (Charmaz, 2000). Participants or interview questions might therefore be chosen strategically in accordance with the direction of emerging concepts and theory (Charmaz, 2014; Glaser & Strauss, 1967).

Constant comparison is a key feature of GT. It provides a means of combining both the coding and theory development processes of qualitative research. Using a constant comparison method, codes are compared to codes, codes to categories, and categories to categories throughout the data analysis process (Birks & Mills, 2011). This occurs until the theory is fully integrated. Unique to CGT is the concept of abductive reasoning (Charmaz, 2014). It occurs mainly through using the method of constant comparison. As such, the researcher considers all possible theoretical explanations for "surprises" found in the data (Charmaz & Henwood, 2017) and either confirms or disconfirms them, until they arrive at, or construct, the most plausible theoretical explanation (Charmaz, 2006). In this way, the researcher moves "back and forth between possible theoretical explanations and data to construct robust theory" (Charmaz, 2017, p. 39). Data collection continues until theoretical saturation has occurred (Charmaz & Henwood, 2017). This is when gathering further data would not reveal any new properties of a given category, therefore providing no further insights relating to the emergent theory (Charmaz & Henwood, 2017, p. 140).

Coding is the process of assigning conceptual labels to the data and is the beginning of the process of theory-making (Urquhart, 2013). Coding guides future data gathering and is

the important link between data collection and meaning (Saldaña, 2021). Different types of coding exist within CGT. Initial coding is the preliminary process of examining every line, or word, of data (Charmaz, 2014). Codes should be kept as close to the data as possible; using gerund, or active, codes help to move the data towards conceptual analysis and meaningful theory rather than description, connecting processes rather than isolated incidents or topics (Chun Tie et al., 2019).

Intermediate coding, termed focused coding by Charmaz (2014), then takes place in order to begin to analyse which codes appear most regularly, or supersede other initial codes in terms of importance. It results in the development of categories (codes which account for larger amounts of data) and begins the process of theoretical analysis and integration. To remain close to the data during the coding process, Charmaz (2014) advises the researcher to remain reflexive in questioning her own response to the data, whilst also remaining attuned to the participants' understanding of their own worlds. In this way, the researcher is also open to scrutiny (Charmaz & Henwood, 2017). After ascertaining which categories most helpfully explain the crux of the research, they are refined and treated as theoretical concepts, which can help the researcher to understand multiple issues that are occurring across the research. This type of coding leads to theoretical integration (Birks & Mills, 2011).

Memo writing occurs throughout the entire process of analysis and is an important feature of GT. As a researcher, it involves writing analytic notes to oneself along the way in order to identify "tentative categories and their properties, define gaps in data collection, delineate relationships between categories and engage in reflexivity" (Charmaz & Henwood, 2017, p. 240). It starts before the data collection takes place (Urquhart, 2013), at the point where the researcher has decided on an area of study. Memo-writing as a process is helpful

because it encourages the researcher to examine both the data and the provisional codes from a new perspective (Charmaz, 2000). As analysis proceeds, memos start to become progressively theoretical (Charmaz & Henwood, 2017) and allow for a higher level of abstraction to the researcher's initial ideas (Urquhart, 2013).

Theoretical sensitivity is the process by which researchers become fully immersed in the data, becoming attuned to the nuances of the participants' words and enhancing their level of insight with the area of research (Birks & Mills, 2011). Codes and meaning start to carry analytic weight and researchers develop "the ability to discern and interrogate possibilities for conceptualising the data in abstract terms" (Charmaz & Henwood, 2017, p. 250).

2.7 Rationale for choosing constructivist grounded theory

Charmaz's (2006) constructivist strand of GT was selected to meet the aims of this study. CGT provides a methodology through which a theoretical framework can be developed which seeks to explain how PWUA experience the process of accessing psychological therapy. In terms of capturing PWUA's experiences, the aim is to make sense of individuals' internal and social worlds and the complex psychological processes that are involved in help-seeking, addiction and marginalisation. A constructivist approach to this research project is also appropriate given its focus on exploring participants' personal interpretations, reflections and experiences of a psychosocial phenomenon. CGT allows for multiple perspectives to emerge, simultaneously acknowledging the role of the researcher in the interpretation of data. CGT seeks to provide an interpretive portrayal of the studied world rather than a static picture (Charmaz, 2014). This is especially useful for the researcher's area of research – that situated within addiction and mental health service provision - given the

recently updated public health policy relating to the provision of psychological therapy in the UK (NHS, 2019).

The researcher's personal philosophical positioning is critical as it undoubtedly influences research design (Urquhart, 2013; Charmaz, 2014). In this study, the researcher aligns with social constructionism, approaching this study from the belief that meanings are co-constructed, whilst also considering her own work history and current role as a trainee psychologist to have a subjective influence on the data. The researcher also consulted with an expert by experience, who acted as second supervisor during the initial planning stages of the study. The expert by experience was also a member of the Essex Service User Recovery Group (SURG), allowing for wider (albeit indirect) consultation with a recovery group to include multiple perspectives. Involving service users in the planning stages of research can be an important way of increasing a study's credibility, as well as ensuring relevance to those the study might impact (Neale et al., 2017). Furthermore, meetings with her second supervisor provided a means for the researcher to determine appropriate terminology, such as using "person first language" rather than potentially stigmatising language. It was agreed that concerns regarding access to psychological therapy was a topic of concern and similarly, the researcher was able to consult with her second supervisor regarding broader ethical decisions such dynamic risk assessing during interviews. Overall, this contributed to the study being grounded in lived experienced of PWUA.

In order to meet the aims of the study, CGT is appropriate because it is a useful methodology for studying power, marginality and inequality as well as implementing social justice research (Charmaz, 2005) and developing social consciousness (Charmaz, 2017). This is suitable to the current study's focus on often contested public health and social policy

within the fields of mental health and addiction service provision. CGT provides "a systematic approach to social justice inquiry that fosters integrating subjective experience with social conditions in our analyses" (Charmaz, 2005, p. 510). The process of "methodological self-consciousness" enhances critical enquiry within qualitative research, scrutinizing power and inequality in a hope to redress forms of oppression and injustice (Charmaz, 2017). Constructivist epistemology is also a useful approach for areas of research that are not sufficiently explained by pre-existing theories (Gasson, 2004); research relating to PWUA experience of psychological services is underexplored in the literature.

Although more traditional approaches to GT are adamant that an avoidance of the literature is key to ground one's theory in the data, Byrant and Charmaz (2007) suggest that it is important to understand and be familiar with the current discourse surrounding the topic of research. Within CGT, it is suggested that conducting a literature review can help to "set the stage for what you do in subsequent sections or chapters" (Charmaz, 2006, p. 166). In addition, Noblit and Hare's (1988) meta-ethnographic approach is grounded in the authors' perceptions of the data and is less "concrete" than a meta-synthesis (El Hyssein et al., 2017). A line of argument provides an interpretation of the data, rather than a synthesis of the data itself, which is congruent with CGT methodology.

El Hussein et al. (2017) recommend a "multistage nonlinear approach to the literature" which the researcher followed, using the process of constant comparison throughout the entire thesis process. Within the current study, a literature review was conducted both prior to and following the data collection process in order to compare existing research on the subject. This aligned with the constant comparison process throughout the

research, allowing the researcher to compare theory back to existing literature following the collection of data and during the analysis process.

2.8 Procedure

2.8.1 Participants and recruitment

Participants were recruited for this study by advertising initially across substance use services and community recovery support groups. In total, four community alcohol services supported with recruitment. The study was also shared via organisations' mailing lists. In addition, the study was advertised on addiction and recovery support groups on Facebook and shared on '*X*'. Initially services and participants were recruited solely from southeast England, but once the study was advertised using social media groups, participants from elsewhere in England were also included. Given the sensitive nature of the subject area within this research project, one-to-one interviews, rather than focus groups, were deemed most appropriate. The inclusion criteria for recruitment were as follows:

a) Adults who identified as having an active alcohol addiction, with alcohol being their primary substance. For the purpose of this study, "active addiction" was defined by a participant who identified as currently struggling with their alcohol use. This allowed the subjective experience to define active addiction, rather than placing strict notions of "drinking" versus "sober" as recruitment criteria which would be inappropriate given the non-linear nature of recovery. Throughout the process of interviewing, the inclusion criteria were expanded to include those who were within six months of

recovery to account for the dynamic and often cyclical nature of addiction and sobriety.

b) Participants were required to also identify as having a mental health problem, either diagnosed or undiagnosed. Participants who had mental health conditions which were managed by secondary mental healthcare were excluded from participating. This was because those under secondary care are likely to have a psychiatrist and therefore are subject to different treatment pathways to psychological support compared with those seeking primary mental healthcare services, such as NHS Talking Therapies.

c) Participants were required to be engaging with a substance use service or another related support service. This was to safeguard individuals during the interview to ensure that they had support in an ongoing capacity.

2.8.2 Sampling strategy

Purposive sampling was initially employed for the recruitment of participants for the research study through the contacting of specific substance use services. This expanded to snowball sampling whereby participants shared information about the study via word of mouth to peers who might be interested in participating. Those who met the inclusion criteria received an initial screening phone call with the researcher. This was to ensure that participants were suitable to participate in the research by assessing inclusion criteria and risk relating to severity of mental health conditions. 15 participants were recruited for the study which was deemed an appropriate and practical sample size given the time limitations of the study, whilst enough to provide rich and sufficient data for the development of a grounded

theory. During the process of recruitment, the researcher was contacted by a further six participants who either did not meet the criteria for inclusion (two) or decided not to participate (four).

A participant information sheet (Appendix F) was produced and disseminated to interested participants. The information sheet explained the purpose of the study, the inclusion criteria for participation, and relevant information relating to consent and confidentiality. The procedure of the study and the purpose of the research project and its potential benefits and risks were also explained clearly. The contact details for the researcher and lead supervisor were also supplied. Participants were also sent a consent form (Appendix G) to sign and return via email as well as a brief demographic questionnaire (Appendix H) in order to gather information regarding age, gender, sexuality and employment status as well as further details regarding length of engagement with current support service. This was to allow for recognition of any notable patterns within the participant data. A signposting sheet (Appendix I) was also sent to participants prior to interview, detailing support services available should participants wish to seek support following the interview. Participants were informed that they would receive a renumeration voucher of £20 via email following the interview. This was in line with University guidelines, which restricted the researcher's ability to pay participants cash.

As the study progressed, theoretical sampling was employed to seek participants specifically, in line with a CGT approach (Charmaz, 2014). As such, after the first five interviews, initial codes were generated, followed by focussed codes. The researcher became aware that the cyclical nature of sobriety and recovery was apparent across the initial interviews. Through memo-writing (Appendix E), the researcher became aware that her

initial plan to exclude participants who were not in active addiction served to reinforce the more rigid 'biological' model of addiction. The first five interviews revealed that the process of recovery was "messier" than this; periods of sobriety and addiction could not be clearly accounted for. As a result, the inclusion criteria were adjusted accordingly. The following ten participants were recruited using the broader criteria of being either in active addiction, or within "recent", i.e. six months of recovery – which could include periods of addiction and sobriety. This accounted for the more volatile, "grey" nature of recovery and to avoid deeming participants ineligible, potentially reinforcing a sense of rejection from services.

According to GT, data collection is deemed complete when theoretical saturation has occurred. This has been challenged by Nelson (2016) who argues that it implies a notion that data can be complete, contradicting CGT's underlying philosophy which postulates that realities cannot be fully "known" as they are constructed. Therefore, Nelson (2016) argues that "conceptual depth" is a more appropriate concept for use in CGT research, implying that the researcher has reached sufficient depth of understanding in relation to the emergent theory. The current study therefore focussed on achieving conceptual depth rather than saturation, not only because of its alignment with CGT, but also because of the reality of the time constraints of this study and remit of a sole researcher. It should be noted that demographic variation within the sampling process was difficult to account for, given the largely White British participant responses received. It is of note, however, that the purpose of the research project was to generate theory rather than provide a wide demographic variety to the sample.

2.8.3 Interviews

Semi-structured interviews were used as they are the most common data collection method in CGT (Charmaz, 2014) but also because they are appropriate for the gathering of in-depth exploration of experiences. Interview length varied from 108 mins (participant 15) to 48 mins (participant 11) (M = 73.6 mins). Eight interviews were conducted face-to-face at various substance use services across the East of England. According to participant preference, seven interviews were conducted remotely via Microsoft Teams.

The interview process was loosely structured according to an interview topic guide (Appendix K); this was amended slightly as the data collection progressed according to notions of theoretical sampling with CGT (Charmaz, 2014). All interviews started by asking participants to describe their experiences of addiction and mental health problems which was a broad, descriptive and open-ended question as recommended by Charmaz (2014). This was in order to encourage participant stories to emerge and is important considering "interviewing is not considered as efforts to mirror reality but as emergent interactions through a mutual exploration of the interviewee's experiences and perspectives" (Charmaz & Thornberg, 2021, p. 317). The researcher's approach to asking questions and following up on the response are a critical component in the construction of the data as well as the quality of the data gathered (Charmaz & Thornberg, 2021). As the interview progressed, follow up questions were honed according to emergent themes (Charmaz, 2014). The emergent categories of chaos and confusion became apparent within the first five interviews, prompting the researcher to explore these topics in more detail as the interviews progressed, as encouraged by the CGT technique of theoretical sampling. Purposefully honing in on specific topics as the interviews progressed was aided by the process of memo-writing, helping the researcher to understand her own responses to the initial interviews. An example interview transcript is included in

Appendix M. Further details regarding the process of conducting interviews will be discussed in Chapter Four.

2.9 Data analysis

2.9.1 Coding, memo-writing & theory building

Several qualitative researchers have discussed manual coding versus using software (Neale, 2016; Braun & Clark, (2022). For thematic analysis, Braun & Clark (2022) suggest both manual or software coding can be used but suggest initial coding to be conducted by hand to allow for greater reflexivity and interpretation. Neale (2016) suggests hand versus software coding comes down to personal preference but advises that the process of moving between summarised data and its specific context requires "intimate knowledge of the data and when, where, how and why they were generated. No computer program can substitute for this" (Neale, 2016, p. 1105). The current research used manual coding, both hand-written and later using Microsoft Excel to organise the codes. This was possible given the current study's relatively small sample size as well as being conducted by a sole researcher, meaning that the process of data analysis, while transparent, was unique to her own system of sense-making and theoretical integration, rather than reliant on colleagues' contributions to a shared software programme and coding system. Furthermore, given the less structured nature of CGT alongside its recurrent and iterative coding process, the researcher preferred manual coding as it facilitated easy movement between data, memos and codes.

Initial line-by-line coding of transcripts (Appendix A) largely used gerund codes in order to maintain close engagement with the data (Charmaz & Thornberg, 2021). The

researcher began to define meanings and actions and make constant comparisons between transcripts. Initial codes are provisional, meaning the researcher remained as open as possible, attempting to avoid placing codes into predetermined categories at this stage. During this stage, the researcher began to recognise links and draw comparisons between codes and meanings. Focussed coding (Charmaz, 2014) (Appendix B) then took place in order to organise the most commonly occurring and relevant, or "fertile" (Neale, 2016) codes under provisional conceptual headings in a Microsoft Excel spreadsheet. These headings were then compared to one another, checking for similarities and repetitions across the data, and comparing initial codes to initial codes.

The conceptual headings were then organised on a separate spreadsheet and clustered again according to relevance and occurrence. At this stage, the researcher referred back to the data, using the CGT process of constant comparison, to consolidate the headings and trace these back to specific segments of transcripts. The researcher decided to manually write down the preliminary conceptual headings, cutting out segments of participant transcripts and beginning to integrate these under broader conceptual headings, beginning the process of theoretical coding (see Appendix C). This process aids close engagement with the data (Urquhart, 2013) and although challenging to organise, CGT researchers are advised at this stage to "tolerate ambiguity" (Charmaz & Thornberg, 2021, p. 322). The aim of this type of coding is to begin to integrate a large amount of data; using paper allowed for a more creative process of theoretical intervention and aided the iterative approach to CGT.

Memo-writing (Appendix E) was an important process that occurred throughout the entire research process, helping the researcher to document, consolidate and process her own reflections (Chun Tie et al., 2019). Memo-writing occurred prior to, during and after conducting the interviews and played an important role in the writing up and consolidation of

results. It helped to generate codes and categorise as well as understand the reasoning and process behind emerging theoretical ideas (Birks & Mills, 2015). Memos were freely written in terms of form and content, as recommended by grounded theorists (Birks & Mills, 2015), providing a means of "conceptualis[ing] the data in narrative form" (Lempert, 2007, p. 245). At the start of the research process, memos were in the form of diary entries, helping the researcher to think about feelings and reflections that arose during the process of initial recruitment as well as throughout the process of data analysis. It also helped the researcher understand her own pull towards the research area. Later, memos were used in a more structured way to help to develop initial codes and subcategories, reflective of how the researcher was beginning to think about links within the data.

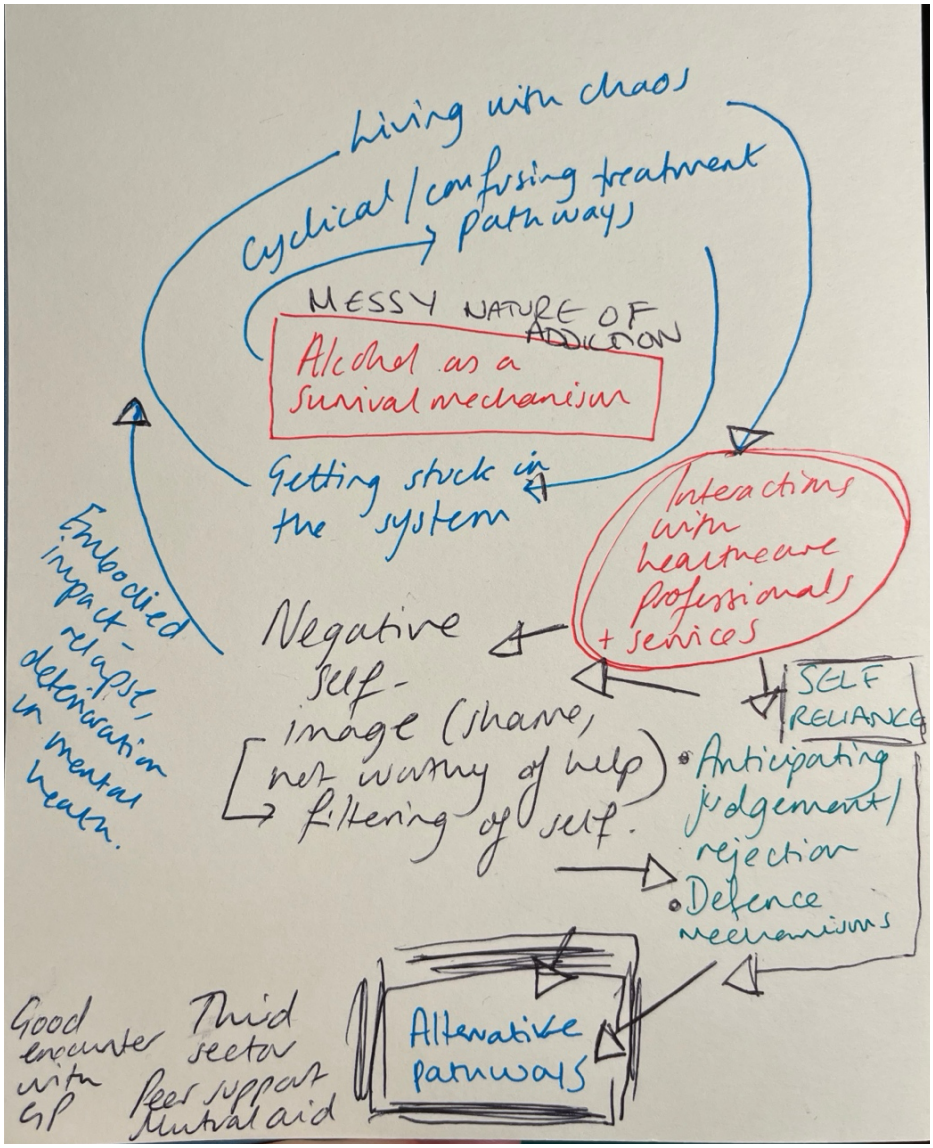
Lastly, more structured theoretical coding (Figure 5) was developed whereby the researcher began moving subcategories into higher order conceptual categories and beginning to integrate the GT into a theoretical model. Creating visual diagrams at this stage can be especially helpful to start building relationships between categories (Urquhart, 2013). Developing a theoretical model is an attempt to provide an understanding of how conceptual categories interrelate, presenting what is essentially "a theoretical interpretation or explanation of a studied phenomenon" (Chun Tie et al., 2019, p. 7). Both traditional GT (Glaser & Strauss, 1967) and more flexible approaches, including CGT, all suggest that a substantial theory is the final outcome of research. Kelle (2007) advises against forcing theoretical concepts on the data. Heuristic categories are recommended, which do not need to be precise or perfect but instead represent the lens through which the researcher perceives the phenomena.

2.9.2 Audit trail

Using a constant comparison process throughout the stages of coding, the researcher was able to continually determine which codes, categories and subcategories were most relevant to the entire data set. For example, subcategories such as the disappointment at not receiving psychiatric diagnoses from primary care services as well as the confusion regarding the role of medication were both experienced by PWUA following interactions with GPs and other HCPs. However, it was the overarching sense of negative self-view – including lowered self-worth and the reinforcing sense of shame – that were the most impactful experiences on PWUA in terms of embodied responses and were therefore identified to be categories that best explained the data. The following chapter presents the categories, subcategories and theoretical model.

Figure 5

Theoretical coding and beginning to build a model



2.9.3 Quality assurance

In contrast to Glaser and Strauss (1967), assessing the quality of CGT studies arguably requires prioritising abstract understanding rather than explanatory power. Quality is assessed based on four criteria: credibility, originality, resonance and usefulness (Charmaz, 2014). Credibility refers to the rigour of the process of data collection, analysis and

evidencing theory development in a GT study (Charmaz, 2014; Charmaz & Thornberg, 2021). Firstly, achieving rigour requires attention to certain systematic processes including theoretical sampling, achieving theoretical sufficiency and demonstrating accurate links between the data and the emergent theory. Secondly, systematic approaches to both coding and constant comparison are also useful markers of a credible GT study (Charmaz, 2014). Lastly, methodological self-consciousness is a means of explaining the researcher's predispositions and assumptions prior to commencing the research and being transparent throughout the study. Providing a sound demonstration of the researcher's own reflexivity and transparency throughout the process is useful means of demonstrating credibility (Charmaz, 2014). More details relating to researcher's reflexivity are discussed in section 4.6 as well as through the process of memo-writing which occurred throughout the research process in its entirety.

Originality refers to the development of an emergent theory as one "offering new insights, providing a fresh conceptualisation of a recognised problem, and establishing the significance of the analysis" (Charmaz & Thornberg, 2021, p. 3016). Situating the study within current research and discussions relating to its originality will be detailed in Chapter Four. Resonance refers to how relevant the study is and the extent to which it offers understanding about other individuals, beyond that of its own participant's experiences. While qualitative research is not intended to be generalisable (Neale et al., 2014), ensuring a GT study is resonant with the research area is important. It can be useful to question whether the categories "portray the fullness of the studied experience" as well as whether the GT makes sense to participants involved in the study. (Charmaz, 2014, pp. 337-338). Usefulness refers to the extent to which the study provides clarity about participants' understanding of their everyday lives as well as providing a "foundation for policy and practice applications" (Charmaz & Thornberg, 2021, p. 316). A useful study will also contribute to new avenues of

research. Further discussion regarding how the study meets these four criteria is provided in Chapter Four which details a critique of the current research.

2.10 Ethical considerations

This study obtained ethical approval from the University of Essex School of Health and Social Care's Ethics Committee (Appendix L). Ethical considerations were also made in accordance with The Code of Human Research Ethics (2021) produced by the British Psychological Society. This Code informs standards of practice relating to consent, confidentiality, appropriate data storage and risks of harm both to participants and researcher. The following section refers to each of these ethical issues within the current research. It explains how various ethical issues were considered and managed during the planning, collection and analysis of the data.

2.10.1 Informed consent

Ethical research must not only rely on participants agreeing to participate, but also being provided with full and open information regarding the study (Denzin & Lincoln, 1998). The participant information sheet (Appendix F) clearly stated the aims of the research and expected outcome; it also stated that participation in the study was entirely voluntary, and consent could be withdrawn at any point prior to the interview or within a specified timeframe following the interview. The consent form (Appendix G) also included a statement of agreement to participate in the research as well as consent for the recording of interviews. Informed consent was gained on three separate occasions; this was to minimise the risk of participants giving consent when under the influence of alcohol and who may therefore have fluctuating capacity. Consent was discussed orally during the initial phone calls with participants regarding the study; it was gained in written form prior to the interview using the

consent form, and lastly participants gave oral consent at the start of the interviews themselves.

2.10.2 Confidentiality

The participant information sheet confirmed that participants' data would remain anonymous; participation in the study would also remain confidential. All identifiable information would be removed from transcripts; participants were assigned a pseudonym for both the write up of the transcripts and the study. All quotes used in the study are void of identifiable information. Participants were also provided with information regarding how their data would be securely stored (see Section 2.10.3 below) and were reminded of this information at the start of the interviews. The researcher informed participants about the limits of confidentiality at the start of interviews. If participants made any disclosure that involved risk of imminent harm to themselves or to others, they were informed that the researcher would be required to break confidentiality and inform relevant services. Participants were invited to ask any questions or voice concerns regarding confidentiality prior to the start of interviews. The researcher confirmed that participants were comfortable with the interview being recorded, as laid out in the consent paperwork, and timeframes for interview length were discussed. At the end of the interview, participants were debriefed and given the opportunity to ask any questions.

2.10.3 Data access, storage, security

Storage of data was detailed fully in the participant information sheet; procedure was in line with guidance from the UK Data Protection Act (2018) as well as specific

requirements from the University of Essex Ethics Committee. Participants' data were anonymised at the point of collection. During the recording process on either a password-protected Dictaphone or on Microsoft Teams, participants were allocated an identifying number before later being allocated a pseudonym. Signed consent forms were kept separately to the recordings in a locked cabinet. Recordings were permanently deleted once they had been transcribed. Transcribed recordings and demographic forms were kept in a password protected folder on the University of Essex's secure host server. The researcher's laptop was also password protected. Access to the transcripts was restricted to the researcher and the thesis examiners only upon specific request. All interviews were transcribed by the researcher herself. The data will remain securely stored for ten years to allow for potential amendments and possible publication before being permanently deleted.

2.10.4 Risk management

Recruiting participants with both an alcohol addiction and mental health problem meant that specific regulations relating to managing risk were considered during the interview process. This was because of the increased likelihood of intoxication during the interview but also because of the potential for emotive topics to be discussed. All face-to-face interviews were conducted at specific substance use services that participants were familiar with; staff members were also present on site for the duration of interviews. Participants were informed that the topic of the interviews might be emotive and that they were under no obligation to share information that they were not comfortable discussing. Participants were reminded that they could take breaks when needed or terminate the interview at any point if they wished. The researcher also made it a requirement of the recruitment process that participants be engaged with a support service (where they had an assigned keyworker) to

minimise risk of participants lacking any form of follow-up after the interview. The researcher continuously considered the dynamic risk assessment (Appendix J) during the interviews to monitor capacity to both consent to and engage in the interview. However, no interviews needed to be terminated for any concerns regarding participants being intoxicated or participants being too distressed to continue.

2.11 Dissemination

All participants as well as services that supported with recruitment will be emailed a summary of the study's findings. Following submission, this study will be uploaded to the University of Essex thesis repository, making the research available to all trainees as well as other students and staff. This study will also be submitted to specific peer-reviewed journals with the aim of publication. The researcher will likely submit to the *Journal of Social Science & Medicine, Journal of Substance Use, Journal of Addiction, International Journal of Drug Policy* and the *Journal of Studies on Alcohol* amongst others. The researcher will also present the findings at the European Sociological Association Research Network's "Sociology of Health & Medicine Mid-Term Conference" in Portugal in June 2025. Opportunities for dissemination of findings at the Society for the Study of Addiction Conference 2025 will also be considered.

2.12 Chapter summary

This chapter has provided a rationale for the researcher's choice to employ CGT over other qualitative research methods as well as other strands of GT. The researcher's philosophical positioning was also presented. The defining elements of CGT were then

outlined, before detailing the researcher's specific approach to the research process, including data collection and analysis. Ethical considerations relating to the research process were discussed before outlining a dissemination plan for the research findings. The next chapter explores the results of the participant interviews.

Chapter Three: Results

3.1 Chapter overview

The following chapter describes participants' demographic characteristics. It then proceeds to present the synthesised data, collected from participant interviews, in the form of a theoretical model. The model draws upon the subcategories and categories that were developed throughout the process of close, systematic analysis of the data. The theoretical model is then followed by an in-depth exploration of the model's key categories and subcategories. Throughout this exploration, participants' quotes are presented in order to illustrate PWUA experiences and provide examples of the model's grounding in the data.

3.2 Participants' demographic characteristics

Pseudonyms were assigned to all participants to protect anonymity (see Table 6). Five participants were male, ten participants were female; ages ranged from 22 to 58 (M=40). Most participants (N=12) were unemployed at the time of interview, described as "long term sick leave". During the interviews, most participants spoke about finding it impossible to maintain employment as a result of both mental health difficulties and active addiction. Nearly all participants (N=14) were White British, reflecting perhaps the nature of the

demographic population base of Essex and Hertfordshire, with 85% and 72% white British populations respectively (Essex Council, 2021; Hertfordshire Council, 2021). However, this is possibly also indicative of the wider issue of ethnic minority groups facing greater barriers to accessing mental healthcare in the UK (Bansal et al., 2022).

All participants were engaged with a support service at the time of interview which consisted of substance use or community recovery services. The length of participants' most recent engagement with their current support service ranged from one month to 25 years. Prior to the current services that PWUA were engaged with, however, participants had experienced a variety of different services. Most participants (14 out of 15) had at some point been supported for their mental health issues by an NHS psychological service. Some participants had also engaged with mutual aid groups such as AA (N=8) and some had experienced private therapy at various stages in their lives (N=5).

Table 6 *Participants' demographic data*

Participant	Pseudonym	Gender	Age	Sexual orientation	Ethnicity	Employment status	Location	Types of service	Length of most recent service engagement
1	Catherine	F	54	Questioning	White British	Employed full time	Hertfordshire	Peer support, private, NHS, substance misuse service	2 years
2	Damien	M	45	Heterosexual	White British	Unemployed	Hertfordshire	Peer support, substance misuse, NHS	1 year
3	Jamie	M	58	Heterosexual	White British	Employed part time	Essex	Peer support, NHS, substance misuse	25 years
4	Alice	F	36	Heterosexual	White British	Unemployed	Essex	Substance misuse, NHS	6 months
5	Jenna	F	27	Bisexual	White British	Employed part time	Hampshire	Substance misuse, private, NHS, peer support	5 years
6	Dennis	M	56	Heterosexual	White British	Unemployed	Essex	Substance misuse, NHS, peer support	7 months
7	Louise	F	53	Heterosexual	White British	Unemployed	Tyne and Wear	Substance misuse, NHS, peer support	3 months
8	Simon	M	35	Gay	White British	Unemployed	Essex	Substance misuse, NHS, private	1 year
9	Liz	F	38	Lesbian	White British	Unemployed	Essex	Substance misuse, NHS	1 month
10	Melanie	F	42	Heterosexual	White British	Unemployed	Hertfordshire	Substance misuse, private, NHS	3 months
11	Phoebe	F	40	Heterosexual	White British	Unemployed	Hertfordshire	Substance misuse, NHS	4 months
12	Marina	F	30	Heterosexual	White British	Unemployed	Hertfordshire	Substance misuse, NHS	9 months
13	Nadia	F	22	Heterosexual	White British	Unemployed	Hertfordshire	Substance misuse	2 months
14	Francesca	F	28	Bisexual	Mixed White / Black Caribbean	Unemployed	Hertfordshire	Substance misuse, NHS, peer support, private	2 months
15	Laurence	M	40	Heterosexual	White British	Unemployed	Hertfordshire	Substance misuse, NHS, peer support	1 year

3.3 Theoretical model

The theoretical model (Figure 6) draws together the range of categories and subcategories outlined in Table 7, which were identified through the close analysis of participant data. The model describes the processes by which PWUA attempt to access psychological therapy. At the centre of the model, alcohol holds a conflicting role in PWUA's lives. Alcohol inflicted chaos but simultaneously provided a lifeline to cope with chaos in its various forms: the chaos associated with challenging life circumstances, that of mental health problems, and PWUA's perceptions of a confusing, complex and cyclical system of psychological support. Alcohol was seen to be a "safer" option than giving up drinking considering PWUA lacked trust that timely sand adequate support would be put in place. Pathways into therapy are experienced as nonsensical. Participants regularly end up back at square one of various referral processes, stuck on waiting lists or bounced between services without a sense of clarity, direction or purpose.

Interactions with HCPs and services are characterised both by experiences of rejection, but also by the anticipation of rejection which can be enough to trigger avoidance of help-seeking. This was often due to poor experiences of treatment from statutory services in the past. PWUA tended to present a modified version of themselves to GPs. For example, downplaying the level at which they were drinking in an attempt to access treatment, whilst simultaneously hoping to avoid judgement.

Two outcomes from interactions with HCPs and services are possible. Negative interactions, both experienced and perceived, tended to reinforce PWUA's entrenched sense of shame and their pre-existing, negative self-image of the stigmatised "addict". This lack of

self-worth often deterred PWUA from help-seeking, believing that they did not deserve treatment. Negative interactions, general confusion and uncertainty regarding the referral process, and the reinforced sense of shame triggered embodied responses in PWUA. Increased likelihood of relapse or physical manifestations of declining mental health such as self-harm or suicide attempts were common. PWUA subsequently found themselves back in the chaos of the system.

Another possible outcome was a movement towards self-sufficiency. Negative perceptions of HCPs and services were often enough to activate PWUA's defensive behaviours, such as putting their barriers up, refusing to return to services and rejecting NHS support entirely. For many participants, this prompted a newfound motivation to seek alternative pathways out of the chaos. This was normally via third sector organisations such as substance use charities, or through support from those around them such as mutual aid groups or family and friends, leading to psychological therapy.

Figure 6

Theoretical model

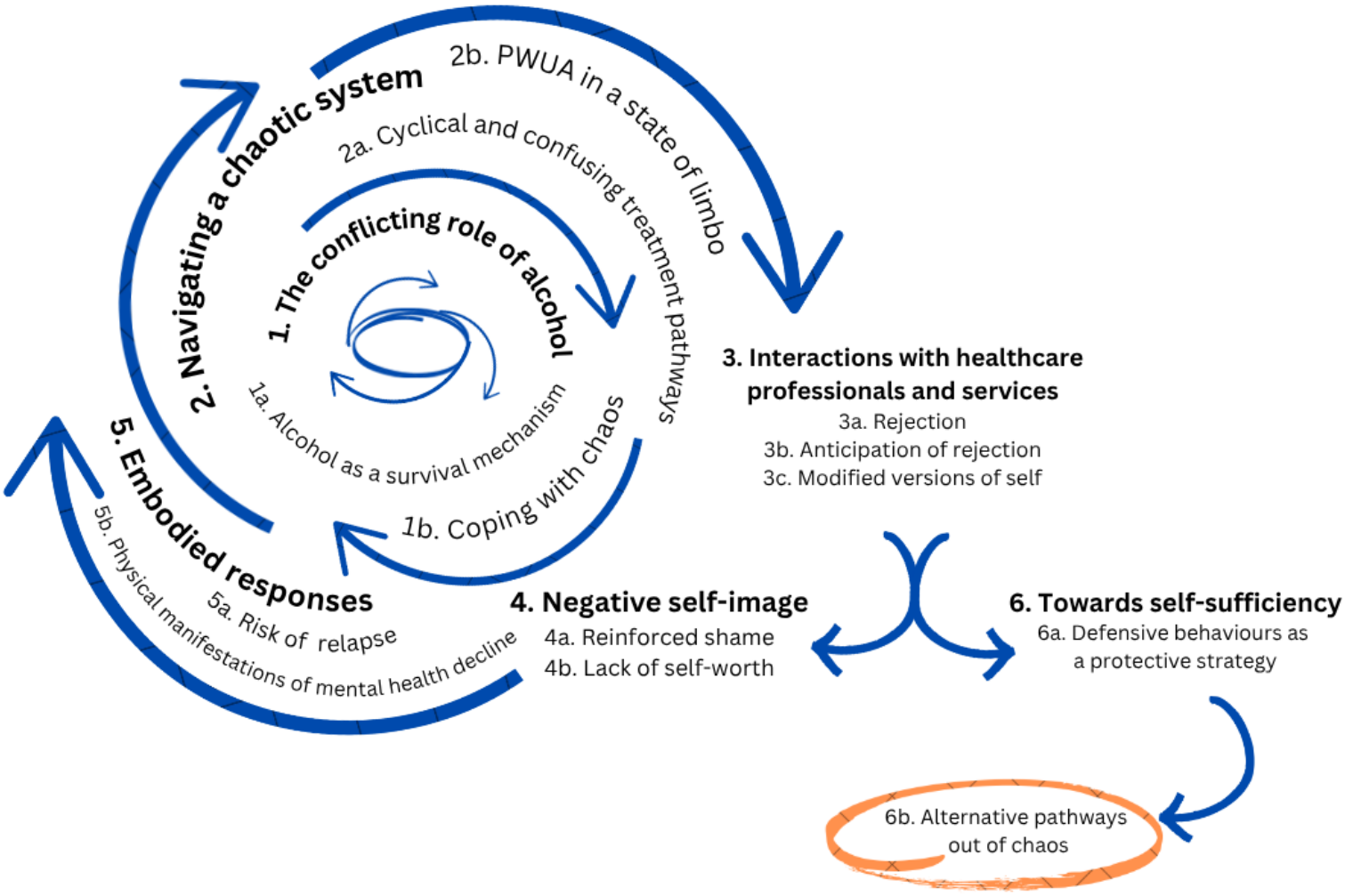


Table 7

Table of categories and subcategories

Category	Subcategory	Frequency (participant number)
1. The conflicting role of alcohol in everyday life	Coping with the chaos of addiction	N=15
	Alcohol functions as a survival mechanism	N=15
2. Navigating a chaotic system	Cyclical and confusing treatment pathways	N=15
	PWUA exist in a state of limbo	N=13 (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 15)
3. Interactions with healthcare professionals and services	Rejection	N=15
	Anticipation of rejection	N=15
	PWUA present modified versions of self	N= 8 (1, 3, 4, 5, 6, 13, 14, 15)
4. PWUA's negative self-image	Reinforced shame	N=15
	Lack of self-worth and its impact on help-seeking	N=13 (1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15)
5. Embodied responses to chaos	Risk of relapse	N=11 (2, 3, 5, 6, 7, 9, 11, 12, 13, 14, 15)
	Physical manifestations of mental health decline	N=14 (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15)
6. Towards self-sufficiency	Defensive behaviours as a protective strategy	N=15
	PWUA's alternative pathways out of chaos	N=15

3.4 Category One: The conflicting role of alcohol in everyday life

3.4.1 Coping with the chaos of addiction

Coping with active addiction was something that impacted on all participants' experiences of help-seeking, as well as their practical ability to engage with services. Many described the inherent ups and downs of alcohol addiction, combined with mental health difficulties, as having significant impact on their ability to access psychological support. As a result, PWUA experienced not only difficulty maintaining engagement with services, such as attending regular appointments, but also in navigating the chronic disruptions to housing, jobs and relationships that were described as the knock-on effects of addiction. This sense of chaos, in turn, made service engagement even more challenging. Liz, who had moved around a lot and experienced periods of homelessness, spoke about the challenges associated with maintaining relationships with services whilst in active addiction. Moving regularly and sofa surfing required continually re-registering with new GP surgeries, often restarting the process of seeking support. This proved especially difficult during active addiction which she described as being in a state of "oblivion" (Liz).

> Liz: I've also moved a lot, like I've been homeless for a lot of years. And sofa surfing all in alcoholics' houses from this place to that place. So I've slipped through a lot of registering with GPs and then you know you've got to go through the whole rigmarole of re-registering, making a new referral. And when you're an alcoholic you haven't got the time, you haven't got the energy. I mean, you've got the time because you've got

> time to drink all day. But you're not thinking of making all the right steps because you're in oblivion in your mind.

For some, the realities of managing an active addiction as well as negotiating withdrawal symptoms meant that alcohol would always be their priority, taking precedence over any form of help-seeking, including getting to appointments or making contact with services.

> Marina: And on top of that there's the drink, because my mind is just trying to not focus on the drink. Drink always comes first, before I can acknowledge anything else.

Managing the demands made on participants by services was felt to be near-impossible. Many participants experienced services as unreasonable, citing unrealistic and unfair expectations to meet rigid appointment times and negotiate inflexible cancellation policies. Furthermore, service policies were often experienced as dismissive of the struggles surrounding compliance that often came with addiction. Catherine described "falling apart" at the expectation to maintain communication with her GP because of the anxiety it created.

> Catherine: I couldn't phone the GP because I was too ashamed… I have a real problem with communication… I'm trying very hard at the moment to keep my phone on. I can't open post, can't open emails. You'll have noticed my communication is rather sporadic. I really, really struggle.

Some participants also described a desire for a second chance when it came to missing appointments. Being discharged from a therapy service seemed counterintuitive to those

struggling to adhere to rigid schedules whilst in the midst of active addiction. There was a sense that stumbling at the “first hurdle” (Francesca) would end support immediately. She shared: “We can fuck up because we're human, we're going to make mistakes, but society's like, oh, if you don't come then we're going to take it [therapy] away from you… I understand you can't give a million chances”. She went on to say: “If I did, after a [therapy] conversation, go and pick up a drink straight away, they'd be like “Don’t come back”… I think it's like policy and procedure … that is what causes a lot of the isolation of not going into systems because I think well as soon as I fuck up you're going to shun me anyway”.

PWUA also expressed some hesitancy to engage with psychological therapy services due to a fear of mental health deterioration and risk of relapse.

> Nadia: I don't want to relapse, I don't want to lose my marbles again, I can't afford to, mentally, physically, everything. And there's a feeling that if you do talk about stuff, things will get worse before they get better. Everything's got to be in place, you know, have a safe roof over my head, have my benefits. And be confident a bit more in my sobriety.

Starting therapy was seen to be associated with a greater risk of relapse and possibility of losing “everything” (Nadia). Opening up to a therapist, without appropriate support to stabilise the wider psychosocial components of her life, was conceptualised as too risky a prospect for Nadia, and ultimately prevented her from seeking psychological therapy. The chaos of addiction itself, as well as its presence in other parts of life, created significant barriers to psychological support for PWUA.

3.4.2 Alcohol functions as a survival mechanism

All participants spoke about the function of drinking alcohol as a means of survival in various forms, paradoxically providing consistency in the face of chaos. Regardless of the societal perspective of addiction as a form of downfall, or giving up, PWUA drank as a way of persevering, self-regulating and staying alive when forced to cope with mental distress. Alcohol represented something reliable and dependable amidst the chaos of intolerable feelings and complicated life circumstances.

All PWUA identified the start of their drinking journeys at a relatively young age (early teenage years), having begun drinking to manage the chaos that had often characterised their early lives. Many had suffered adverse childhood experiences and trauma during their upbringings and saw alcohol as a lifeline. For some, it was "the only way I learned to cope" (Melanie) or "an escape from all the chaos that had just kind of been dropped into my life" (Jenna). Jenna also described becoming "attached to this coping mechanism of drinking", unable to separate herself from alcohol. Reflecting on his journey to becoming addicted to alcohol, Simon said:

> Simon: I was managing in ways that are not so good. So with drinking, I guess it was just as a coping mechanism, to have a sense of control, because I felt that life was just chaos and I couldn't control anything. Then obviously that's when I started to use alcohol.

Drinking afforded PWUA some control over their feelings – by disconnecting them from reality, blocking out particular emotions, or by contributing to some sense of feeling

amidst the numbness. PWUA were not ignorant about the negative effects of alcohol - most acknowledged alcohol as detrimental to their health overall – but alcohol's function as a lifeline meant it was heavily relied upon, often keeping PWUA afloat whilst waiting for services. For Francesca, the prospect of living without alcohol was overwhelming. She attributes being alive today to her addiction, which allowed her to keep going despite the intensity of her psychological difficulties.

> Francesca: But without my addiction, I don't think I would have survived as long as I have. Because in addiction, my mental health wasn't a problem. So it's a survival strategy. It relieves all the pressure that is going on mentally for me.

Sometimes a reliance on alcohol was a barrier to treatment; participants feared giving it up in case appropriate and timely support was not put in place. Alcohol was a lifeline in terms of providing reliable psychological support, given that many PWUA could not trust that services would step in to support them if they were to stop drinking.

> Louise: They [the GP] asked about my drink and then I said "Yes, I am drinking heavy at the moment as a way of really trying to normalise everything out of my head" and they said, "Do you want any help with that?" And I said "No, because if you take away that I don't know how I'll cope."

Physically stopping drinking was often considered dangerous due to risk of withdrawals. In this sense alcohol was a literal lifeline to many. For Liz, being admitted whilst inebriated was not accommodated by her hospital's inpatient assessment policy, and therefore she was denied treatment whilst in mental distress.

> Liz: So when I was nineteen, I tried to get myself sectioned in hospital and they wouldn't take me seriously because I was drunk. I needed to be sober for the assessment. But I was alcohol dependent, so it wasn't possible to be sober, so I tried to explain to them "Look I have to drink because I'm physically addicted, otherwise it's dangerous".

A fear of giving up their lifeline by reducing or stopping drinking was also described by many as a terrifying prospect given the amount of trauma they had been through. Being asked to confront their emotions through psychological therapy felt like a reason to avoid services. They feared that they would have to give up the crutch of alcohol and be forced to acknowledge memories that many had grown accustomed to blocking out by drinking. For some, drinking was a "camouflage" (Dennis), a way of blending into society, avoiding their mental health problems and distancing themselves from mental distress.

> Dennis: But you know then I turned to drinking. And it was alright, but fucking hell then when I stopped drinking I thought everything will be alright and it… and it's not because it goes the other way. I'm more aware of the problems I had before I started drinking. Yeah and it just escalates way back. Like when I was a kid…. Yeah, it's not as easy anymore to just dust it off. And if I think about it I'm like why did I open Pandora's box?

3.5 Category Two: Navigating a chaotic system

3.5.1 Cyclical and confusing treatment pathways

Confusion regarding what psychological support was available and how to access it was a common experience amongst all participants. Understanding the system was an initial hurdle. Many were unsure about which service was the most appropriate to seek help from or how to go about making contacting or initiating a referral. All PWUA described what they perceived to be a chaotic and complex system with no clear pathways or routes into therapy, leaving them feeling frustrated and unsure how to proceed.

> Dennis: Yeah, can't get through [to Talking Therapies] or they say this number's disconnected. And I'm looking at it, thinking it's the same number they gave me. So you're left with nothing…. Who shall I talk to? The doctors? Tried that. So no, I don't know who else exactly.

PWUA's perceptions of a complex system were intensified after receiving conflicting and sometimes inaccurate information regarding referral pathways, experience as "mixed messages" (Melanie). This was particularly challenging for PWUA who often reported a heightened sensitivity to feeling "out of control" (Jamie) as a result of their upbringings. Feeling out of control within the referral system therefore stirred up the same emotions, making the unknown particularly challenging to endure. Many did not know where to begin in asking for help; nearly all participants had never heard of NHS Talking Therapies or IAPT, resulting in numerous referrals to the wrong service. Some spoke about moments where their GPs had confessed that they were also unsure of the protocol for getting mental health support.

> Louise: I referred myself to about three wrong places before I finally got to the right place. It's an absolute minefield getting to the right service… One of the GPs even said, “I find it very difficult to navigate, to be honest.”

All PWUA attributed their alcoholism to their mental health problems. Drinking was a way of coping with such problems, for which they were unable to access support. Oscillating between mental health and addiction services was something that was common to all participants, often described as a “ping pong”-like process (Jamie, Jenna, Dennis). They reported that they were not being accepted into psychological therapies whilst in active addiction but were unable to stop drinking without getting mental health support in the first place.

> Jamie: I know that with dual diagnosis, you get this really, really bizarre situation. If you've got mental health problems and you're drinking or taking substances, you go for help with your mental health, and they say, “Well, we can't help you because you're drinking.” So you go to an alcohol or drug service, and they go “Well, we can't help you because you got mental health problems.” And it's like ping pong. So who helps you? No one does, because no one wants to pick you up.

For most PWUA, not feeling able to access help was experienced as direct rejection from a hostile and uncaring system. This was compounded by a sense that PWUA were left to fend for themselves in order to progress along the referral pathway.

> Jenna: So anyway, I got rejected from the community team, that's how I felt anyway… I was discharged back to the care of my GP and so basically that leaves the

> ball in my court…. they're ping pong-ing each other back and forth saying you need to get support with mental health. Mental health services are saying you need to get support with your substances and you're like, yeah, well, I need both. They're both interlinked.

Some said that even after jumping through the required hoops and getting sober, they were still not offered timely support by psychological services. This led them back to the beginning of the process, experiencing the system as cyclical rather than linear.

> Dennis: I tried to get help before I came here [substance use service] and they went, "Well, I can't really help you because you're drinking." And that's… that was such a negative thing to say to somebody. That's why I'm reaching out to get help here. And I mean, they just say "Oh, well, you're drinking so sort your drinking out then come here". So, I did, I went to get help and sorted that out. And still nothing… So it's come full circle, hasn't it? I've gone full circle with them twice and there's still no help.

PWUA also described help as being patchy and fragmented. Many felt themselves endlessly oscillating between getting better and then worse again.

> Damien: The only thing I would say when it comes to all this kind of help is, it's all a bit like piecemeal. It's all a bit all over the shop and not coordinated, so there's periods where I got better. Got worse, got better, got worse, got better, got worse. It's like you have some level of success… but because the support is not progressive you fall back down. It's like snakes and ladders.

3.5.2 PWUA exist in a state of limbo

Alongside attempts to navigate their way through a chaotic mental health system, many participants also spoke about regular feelings of being stuck or left in limbo. Spending times on waiting lists for psychological therapy was a common experience for all participants. While some were aware of their position in the process, other PWUA reported uncertainty about wait times, or if they were even on a list at all. Catherine described her experience as “one step forward, one step back. You know, you just end up standing still”. For Louise, the experience felt entirely pointless.

> Louise: It was never ever getting anywhere, you know, we’d wait a couple of months to get seen by them [NHS] initially. And then they'll say, “Right, well, we'll refer you to this.” And then it's another couple of months… it just becomes frustrating because it's such a long, drawn out process and then at the end of it, you're not really any further forward… And you get, you get to the point of thinking what is the point of all of that?

Some PWUA found the process of waiting to be anxiety-inducing. Having been accepted to start a rehabilitation programme, Damien had been left in the dark regarding his position in the queue or likely starting time. Being left in limbo meant he was forced to resort to self-management strategies in order to keep himself psychologically afloat. He spoke about an exercise group he had joined:

> Damien: I guess I’m slightly waiting forever. And there's no updates, like what position I am in the queue or anything. So I just don't know. Just a lack of

> information. Really, I'm just having to learn how to manage my own head… I engage regularly with this group of guys who play football every week... I've got like scraps of support here and there.

Other PWUA spoke about their lives being "on hold" (Dennis). Being in a limbo state was also especially difficult for those in a precarious stage of recovery, having tentatively managed to maintain sobriety in order to access a therapy service, but being then left to wait without an indication of when, or if, they would be assessed.

3.6 Category Three: Interactions with HCPs and services

3.6.1 Rejection

All PWUA reported experiences with HCPs and services during which they had felt rejected, dismissed or judged for their drinking and/or their mental health problem. These experiences regularly served to reinforce PWUA's preconceptions that attempting to get help was pointless. The experience of rejection occurred not only at a service level, through regular bouncing between services, but also from individual HCPs who often delivered direct rejections following assessments, described by some PWUA as "final decisions" (Dennis) with no follow up or signposting to other services. Dennis remembered a psychological assessment he had attended:

> Dennis: I opened up and poured my heart out. And what, what for?... You've made me cry. I've gone home. And they just said, "Oh, well, you're not psychotic". So there isn't even a follow up with me being on the medication. No phone calls, nothing. So I

> think like, what was the point of telling people I don't know, what's the point of telling strangers all my deepest stuff if you're not going to help me?

He went on to describe how he had been told on multiple occasions by NHS psychological services to "fix that [the alcohol use] before we help you" (Dennis). Liz spoke about an experience of being told during a psychological assessment that her mental health difficulties were a result of "watching too many scary movies" which she experienced as rejection, or as she put it "a brush off" (Liz). Her experience resulted in her telling her GP she never wanted to go back to the psychology team that had assessed her. A sense of rejection was also distressing for Jenna, who received the news that she was being removed from her NHS Talking Therapies waiting list following a GP referral because of her drinking.

> Jenna: And at this point I was told I didn't meet the criteria. I've got the text message on my phone. It's really triggering. I've got a text message. See that? How is that safe? Send me a text message saying I don't meet the criteria for care and then discharged me because of my drinking.

The sense of being rejected was further enhanced by the news being delivered in what Jenna felt to be an impersonal and ultimately unsafe way. This was especially challenging due to the extent of her mental health crisis that she was in at the point of referral, leaving her to navigate both her pre-existing difficulties as well as the added experience of rejection on her own.

3.6.2 Anticipation of rejection

Pessimistic views of services left PWUA feeling ambivalent about the prospect of help-seeking. Earlier experiences from childhood, combined with more recent interactions, had caused many PWUA to develop poor views of services and an expectation that they would be met with rejection or judgement. This anticipation and ingrained loss of faith in services was often enough to cause PWUA to avoid asking for help, feeling resigned to their pessimism and accepting of the unlikelihood of a psychological therapy referral. Jamie had a history of extensive failures from statutory services when he was growing up, including having his history of childhood abuse dismissed by professionals in the past. This had instilled a long-standing pessimistic view of services which affected his relationship to help-seeking today: "I just thought it [asking for help] was not worth the time. You've let me down with my mental health, why would my drinking be any better?" (Jamie). He went on to say:

> Jamie: You know, I was very, very, very much dismissed. They say, "Well, you're making excuses, you've got to get on with it" and that's the kind of reaction I got from most people. You know, "It's [the abuse] in your past, why are you making such a big deal of it now?" So in the end I just thought it's just pointless to try and get help, particularly from the health service.

Francesca had also been let down by services in her childhood. She recounted a time when she had overdosed when she was 12 and had not received adequate aftercare when she was in hospital. As an adult, even when help was offered to her, she had a difficult time accepting it.

> Francesca: Yeah, so it's difficulty trusting. That's the mindset. That kind of thing. Yeah. Um, and obviously like, mentally, now I'm learning I have to be open to get the

> right help…. nothing's ever been handed to me, I've always had to work for it. So when somebody sits down in front of me like… it's hard to believe.

Francesca carried both resentment and a strong urge to protect her child-self who had been overlooked repeatedly by services. This was something she was attempting to overcome in her current therapeutic relationships as well as relationships with services more generally. She went on to describe the challenges she has in terms of opening up in her therapy sessions that she currently attends at the substance use service she is engaged in. She said "And when I do speak to people now, I say that a lot of the time. I say 'Don't think I'm not opening up, I am opening up, but it's very hard because I'm still quite resentful for the little girl in me. She's so broken and battered and bruised and hurt and sad'".

Despite lots of PWUA reporting some good experiences and interactions with GPs and other HCPS, the ingrained fear of judgement or rejection remained prominent and affected their views of help-seeking. The perception of hostility amongst HCPs and services regularly caused PWUA to avoid asking for help. Discussing the reasons behind her avoidance of asking the GP for a referral for therapy, Melanie said:

> Melanie: A lot of it was just my own stubbornness, but a lot of it fear, I suppose. Fear of being judged, fear of not being believed. Not being taken seriously, or like drinking was my own fault. Um I guess it's just hard to face it, like, you know, admitting it to myself… I was so scared of being judged.

For other PWUA, their own negative self-view combined with their anticipation of judgement into what appeared to be a well-ingrained fantasy about the outcome of help-

seeking. Nadia described with certainty how she believed her GP would view her as “just another person feeling bad for themselves that can’t sort it out” despite having not received this response previously.

3.6.3 PWUA present modified versions of self

PWUA often moderated how they presented to therapists and other HCPs, caught up in what was felt to be a complex negotiation of help. Sometimes participants diminished their problem for fear that being honest about their drinking would lead to rejection from services. At the same time, PWUA could not minimise their problems too much, for risk of dismissal if they did not meet the threshold for mental health support. PWUA sometimes carried the burden of shame regarding their alcohol use on behalf of professionals, moderating their experiences in order to protect HCPs from the “upsetting” (Francesca) aspects of addiction.

> Francesca: And after a counselling session, I’d have to go and use. And then sometimes I'd be like, I can't be too honest because that's not a nice story to tell somebody. I don't want to upset them. Not knowing that they're a counsellor and that's what they're there to do. So I would, like, make things not seem as bad.

For Catherine, who had sought private therapy, the therapeutic process and relationship had felt pointless because she was dishonest about her drinking, afraid that her therapist might assume that alcohol was the cause of her problems rather than her way of coping. When asked what prevented her from being honest, Catherine responded “It’s just judgment. And also I think because… because I don't want them to think alcohol is the cause. Because it isn’t. I think it's an attempted solution.”

Others were dishonest for fear of direct rejection if they were open about their alcohol intake. Jamie was concerned that he would be judged by his GP for disclosing his alcohol use, but he also worried that if he under-reported his drinking, he may not meet the threshold for help. This left him feeling uncertain regarding how much to disclose and what the appropriate amount to drink was to deem him worthy of help. He said: “And then with the GP, you know they’re judging us because you're drinking too much. So you're not worthy of treatment. Or you're not worthy of treatment because you're not drinking enough” (Jamie).

He went on to describe his tendency to present a modified version of himself in front of professionals, striking a complex balance between telling the truth and keeping his addiction a secret: “It's a lot of games played between health professionals and patients. And I think that's really sad. You know, we're all adults, but it does feel like a game sometimes” (Jamie). He described the game as a form of bargaining for support: “So I thought, well if I say I've plugged 30 units and you're giving me a lecture, if I tell you what I'm really drinking, will you just kick me out the door?” He believed this lack of honestly ultimately undermined the relationship with HCPs, making a mockery of the interactions he had had with his GP.

3.7 Category Four: PWUA’s negative self-image

3.7.1 Reinforced shame

Intense feelings of shame characterised all PWUA’s experiences of alcoholism, sometimes leading to a reluctance to approach services or a desire to disengage. Shame was often a result of an extensive history of feeling ostracised or rejected by services for both

their addiction and mental health problems. PWUA often preferred to avoid asking for help for fear of disclosing their alcohol use and the possibility of facing judgement, a result of the internalisation of stigmatising societal narratives about being labelled “an addict” (Melanie) or “just another junkie” (Nadia). Shameful feelings and subsequent avoidance tended to keep PWUA trapped in the cycle of the chaotic system.

> Alice: And it's just the embarrassment, I suppose, like normally, you know, I don't really want to talk about it [drinking] to anyone. I just wanted to keep it to myself, I didn't want to reach out.

There were also other, more complex assumptions about how others would view alcoholism, as though drinking was seen as PWUA’s fault and a demonstration of being somebody who “couldn’t control myself” (Melanie) or a “failure” (Laurence). Melanie described her self-loathing of getting physical shakes when she was withdrawing from alcohol, angry at having allowed her drinking to escalate to such a level.

> Melanie: I thought, how ridiculous am I that I've got myself so bad that my arms are shaking so much. Like, I'm not in control of the drink now, the drink's controlling me. I can't even use, physically use, my own body. And I just felt so stupid that I've let myself get so far with everything, like how did I let my drink get so bad? … That kind of drinking, it's shameful…. You've done it yourself, forced it on yourself.

There was also an indication that if PWUA disclosed their drinking to HCPs, they imagined they might be thought of differently. Alcohol would be seen as the root of their issues, which was viewed societally as a problem not worthy of help.

> Melanie: People see you as a waste of space if you're a drunk, if you drink. I tried to not do it, obviously no one forced it down my throat, and I do know I've done it to myself. You know what I mean? … So if someone's depressed, without drinking, you've got all the help in the world, but when you drink and you're like that, it's not, it's just, it's looked upon differently, you know, people just think, oh, she's not, she's not that bad, she's just drunk all the time.

Francesca was accessing therapy from a substance use service. She described emotionally shutting down due to her sense of shame, reluctant to return to her therapist because she had relapsed. She feared disappointing her therapist and the feeling of having failed was overwhelming, leading her to disengage:

> Francesca: Once I picked up the drink again, I thought, I can't go back there. Like, they're going to be disappointed. Do you know what I mean? Like, I was battling, I was battling with myself. Even though they never made me feel like that, but because internally, and the way I process things, I was like, no, that's it, that's done. I've messed up. That's done, I can't go like that. And then I would just shut it off.

Jamie, who had worked in the substance use sector himself, struggled with his own self-image after relapsing. His shame at being back at square one meant that he was reluctant to seek help.

Jamie: And I think it made me feel more of a fraud. That, you know, I've done all this work for all these years yet I'm back here. Stage one and that self-doubt you know, and that shame.

Laurence described a similar sentiment. His shame was a reflection of the stigma faced by PWUA and a sense that he should be able to cope, yet he had failed. On the outside, he described looking as though he was functioning well, whereas in reality he was struggling.

Laurence: I was embarrassed. I felt like I'd let myself down, let everyone down.

Interviewer: What do you think you were ashamed of?

Laurence: I think because I was holding it together. Like, you know, if you look from the outside, at the time I was working a corporate job, getting paid a load of money, I've got the girlfriend, the flat, all that... So I had to keep up a façade, I guess.

3.7.2 Lack of self-worth and its impact on help-seeking

A poor sense of self-worth also affected many participants' relationship to help-seeking and often led to an avoidance of interacting with services and HCPs. PWUA commonly believed they were not deserving of support, an idea that had become internalised not only from the stigma surrounding addiction but also from long-standing, often negative, experiences of services that stemmed from PWUA's childhoods. For example, Francesca had been dismissed regularly by children's social services when she was growing up, despite displaying what she described as obvious signs that her father was physically and emotionally

abusive. Feeling chronically ignored when she needed help as a child had led her to believe that she was not worthy of being helped. She described a combination of the shame of her addiction alongside her early traumatic experiences as causing her to believe she was "broken" (Francesca), making her attempts to seek help patchy and inconsistent. She had one positive relationship with a GP who had gone to lengths to encourage her to look for help from services.

> Francesca: Since I've moved over here, the last thing he [GP] said was, "Take all the help you can get, go out and look for it, because people want to help you." Because for a long time, I didn't feel like I deserved to be helped.

Other PWUA also described historic experiences of rejection from services that had instilled a sense of being beyond help, diminishing their sense of self-worth. For Nadia, this had escalated to a perception of herself as being unworthy of not only support, but of other basic needs such as housing.

> Nadia: And that [rejection] makes you completely lose your faith in humanity and think, you know what, maybe I am unvaluable. You know? Maybe I should just go live on the street, because that's all I'm good for.

An internalisation of rejection was also alluded to by Laurence who described a belief that he was "being a pain" by inconveniencing HCPs and bothering services. Phoebe also alluded to a diminishing sense of self-worth, thinking she was "too much" for services to support.

Phoebe: When I got told I couldn't have counselling they didn't even tell me to my face. I'd just get a letter. I've just got quite few letters saying, "Sorry, we can't handle you, we can't deal with you at this time, please re-refer in future when you're sober."

Jamie spoke about the combination of alcohol use and mental health problems worsened his sense of self-worth, which in turn made him feel hopeless about help-seeking. He said "When you're depressed you haven't got the energy to do anything or the kind of self-respect or self-worth. So you know, I couldn't see any benefit, really, of going to see anyone" (Jamie).

3.8 Category Five: Embodied responses to chaos

3.8.1 Risk of relapse

The implications of being rejected from therapy, or having disappointing or judgemental interactions with HCPs, were often recounted by participants in the form of profound embodied experiences. This referred most commonly to PWUA's tendency to relapse as a response to feeling rejected or judged and shut out from accessing therapy. This could feel intolerable to some PWUA, due to the chronic and enduring impact of having been rejected over the course of their lives by multiple services. For others, the experience of waiting on seemingly endless lists became too much, prompting a desire to return to drinking.

Interviewer: And did you get any mental health support after your son passed away?

> Phoebe: So I went straight to the doctor and they said, “Well, we can make you an appointment” but there was nothing. There was a three month wait or something, to process the trauma. But by that time I’d started drinking, ‘cause it was too long. It was like help, my son's died I don't know what to do. So when they said, “Well, we can make you an appointment but you have to wait three months”, I ended up… I got quite angry and I ended up drinking again. And then because I was drinking I was never able to get the counselling. So I ruined that for myself I guess.

Phoebe’s experiences of being kept on a waiting list led her not only to relapse, but also triggered self-blame, believing that she had ruined her own chances of future treatment by drinking again. As a result of her relapse, she re-entered the chaotic system, and unable to get support for her trauma because she was in active addiction. Marina expressed how her lack of trust in services contributed to her avoiding seeking help, for risk of relapse if she is rejected: “I’ve just been let down so many times. And if I get, let, let down again, I don't know if it's going to make me spiral and result back in relapse or something” (Marina). Dennis described a sense of frustration at having gone through the motions required for getting psychological help through the NHS, but ending up back at square one because the support was not in place after he had finally managed to achieve sobriety. This caused him to relapse, which was experienced almost as a defiant response to rejection, an outcome that he believes was inevitable given the lack of support.

> Dennis: I've done everything they've asked me to do but I’ve ended up back at square one drinking again…. So I'm back to square one. I’ve done everything I've been asked… And obviously I've started drinking again.

Francesca, whose housing situation had meant she had to move areas, disengaged from therapy that she had been accessing through a substance use charity. Being in a new county made it unsustainable for her to keep attending. The impact of this led to relapse: “I was straight back into addiction, and I cut all my resources off” (Francesca). The shame that went alongside her addiction meant she felt compelled to isolate herself. Some PWUA also described turning to new substances to manage their mental health issues after the slow realisation they were not able to access psychological therapy. This was often combined with a sense that their alcohol use had steadily worsened over the years of being denied support, and could have been prevented had they been helped to access therapy at a younger age.

> Jenna: My situation is that they've left it and left it and left it and left it, you know, as I say, first reaching out for support. Asking for help when I was 19, and now I'm sat here at 27 with a lot worse drink problem a lot worse social issues as well in terms of housing and, you know, work. And now the other substances that have also started to creep in and become part of my way of trying to cope.

For Liz, feeling motivated to engage with services coincided with her periods of sobriety. Long waiting lists meant that she would lose motivation and return to drinking and, once back in active addiction, she described not caring about persevering to access help:

> Liz: I could even wait too long and then I give up and go back to drinking. You know, it's like when you finally do get a call we'll be back drinking and then I'm not bothered when I’m drunk… I need the help and I'm willing to accept the help. But yeah, everything is a waiting process.

During an assessment with a mental healthcare professional, Liz was confused by the lack of explanation regarding a potential diagnosis. She described having what she felt to be a “long check in” rather than being given the reassurance of a treatment plan, which made her feel that she was beyond help. Like Dennis, some defiance was noted in her response to rejection, as though it confirmed her suspicions that help was not available.

> Liz: I actually went back home and relapsed… I'm un-helpable. Well, there's no help out there, you know. So then I left the rehab and then went back to being street homeless.

Coming away from the appointment, she felt more confused, describing the experience as causing her to feel “mad” and questioning what was wrong with her. She returned to both drinking and homelessness, both situations offering some form of familiarity amongst the chaos of a confusing system.

3.8.2 Physical manifestations of mental health decline

The embodied consequences of trying to navigate a chaotic system and being unsuccessful in securing therapy also led, in some cases, to deteriorating mental health symptoms - both psychologically and physically. For some, the uncertainty regarding position on a waiting list, or how to access help, had led to incidences of self-harm. This was compounded by stopping drinking, with many PWUA describing worsening mental health symptoms after they had managed a period of sobriety in an effort to get psychotherapy.

> Louise: It does worry me how long it's going to take. You know, I haven't been given a time scale as yet, so I'm just told I'm on the waiting list and I know in some places

> that that can be a very long time. Yeah. There's, you know, there has been a couple of incidents where I've hurt myself since I've stopped drinking and so, you know, it is still there.

Damien described his experiences of “white knuckling” his way through the waiting list whilst maintaining sobriety. Without alcohol to self-medicate with he was “just about managing get through the day” (Damien). Similarly, Laurence described being “at the end of my tether” and deteriorated into a mental health crisis after a rejection from his GP surgery following a disclosure of suicidal ideation. His deterioration in mental health was a message to the GP that his situation was worsening to the point of wanting to end his life. He continued drinking when he got home, experiencing a sense of total isolation whilst simultaneously a desire to act destructively both towards himself and the GP who he felt had dismissed him.

> Laurence: I clearly remember the last time I left the doctors, I left that surgery after he [the GP] said there was nothing they could do, and it sounds mental, but I was gonna drive my car through their wall. And I remember going home, and I was drinking more, and I was just so angry. And I was like, are these people serious? Like, I've just told him, like, I'm gonna kill myself and he's giving me a [self-help] website and I'm just like… I don't know where to turn now. Having these thoughts like, I have no one around me, like what do I do… and my, my brain was that gone… it's hard to even describe, but I just felt so infuriated, but it just reinforced that whole, like, there’s literally no help out there.

Professionals' response to worsening mental health conditions was often to prescribe antidepressants. This was experienced by many PWUA as medication being "chucked down my throat" (Laurence) or "thrown at me" (Louise) as a quick and easy solution, giving GPs permission to dismiss their needs. Antidepressants were seen as a poor substitute for therapy in the eyes of PWUA, contributing to an already deeply embedded sense that their needs were regularly dismissed.

> Interviewer: And NHS Talking Therapies or anything like that, was that suggested to you?
>
> Melanie: No, just they just give me antidepressants, which they love to do. I mean even when I went to my doctors just for stomach pains they'd try and give me antidepressants. I was like, no, just tell me what the pain is, I'm not here for meds.

Dennis described minimal aftercare following his prescription for an increased dose of antidepressants. Being left to fend for himself after being prescribed medication for his mental health was experienced as more evidence of being abandoned by services, a sense of having been "left" (Dennis) without follow up.

> Dennis: One phone call. Haven't heard since. No follow up. Same with medication. There's no follow up, no like "Are these new tablets working?" It's like I'm taking them and I'm left to deal with it…. Who's going to pick me up and go, "Oh, do you know what he needs?" So all they do is up your medications.

Jamie recounted his experience of attempting to get psychological support for his mother, whose mental health was worsening. His own experiences of rejection from the NHS and other statutory services in the past bore such a weight in terms of the impact on him, that the vicarious rejection he experienced from his mother left him struggling with suicidal thoughts.

> Jamie: So I tried to get help for that again from the NHS. And they just said "There's nothing we could do. It's just dementia". So a couple of years ago, it really sent me into a dark place. So I went right back and started drinking heavily and started self-harming again. And felt really suicidal.

For Francesca, she managed to go for stretches of time without drinking, as a result of attending church regularly. She described the lack of psychological support in place as detrimental to her mental state. She shared: "I was just kind of like floating about really. But thought I was doing amazing because I wasn't taking drugs and drinking. So mentally, it was just like, I was just existing" (Francesca).

3.9 Category Six: Towards self-sufficiency

3.9.1 Defensive behaviours as a protective strategy

All participants talked about strategies of self-protection and self-preservation that they employed to defend against the anticipated judgement or rejection from services. Such strategies included lowering their expectations of help, avoiding help-seeking, putting up psychological barriers (such as not opening up emotionally to professionals) or at the extreme end of the spectrum disengaging completely and attempting to manage their mental health

problems themselves. Catherine, who had received various types of therapy both privately and from the NHS, spoke about her sense of being let down when the group that she was attending stopped due to funding issues. This solidified her negative view of services; she shut herself off from the prospect of being helped in the future. She said: “It was just another nail in the coffin of pessimism… you get something that, that’s actually working and no, they’re just gonna pull it" (Catherine).

Lots of PWUA exhibited tendencies to avoid attempting to get psychological help following negative experiences and interactions with professionals. For Laurence, being rejected confirmed his pre-existing suspicions and earlier life experiences that help was unavailable, to the point that he avoided going to the doctors even for physical health concerns and would instead try to cope on his own. He said: “I'm quite anti going to the doctor. I won't go to the doctor unless I'm sort of dying. Because I have got a lot of resentment for them because of the way I've been treated… I've just been turned away when I've needed them the most” (Laurence).

Psychological barriers and putting a guard up was another defence mechanism employed by PWUA in order to protect themselves from the prospect of rejection. Some felt that it was easier to not go into detail about their mental health problems and that bringing up their personal experiences would feel too painful. Therefore, it was felt to be easier to cope on one’s own. Alice spoke about her tendency to keep her alcohol use and mental health difficulties to herself:

Alice: No, I wouldn't have told anyone else.

Interviewer: Why was that?

Alice: Not wanting to talk about it because I think it's quite common to say “I'm ok” because you don't want to really go into it. Actually, it's easier, isn't it? Because you're protecting yourself, you don't really want to hurt yourself or bring that up or get sad.

Jamie also spoke about a fear of making himself vulnerable and the prospect of further rejection, leading him to put a guard up when interacting with HCPs.

Jamie: I think if you've taken that courageous step to go forward and ask for help and it's not there almost immediately, there's a sense of rejection, maybe sense of let down and you start to build the barriers up, because obviously to get to ask for help, you dropped your barriers you've got because you've made yourself vulnerable. So therefore, if the help isn’t there, I think those barriers go up quickly.

Similarly, Jenna described her reluctance to speak to professionals and open up, given her low expectations when it came to psychological support which contributed to a feeling of “learned helplessness” whereby accepting help felt particularly hard given the extent of rejection she’d experienced. Even approaching somebody for help took a great deal of courage because of an ingrained fear of being dismissed.

Jenna: Because you get, like I said, the learned helplessness thing where you you've asked for help so many times that you think, you know what you know, and then you're not receptive to it. So I was like, I actually can't physically open everything up

> again to go through another assessment, you know, in case it might get battered back. Because it's a big deal even just asking for help in the beginning.

Marina, who had spent years rough sleeping, said that she protected herself by avoiding seeking help at certain points in her life because beginning the process of therapy would make her more vulnerable and she was afraid of her mental health deteriorating any further. Given other parts of her life had not been safe, such as stable housing and employment, she did not feel equipped to open up within a psychological setting. Engaging in therapy meant giving up her coping, or self-protective, strategies that she had put into place. A preferable position was to manage on her own:

> Marina: No, I just didn't want to go through it all again, because you sort of lose trust in the system completely, from being on the streets for so long. You know they're gonna take away the coping strategies that you've already put in place for yourself and try and open you up. And you're not ready to be that vulnerable... So yeah I didn't want to talk about it again. I thought I could do it on my own because I'm so hyper-vigilant.

Some PWUA completely disengaged from services and attempted to manage independently. One particular interaction with a healthcare professional left Liz so confused that she "didn't bother going back" to mental health services. Her disengagement was a symptom of struggling to cope with perceived rejection and dismissal – returning to the service and trying again was beyond her capacity given the pessimistic view of services had been confirmed.

3.9.2 PWUA's alternative pathways out of chaos

Throughout the process of attempting to access psychotherapy, there were many moments during which PWUA decided to either temporarily or permanently give up on trying to navigate the NHS system or wait for an appointment. In these moments, PWUA resorted to navigating their own pathways out of the chaotic system and into various forms of psychological therapies. Most commonly, therapy was sought through alternative, third sector service provision outside of the realm of the NHS mental health system. These included substance use, housing or homeless services, domestic abuse refuges or other third sector mental health services. Often these services either offered therapy themselves or facilitated referrals to NHS therapy and therefore provided guidance and stability throughout the complex process.

Francesa spoke about going back to church which helped her get sober for a short period of time. Her private counsellor, who she described as "amazing" also referred her to mutual aid meetings. In the end, she sought help from a substance use service and received therapy from them directly, which she attributes to another stretch of sobriety while the support lasted. For many, the third sector was a lifeline, providing support in times of crisis that PWUA were unsure how they would have survived without. Often, meeting with a substance use charity was the first time PWUA had been properly listened to or taken seriously. Jamie had a unique experience of being offered three years of therapy through a charity, which he believed would never have been possible through the NHS.

> Jamie: So I then turned to the third, the charity sector, and that's when they gave me counselling for three years. And that was the difference. They didn't say "Oh, you

make it too much of it". It was "you don't make it enough of it, this is such a profound thing that's happened to you".

Melanie spoke about the role a substance use charity had played in her recent recovery as a literal lifeline when she was experiencing suicidal thoughts.

> Melanie: Yeah, and then, so, I got more help from them [substance use charity] in that, in all ways, to be honest if it weren't for them, I wouldn't be here. I wouldn't be, like, like, feeling emotions, because like I said, like, bury them, bury them and hold them tight, and then drink, to, to just, you know, block it out… but they were good. I never ever thought I would find anything like that. Never in my life. But if it weren't for them I don't even know where I'd be. I don't know, I just don't.

She went on to describe their consistency in contact and a sense that she was being held in mind throughout the process, being called and contacted, describing them as being "On my side" (Melanie). Some participants also received support from friends or family who supported them into private rehabilitation facilities as a stepping stone to recovery. Laurence said:

> Laurence: He [friend] came round to my flat that I was in at the time about two weeks later and was just like, right, booked you in this rehab. This had all been going on in the background. He's like, you're going there tomorrow and I'm coming to pick you up. And you're coming, that's the end of that, which obviously started this whole journey.

Not all experiences with NHS HCPs and services were negative. Some PWUA had been able to access NHS Talking Therapies or other NHS psychological therapy services, often through their GPs who were confident about the referral pathway. Francesca described a GP that gave her “the space for me to be”. He continued to offer referrals to counselling in a non-judgemental manner, despite Francesca refusing help at the time because of not feeling ready to enter into a therapeutic relationship.

> Francesca: And this, this one GP, he was the only doctor that I did have an appointment with who just sat with me for about an hour and he just let me cry and he was like, “I'm just here. If you want to talk, we can talk. If you don't, don’t, he said, but you can't leave this doctor's until I know that you're in a better place. And if that takes me all day, that's what I'm here to do”.

Mutual aid, including community recovery groups and local AA groups, were also regularly sought by participants, although experiences were mixed. Catherine’s experience of a therapeutic group was provided by the NHS. Before it was discontinued early, she described the process of sharing her experiences with other like-minded people as “a breath of fresh air” giving her a sense of “real connection” to others (Catherine).

3.10 Chapter summary

This chapter initially presented a summary of participants’ demographic characteristics. It then introduced a description of the findings and presented the categories and subcategories within a theoretical model, in order to explain the processes by which PWUA navigate the pathways into psychological therapy. The chapter then provided a

detailed account of the conceptual categories and subcategories, providing examples from participant interviews. A discussion of the study in relation to existing literature is presented in the next chapter.

Chapter Four: Discussion

4.1 Chapter overview

This chapter summarises the results of the study and the theoretical model outlined in Chapter Three. It then proceeds to discuss the main findings of the study according to the research aims as well as detailing the findings in relation to current research in the field of PWUA experiences of psychological therapy services, as well as other healthcare services more broadly. The discussion incorporates theoretical ideas from various schools of psychological thought, including psychoanalytic psychotherapy and attachment theory as well as clinical guidelines for working with common mental health problems, including trauma. The chapter then outlines the limitations of the study, suggesting possible areas for future research and policy regarding psychological therapies service provision. The chapter concludes with a self-reflexive account of the research process.

4.2 Summary of study findings

This study has explored the experiences of PWUA as they attempt to access psychological therapy. The current study is the first specifically to explore the psychological therapy pathway and therefore provides a novel perspective on this phenomenon. Other qualitative studies, identified in the meta-ethnography, have explored PWUA experiences of

other healthcare providers including substance use services (Gilburt et al., 2015; Parkman et al., 2017a; Roberts et al., 2020), inpatient detoxification settings (Dorey et al., 2021), A&E departments (Parkman et al., 2017b), primary care settings (Montgomery et al., 2023) or experiences of treatment seeking across the healthcare system in general (Haighton et al., 2016; Jackson et al., 2024; Naughton et al., 2013; Roper et al., 2012). Considering the meta-ethnography identified evidence of a gap in the literature relating to PWUA's experience of the psychological treatment pathway, the current study was conducted as a first step in closing this gap. The study's results offer a unique opportunity to compare participant experiences of the psychological service context to those identified within healthcare settings more broadly. The following sections (4.3.1 – 4.3.7) will outline a discussion of the study's findings both in terms of novel findings as well as comparisons (both similarities and differences) to the existing literature identified in the meta-ethnography. The current study also fills the gap in the literature by providing specific clinical implications for the psychological therapy sector, which will be highlighted in section 4.5.

This study also offers a unique theoretical framework, guided by CGT, through which to understand the complex process of PWUA help-seeking. This is the first GT study exploring PWUA experiences not only of psychological services but of healthcare services generally. To date, only three studies have used a GT methodology to explore substance users' (both alcohol and drugs) experiences of UK healthcare services (Harris, 2020; Lawson & Griffiths, 2023; Monks et al., 2013).

The results of the study, generated from 15 interviews with PWUA, were analysed using a constructivist grounded theory methodology. Participants' accounts of their experiences led to the development of a theory, grounded in the data, that comprised of six interrelated

conceptual categories. PWUA in this study described lived experiences characterised by chaos, both in their personal lives and in attempts to navigate pathways into psychological services. Alcohol played a contradictory role in PWUA's lives. Despite awareness of its negative effect on their lives alongside a keen desire to stop drinking, alcohol represented stability and familiarity amidst the chaos. It provided a lifeline for PWUA considering the lack of support from psychological services, helping them to survive the myriad challenges and distress associated with mental health problems.

Experiences of treatment pathways within "the system" were also characterised by confusion and uncertainty; PWUA found themselves bounced between services or stuck on seemingly endless waiting lists. Most were uncertain about which services were meant to support them, or unaware of how to self-refer. The role of alcohol was bound up with the experience of a chaotic system, often a contributing factor to making therapeutic engagement more difficult. In the presence of alcohol dependence, these systemic constraints were appraised by both interviewees and often the professionals they engaged with, as no more than individualised practical failings, such as poor time management and deprioritising of attending appointments whilst in active addiction. However, understood within the context that such alcohol consumption occurred, this behaviour was often born out of fear that giving-up alcohol was a risk because interviewees were not convinced adequate support would be put in place. It is important to note that these findings are not intended to assign blame to HCPs, services or participants, rather this study hopes to demonstrate the extent to which chaos has permeated PWUA experiences across all aspects of the psychological treatment pathway.

PWUA's interactions were often influenced either by current experiences or past memories of rejection. They were regularly told that they did not meet the threshold for psychological support or that they needed to stop drinking before they would be accepted into therapy services. PWUA tended to modify how they presented to professionals, negotiating a balance between appearing worthy of help but fearful of disclosing their true alcohol intake for risk of rejection. Simultaneously, the anticipation of rejection was often enough for PWUA to avoid help-seeking entirely, the lasting impact of years of dismissal at the hands of statutory services.

The theoretical model explains the two possible outcomes that are triggered by interactions with HCPs and services. These interactions shaped whether PWUA would either relapse and re-enter the chaotic system or alternatively develop a self-sufficient approach to help-seeking, propelled to seek alternative pathways to psychological therapy. Precise numbers of participants that followed each route were impossible to state: most participants had experienced both outcomes on multiple occasions, entering and re-entering the chaotic system multiple times whilst also achieving periods of sobriety and engaging with services before relapsing again.

One outcome was that poor experiences with HCPs and services, both recent and historic, contributed to what was often a pre-existing negative self-image for PWUA, reinforcing already chronic feelings of shame around addiction, or a sense that participants were not worthy of help. Judgemental, rejecting or dismissive interactions combined with an already confusing and chaotic experience of being stuck in the system often triggered embodied responses such as relapse, or alternatively acts of self-harm or attempts at suicide. Following this deterioration, PWUA tended to find themselves unable to seek further help due to recent

relapse and a deterioration in mental health, finding themselves rejected by services because of recent relapse, or alternatively lacking the motivation or ability to reach out for help again. The conflicting role of alcohol was also notable at this stage in the process of help-seeking – relapse represented both a failure but also an act of defiance via a return to familiar and comfortable chaos of one's own making.

An alternative outcome from interactions with services was a surprising movement towards self-sufficiency and independence. This was triggered by the activation of defensive strategies. Many decided that they no longer wanted to be reliant on NHS services or risk opening up again to HCPs. Some participants would disengage completely, cutting off ties with the NHS and resorting to modified and individualised pathways into psychological therapy. These routes were mainly facilitated by third sector providers such as substance use services or mental health charities. Other referrals into therapy were sometimes facilitated by mutual aid groups, an experience with a supportive GP, private therapist or support from friends and family.

4.3 The theoretical model in relation to existing literature

4.3.1 Navigating chaos within the self and the system

While this study is by no means the first to associate the concept of chaos with that of addiction, it is the first to conceptualise chaos across psychological treatment pathways, operating simultaneously at both an individual level, through the day-to-day lived experiences of addiction, as well as at a service level, through PWUA's experiences of attempting to navigate the treatment pathway. The term "chaos" has negative connotations in

research, namely when used in opposition to a positive state of "order" or "stability" (Fraser et al., 2007). This study, however, does not locate the "problem" of chaos in the participant; on the contrary it seeks to explain how chaos of the "system" interacts with and enhances the complexity of living with addiction. Rather than a derogatory term that assigns blame or judgement to participants' lives (Fraser et al., 2007), "chaos" was used to describe the complexity of this interaction and its impact on participants. Furthermore, the word was used specifically by multiple participants during the interviews when describing their own experiences, making sense for the analysis to employ participant-led language.

The complex and often disjointed nature of the lives of participants struggling with alcohol addiction has been documented in existing studies of healthcare services across the UK (Dorey et al., 2021; Gilburt et al., 2015; Jackson et al., 2024; Montgomery et al., 2023; Roper et al., 2013). Some have explored the difficulties PWUA face when attempting to meet demands from healthcare services. For example, attending regular appointments whilst intoxicated was challenging because living with addiction was akin to being "out of control" for reasons such as regular seizures due to alcohol withdrawal and other physical health issues (Gilburt et al., 2015, p. 446). Demands from services were experienced as distressing and punitive, especially when faced with penalties or discharges for missed appointments (Jackson et al., 2024). PWUA often approached inpatient hospital or other care settings when in physical, mental, or social crisis (Dorey et al., 2021; Montgomery et al., 2023; Roper et al., 2013).

This study found that patchy engagement with services in terms of attending appointments, deprioritising their own mental health needs due to the need to drink and struggling to meet demands from services characterised the chaotic nature of addiction and

contributed to individuals' barriers to help-seeking. However as discussed, such practices were often the result of chronic alcohol use which PWUA struggled to give up, being uncertain that appropriate replacement support would be put in place. Alcohol therefore was often viewed as the only option for survival for PWUA when faced with an uncertain and complex system that did not appear to be providing adequate support. Despite this systemic issue, the individual "failings" of participants was often alluded to during interviews – PWUA were often reprimanded for missed appointments or poor engagement. This connected to the notion of healthism (Crawford, 1990), whereby the onus and responsibility for achieving good health is placed on the individual, rather than addressing the social and structural causes of addiction.

The notion of epistemic injustice (Fricker, 2007) is also relevant to the findings of this study. Hermeneutical injustice was detected amongst participants' accounts of "the system". Hermeneutic injustice occurs when "a gap in collective interpretive resources puts someone at an unfair advantage when it comes to making sense of their social experience" (Rance et al., 2017, p. 2224). The majority of PWUA had neither heard of NHS Talking Therapies, nor were aware that they were eligible for support from this service. It was therefore difficult for most to articulate what exactly they were seeking from services, often unable to recall what service they were on a waiting list for, or which service they had attended a psychological assessment with. As such, the chaotic and complex nature of the referral pathway represents a form of structural discrimination that skews power relations (Fricker, 2007) between services and service users, making it more difficult for PWUA to "know", or to make sense of, their exclusion.

Prior to the current study, the experience of chaos in addiction had yet to be conceptualised as a chronic feature of everyday life, interacting with the broader systems associated with psychological treatment pathways. One study briefly alluded to the dual nature of the complexity of the alcohol treatment pathway specifically as being attributable to both "the fragmented services provided, but elsewhere it highlighted a participant's chaotic pattern of engagement" (Gilburt et al., 2015, p. 446). Similarities between service user experience more generally and the study of organisational dynamics has been discussed in existing psychoanalytic literature, finding "the fragmented minds of the chronically excluded are reflected in the fragmentation of the systems that exist to accommodate them" (Brown et al., 2011, p. 318). The results of the current study go further to suggest that PWUA experience the services that are designed to support them as more than just fragmented or complex – services themselves not only mirror the chaotic experience of addiction but actively interact with PWUA's experiences by triggering relapse or mental health decline. In this sense, the complexity of the system aggravates the already turbulent nature of living with addiction. The cyclical nature of this interaction is recurrent - following relapse for example, treatment pathways become even more difficult to navigate. This interaction is highlighted by the circular, repetitive and seemingly "messy" theoretical model (Figure 6) discussed in Chapter Three.

From a broader perspective, the complex structure of UK healthcare services for PWUA has been well-documented in recent studies (Dorey et al., 2021; Gilburt et al., 2015; Haighton et al., 2016; Jackson et al, 2023; Montgomery et al., 2023; Parkman et al., 2017a; Parkman et al., 2017b; Roberts et al., 2020; Roper et al., 2013). For example, the problem of the "revolving door" practice, whereby PWUA are bounced from one service to another and re-enter services multiple times, has been reported in studies as far back as 2009 (Resnick &

Griffiths, 2010, p. 453). Current research has also highlighted the fragmented nature of psychological support for PWUA specifically alluding to the gap that has emerged between mental health and substance use services (Dorey et al., 2021; Jackson et al., 2024; Roberts et al., 2020). PWUA are regularly turned away from psychological therapy, with services citing a required period of sobriety lasting six months or longer (Dorey et al., 202; Roberts et al., 2020). Other studies have highlighted that HCPs often lack knowledge regarding appropriate referral pathways for both mental health and substance use services for PWUA (Jackson et al., 2024). PWUA experiences of healthcare systems are characterised by uncertainty not only about the remit and role of HCPs but also the function of services with which they were engaged (Gilburt et al., 2015).

NHS Talking Therapies aim to provide psychological therapy for those experiencing CMDs, offering "clear pathways" into treatment (NHS England, 2024, p. 73). The findings of the current study, however, support the existing body of literature surrounding complexity and fragmentation, particularly in relation to the segregation of mental health and substance use services. Participants regularly reported feeling "ping-ponged" between the two, with neither accepting responsibility for their care. Holistic working has been cited in lots of research as a "valued and desired" approach to working with co-occurring addiction and mental health issues (Montgomery et al., 2023, p. 8) yet this study adds to existing literature which finds that such an approach is lacking in participant accounts. Other studies have also documented that the lack of broader social support often required by PWUA left participants eager to seek help not only for alcohol-related issues but also for their physical, psychological and social healthcare needs from A&E departments (Parkman et al., 2017a; 2017b).

The study also noted the geographically inconsistent, or "postcode lottery", nature of psychological service provision for PWUA. Occasionally, participants were able to access therapy via counsellors or psychologists within their substance use service; for the majority, however, this option was not available. The fragmented and patchy nature of service provision is perhaps unsurprising given the decommissioning of NHS community substance use services to local authorities following the 2012 HSCA (King's Fund, 2021; Poulter et al., 2021; Roberts et al., 2020). Multiple reports have highlighted concerns regarding changes in commissioning of substance use services and the tendency for people with addictions to fall through the gaps (Kings' Fund, 2021; NHS England, 2016; PHE, 2017; Department for Health, 2017; NHS England, 2024). Fewer NHS-led substance use services has meant that integrated service provision between mental health and substance use providers has suffered. Nonetheless, research has found PWUA struggle to navigate community alcohol services both prior to and post the HSCA (Drummond et al., 2015; Resnick & Griffiths, 2010; Roberts et al., 2020). This study has highlighted that despite numerous targets set by public health and government bodies over recent years (Black 2021; Darzi, 2024; NHS APA, 2025; NHS England, 2024; PHE, 2017), the lived experience of PWUA continues to be largely characterised by confusion and chaos.

4.3.2 Alcohol as a survival mechanism

Another key finding in this study was the complex and conflicting role that alcohol played in participants' lives. In the context of therapeutic help-seeking for PWUA, this study found that the familiarity and safety of alcohol was a contradictory but fundamental experience of PWUA's addicted lives. Of note was a particularly interesting oscillation between attempts to access support, perceiving or experiencing rejection, and then returning

to drinking often after periods of sobriety, finding themselves back at “square one”. Relapsing and returning to the chaos of the system was often a trigger for a tumultuous period of poor mental health and challenging social impacts such as homelessness. PWUA would often disengage and isolate themselves from services at this stage, in part due to the shame of having “failed”. This finding has been reported in existing literature whereby feelings of shame were intensified after perceived “failure” upon relapsing (Gilburt et al., 2015). This study, however, is the first to note the dual role of alcohol in relation to the experiences of PWUA in seeking psychological help. As well as the shame and sense of failure that accompanied relapse, this study aligned with the conceptualisation of alcohol in psychoanalytic literature as both the cause of distress but also a safe and often vital component of PWUA’s lives.

The function of substances as providers of safety and comfort has been explored more widely in psychoanalytic literature, through concepts such as the “container” (Bion, 1963; Reed, 2002) as well as the therapist’s role of an indestructible and transitional object for the client to depend upon (Hale, 2013; Rodriguez de la Siera, 2002). Attachment theory (Bowlby, 1969) has been a helpful framework through which to understand the causes of substance use disorder, with insecure attachment styles having been linked to increased rates of substance use disorder (Schindler, 2019). The role of substances in addiction has also been explored in psychoanalytic literature through the notion of early wounding and trauma that results in later life addictions, defences and compensatory behaviours. Addiction is recognised as a way of coping with a “primal wound”, one which tends to send people with addictions into states of “non-being”, removing a sense of self and disrupting interpersonal development (Firman & Gila, 1997). Addiction in this sense is a way to cope with such a threat related to “non-being”

or not existing, which for many who have experienced childhood abuse can feel more of a threat than death itself (Firman & Gila, 1997).

Continued substance use also affects the ability to form relationships, which may provide some indication of the difficulties in trust that many PWUA find when relating to services. Furthermore, the "safety and comfort of the addictive process" can replace the need to form connections and relationships with HCPs (Firman & Gila, 1997, p16). Many PWUA reported suspicious views of HCPs which were attributed to years of poor treatment, often experiences of not being believed when sharing their stories. Some studies have explored the concept of alcohol as a providing a "regulatory function" to PWUA whereby substances serve as a "complex compensatory mechanism" for an absent attachment bond (Padykula & Conklin, 2010, p. 351) or as a method of regulating PTSD symptoms (Bowen et al., 2024). The impact of using substances on forming a therapeutic alliance has yet to be explored in the context of PWUA's tendencies to avoid help-seeking. However, if researched in more detail, could provide a useful insight or theoretical framework through which to understand PWUA's patterns of engagement with services and HCPs.

All participants in this study described or alluded to early as well as more recent traumatic experiences, ranging from childhood abuse to domestic abuse as adults. Alcohol served as a survival mechanism and a remedy for distressing psychological problems and a way of staying alive in the face of challenging mental health problems. As noted in the current study, existing research has identified a fear of worsening mental health problems or withdrawal symptoms if PWUA were to stop drinking (Haighton et al., 2016). This was compounded by a fear of opening up to HCPs for risk that they would be re-traumatised by vocalising or sharing their experiences. Many PWUA reported that they felt safer to exist in

the chaos of their own making, rather than chaos at the hands of the system. This is because being out of control was often triggering to participants in terms of early or recent trauma in their personal lives, but also because stopping drinking felt too risky without the guarantee of psychological support.

4.3.3 Chaos within the literature

The theme of chaos was mirrored not only in the findings of the current study, but also in the state of the theoretical literature surrounding addiction as well as the research process itself. The complexity of conducting research amongst this population, including gaining access to services and setting up interviews, will be discussed in more detail in the reflective account (Chapter 4.6). Within the literature, both addiction research and guidance for treatment exist in "a state of conceptual chaos" (Shaffer, 1997, p. 1573). While this is a long-standing contested issue in research (Albanese & Shaffer, 2012; Shaffer, 1997; Shaffer & Albanese, 2005; Teeson et al., 2011), competing theories of addiction persist today, with the causes of and 'solutions' to addiction remaining highly debated (Fisher, 2022; Pickard, 2020; Rosenthal & Faris, 2019). Complexity and disagreement between various models and theories of addiction (such as biological versus psychological) has been argued to make the alcohol treatment pathway even more inefficient and fragmented (Gilburt et al., 2015) while establishing treatment need and guidelines for appropriate healthcare is likely to remain challenging (Shaffer, 1997).

Mathematical models using chaos theory and the study of non-linear dynamics have also been applied to substance use problems in an attempt to challenge the linearity of the transtheoretical model of change (Resnicow & Vaughan, 2006; Skinner, 1989; Warren et al.,

2003;). However, attempting to apply mathematical formula to something as complex as addiction has been criticised as reinforcing the issue of over-simplification (Warren et al., 2003). The transtheoretical model of change (Prochaska & DiClemente, 1982) is still widely used in addiction treatment; the five stages of precontemplation, contemplation, preparation, action, and maintenance laid out in a linear fashion. While the process of recovery is now more widely recognised to be non-linear, accommodating relapse as part of recovery (O'Brien & McLellan, 1996), this study found that participants still experienced diametrically opposed requirements of "sober" versus "addicted" in terms of treatment criteria, suggesting that the complexity of addiction and recovery has yet to be embedded in NHS policy. The current study used qualitative data to begin to make sense of the chaos and complexity associated with PWUA experience, inadvertently responding to suggestions as far back as Skinner (1989) who advocated for increased acceptance of chaos in attempting to understand and conceptualise addiction.

4.3.4 Rejection, anticipated rejection and modifying oneself

The grounded theory developed highlights the complexity of interactions between PWUA and HCPs, for example GPs, and other psychological services such as NHS Talking Therapies. PWUA often reported experiences of direct rejection due to their alcohol use or for not meeting the threshold for mental health support. Others described a common perception amongst HCPs that their alcohol use was the cause of their mental health problems, a notion that all participants strongly denied, claiming that, on the contrary, alcohol use was a coping mechanism for mental health problems. Some existing studies have also reported negative perceptions of seemingly dismissive GPs and services more generally (Coste et al., 2020; Haighton et al., 2016; Jackson et al., 2024; Roberts et al., 2020). One

study in particular found GPs to be focussed on alcohol misuse as the main cause of health difficulties and it was rare that GPs linked PWUA's mental health concerns, such as depression, to be a key cause of their alcohol use (Jackson et al., 2024). Similarly, GPs have been found to refuse to view alcohol use as a legitimate illness (Haighton et al., 2016).

Not all perceptions of GPs and healthcare services were negative. In England, research has found GPs to be the preferred first point of contact for PWUA seeking support with alcohol issues (Lock, 2004); while more recent literature has reported PWUA's and other substance users have generally positive views of staff in healthcare settings (Neale et al., 2024; Parkman et al., 2017b). An important finding from this study, however, was that even the anticipation of a negative interaction with HCPs could be enough to prevent PWUA from help-seeking, or would cause them to moderate or filter how they presented themselves to professionals for fear of being judged or rejected. This could lead to barriers to help-seeking that were not necessarily founded on experiences of rejection from GPs or psychological therapy services, but rather a historic perception of statutory and other services that had built up over years. Playing "games" with HCPs was identified to be part of a complex negotiation for support. Some participants hid their alcohol intake for fear of judgement, although downplaying their problems also risked dismissal based on not meeting the threshold for a mental health referral. Other participants felt pressured to protect their therapists from their distressing stories. While one study reported that PWUA felt able to conceal their alcohol use with ease from GPs, citing fears of judgement (Haighton et al., 2016), this study is the first to identify the complex and often unspoken negotiation between PWUA and HCPs.

A report by the BMA (2024) into doctors' (including GPs and psychiatrists) perspectives of working on the frontline of the mental health system in England found similar

difficulties from the perspectives of professionals. Often, doctors struggled with the lack of service options available for those with addiction issues. The report noted that "patients are sometimes told different things by services. Some patients are told to seek treatment for their mental health before getting treatment for their addiction, but are then told they have to seek treatment for their addiction before getting treatment for their mental health" (p. 35) demonstrating that the issue exists for both sides in relation to the mental health system.

4.3.5 PWUA's negative self-image

This study identified interactions with HCPs and services as a contributing factor to PWUA's pre-existing negative self-image and lowered sense of self-worth. It also connected a negative self-image from a cognitive perspective with that of the embodied impacts on PWUA – namely relapse and deterioration in their mental health condition. A common experience for people with addictions has been mentioned previously in relation to the "primal wound" of early traumatic childhood experiences (Firman & Gila, 1997). Feelings of low self-worth, shame and being unworthy of treatment tended to re-appear in interactions with services. Considering the extent to which participants in this study had experienced early years trauma, it is unsurprising that perceived rejection from services or HCPs triggered particularly strong responses. This has been described in psychoanalytic literature relating to those with addiction issues to be a risk of returning to a well-known state of feeling invisible, non-existent, or in a state of "non-being" (Firman & Gila, 1997).

More broadly, the impacts of shame and stigma have been identified in existing literature as key barriers to accessing healthcare amongst PWUA (Gilburt et al., 2015; Haighton et al., 2016; Jackson et al., 2024; Naughton et al., 2013; Probst et al., 2015; Roberts

et al., 2020). Similar to the findings of this study, being dismissed by services has been found to increase PWUA's "internalised negative identity" (Gilburt et al., 2015, p. 446). In addition a dismissal of the link between alcohol addiction and poor mental health has been found to contribute to lower senses of self-worth and a feeling of being uncared for (Jackson et al., 2024). This was certainly noted in the current study too. Many participants expressed a genuine belief that they were not worthy of help, an indicator of shame becoming internalised likely due to many years of perceived rejection. However, while some studies have found that PWUA prefer to avoid identifying as an "alcoholic" due to shame (Montgomery et al., 2023; Naughton et al., 2013; Roper et al., 2012), this study found some PWUA openly used denigrating language such as "junkie" in relation to themselves, perhaps indicating the extent to which a negative self-view had become internalised.

Beyond the UK, multiple studies in the global North have also found that stigma and shame prevented people with addictions from seeking treatment (Cunningham et al., 1993; Hingson et al., 1982; Lamb et al., 2021; May et al., 2021; Motta-Ochoa et al., 2017; Oleski et al., 2010; Tarp et al., 2022; Wagner et al., 2017). Shame also caused people to minimise the severity of their addiction and in turn created a strong belief that they were able to handle the problem on their own. This often extended to a lack of acknowledgement that there was a problem in the first place (Cunningham et al., 1993; Hingson et al., 1982; Motta-Ochoa et al., 2017; Oleski et al., 2010; Wagner et al., 2017). For PWUA more specifically, some studies similarly found participants to be ambivalent to help-seeking for alcohol treatment specifically (Montgomery et al., 2023; Naughton et al., 2013; Parkman et al., 2017a; Parkman et al., 2017b; Roberts et al., 2020). On the contrary, this study identified that all PWUA intended to pursue psychological therapy in different ways, whilst also identifying unreservedly with having an alcohol addiction for which they needed support.

4.3.6 The embodied response to chaos

Contrary to some studies which identified shame as a motivating factor for change (Naughton et al., 2013), this study found that a reinforced sense of shame and/or feelings of rejection often triggered relapse and worsening mental health conditions, dragging PWUA back into the chaos of the system. Other studies have recognised the impact of rejection from statutory services as a contributor to suicidal ideation and relapse (Jackson et al., 2024); PWUA have also been found to risk relapse after leaving rehabilitation or detoxification programmes if adequate follow-up was not provided (Haighton et al., 2016; Montgomery et al., 2023). This study, however, is the first to identify the cyclical and interconnected nature of the system and individuals, as well as the contradictory role of alcohol that appeared to be tied up with this process. On the one hand, participants referred to relapse as a symbol of giving up, a choice to return to chaos and an acceptance that drinking would entrench them even further in barriers to psychological help. This idea has been alluded to in current literature in relation to the self-destructive mode triggered by negative self-perception. For example, alongside specific social circumstances, addiction is often "compounded by a negative self-concept that is part and parcel of a self-destructive mindset" (Pickard, 2020, p. 42).

On the other hand, this study found that relapse represented an act of resistance and defiance in the face of a chaotic system. A key finding of the current study was PWUA's comfort and familiarity in returning to alcohol, the straightforward nature of knowing how to cope with the impact of alcohol on the body as opposed to the physical discomfort of anxiety and waiting, or "*white knuckling it*" as one participant phrased it. If help was not available,

PWUA could find safety and solace in the "container" (Bion, 1963) of alcohol, connected to the concept of alcohol as a survival mechanism.

This study also found self-harm and overdose to be violent but meaningful acts of aggression towards participants' own bodies, representative of being left at rock bottom and a need to take autonomous control over themselves in ways that they could. Acts of self-harm also sent a message to the system indicating their distress and were an expression of the severity of their psychological condition. The role of alcohol amongst participants supported findings relating to the everyday structural violence associated with living with marginalised status as an "addict" in society, and the adjustment to normalised pain (Harris, 2020). Seemingly self-destructive acts, such as injecting, can, on the contrary being meaningful and protective acts of self-care (Harris, 2020). Despite the obvious discomfort associated with withdrawal and injection, control is inadvertently regained. For participants in the current study, relapse and the associated assault on the body also represented a site of resistance - disengaging with healthcare services represented powerful terms of agency whereby "avoidance of medical institutions can protect against further emotional and physical assaults" (Harris, 2020, p. 6).

In general, the embodied impact of addiction remains relatively under-explored in the literature. Some studies have alluded to the effects of dependence on alcohol, such as pain, seizures, withdrawal and hangovers as a precursor to PWUA deciding to seek help (Gilburt et al., 2015). Most literature on recovery from addiction, however, tends to focus on the more rational and cognitive elements of the process, such as recovery from shame, and moving forward with new identities (Nettleton et al., 2011). One study exploring people who use drugs' bodies finds that the recovering body represents a loss of the structure and habituation

of the drug-using body (Nettleton et al., 2011). This is contextualised as a 'dys-appearance' or absence of the functional body – one which demands attention because it has grown accustomed to the cyclical nature of sourcing money, scoring drugs, then injecting. Following recovery, users' bodies struggle to renegotiate their function, because despite the harm of drug use on the body, habituated action can in fact "provide comfort, reassurance and familiarity, even if it is action we would cognitively prefer not to do" (p. 352). This concept is comparable with the findings of the current study; participants reported familiarity and comfort in the return to drinking, despite the obvious negative consequences that relapse inevitably incurred.

4.3.7 Towards self-sufficiency

4.3.7.1 Defensive behaviours as a protective strategy

The findings of this study bear some similarities with the "why try phenomena" (Corrigan et al., 2009) whereby people with psychological problems can suffer with internalised or "self-stigma" and are dissuaded from pursuing processes like help-seeking, perceiving them to be pointless. Simultaneously, a paradoxical impact of self-stigma can also evoke a sense of personal empowerment and drive to pursue goals, encouraging individuals to take a more active role in treatment (Corrigan et al., 2009). In the current study, two opposing responses were apparent when faced with either anticipated or experienced rejection from HCPs and services. Rejection could reinforce PWUA's already negative self-perception, triggering a downward spiral into relapse and worsening mental health problems. At the other end of the spectrum, interactions that were dismissive or judgemental could in

fact prompt a movement towards self-sufficiency, prompting PWUA to look for alternative pathways into psychological therapy.

This study found that defensive behaviours were often the precursor to self-sufficiency. In psychoanalytic theory, defences are strategies employed unconsciously to decrease internal stress (Lemma, 2013) and can include help-rejecting at a more extreme end of the spectrum, compared with a more stable response like common problem-solving in the anticipation of situations before they arise (Perry & Bond, 2012). This study noted that responses to rejection or other negative experiences with staff and services often prompted PWUA to put up a metaphorical guard and avoid opening up to HCPs. Withdrawing or disengaging from services was often deemed to be the safer option, a choice made partly out of necessity but also partly an act of defiance via a demonstration of not needing the NHS's support.

While this study is the first to report this phenomenon in PWUA experiences of psychological therapies, a tendency to "go it alone" and rely on one's own self-efficacy has been well-documented in the literature in relation to the wider healthcare system (Gilburt et al., 2015; Haighton et al., 2016; Jackson et al., 2024; Montgomery et al., 2023; Parkman et al., 2017a; Parkman et al., 2017b). Some studies have highlighted the resourcefulness of PWUA; approaching A&E departments for help was experienced by PWUA as taking proactive action to get timely and compassionate healthcare (Parkman et al., 2017b). Self-sufficiency amongst PWUA in relation to help-seeking is arguably empowering on the one hand, contributing to an increased sense of agency, but also "balanced against considerable pressure associated with the inherent responsibility" (Gilburt et al., 2015, p. 448). Self-sufficient attitudes to help-seeking have also been documented in other fields relating to

experiences of marginalised communities. A qualitative meta-synthesis by Lamb et al. (2012) found that across northern Europe, hard-to-reach groups such as the homeless or asylum seekers in general tended to opt for more independent, self-management solutions when it came to seeking mental health support in primary care settings. This was due to a reluctance to seek professional help and increased tendencies to socially withdraw, partly because of the stigma associated with acknowledging mental health problems. Interactions with GPs were negatively affected by status power differentials, especially in the context of mental health consultations, leaving marginalised groups less likely to reach out for help.

4.3.7.2 PWUA's alternative pathways out of chaos

This study is the first to suggest that idiosyncratic pathways into psychological therapies were often a successful outcome of the self-sufficient, defiant and defensive behaviours that had developed as a response to perceptions of a hostile and chaotic system. Most participants reported that they had accessed psychological therapy at various stages throughout their journey of addiction via the third sector – namely substance use services, or mental health charities. In contrast to existing studies which found PWUA's views of community substance use services to be mixed (Dorey et al., 2021; Gilburt et al., 2015; Jackson et al., 2024; Montgomery et al., 2023; Parkman et al., 2017a; Roberts et al, 2020), the current study found PWUA view community substance use and other third sector services as a lifeline, often providing the only accessible routes into either NHS therapy, or alternatively therapy provided by the service itself or another third sector organisation.

Other studies have also noted that PWUA find creative and alternative routes into broader healthcare services to meet their specific needs (Gilburt et al., 2015; Haighton et al.,

2016; Jackson et al., 2024; Montgomery et al., 2023; Parkman et al., 2017a; Parkman et al., 2017b; Roper et al, 2013). Notably, the social dimensions of addiction often propel PWUA into help-seeking from a variety of healthcare settings (Parkman et al., 2017a; Parkman et al., 2017b). Alongside existing literature (Jackson et al., 2024; Roper et al., 2013), this study also notes the crucial role played by support systems beyond that of the third sector. For example, some participants had paid for private psychotherapy or alternatively accessed mutual aid groups. Many relied upon on friends and family for support into residential rehabilitation programmes, for example, which provided in-house psychotherapy. Although such pathways often resulted in positive outcomes for PWUA in terms of accessing therapy, it is concerning to note that concepts such as healthism (Crawford, 1980) continue today. The self-reliance and resilience of individuals and their families, as well as community led mutual aid or recovery groups reinforce the notion that the ultimate responsibility for health is down to the individual, rather than the state.

As discussed previously, PWUA experiences of the NHS were not all negative. Often PWUA reported specific encounters with GPs or HCPs where they felt supported and listened to and were offered appropriate referrals to services such as Talking Therapies. Such experiences, although relatively infrequent, were often described as transformative in PWUA's pathways of care. Such encounters have been noted in some existing studies as windows of opportunity for change (Roper et al., 2012). The importance of referrals being made at the right time from supportive and trustworthy professionals has been found to be critical in terms of supporting PWUA into treatment (Roper et al., 2012; Orford et al., 2006; Jakobsson et al., 2005). This study supports the notion that positive experiences with HCPs can be the gateway to successful access and engagement with psychological therapy services.

4.4 Limitations

There are specific limitations to this study which should be acknowledged. The sample's representativeness of PWUA experiences across southeast England could be considered problematic considering the high proportion of white British participants. Given the lack of racial diversity, this study provides insight only into the experiences of a specific demographic of PWUA. The Race Equality Foundation (2023) found black and minority ethnic populations to have worse outcomes, longer waiting times and were less likely to access support from NHS Talking Therapies. This study also raises important questions regarding why more participants from black and minority ethnic backgrounds did not respond to recruitment advertising, highlighting concerns regarding the visibility of minority ethnic participants in healthcare services more generally, as discussed earlier in this study.

Participants recruited to the study were also relatively limited in geographic variability. Considering the nature of qualitative research, however, this is not necessarily problematic (Leung, 2015). Credible qualitative data should be transferable, rather than generalisable (Lincoln & Guba, 1985) and in CGT in particular, results are based on fewer but more intensive efforts at data collection (Charmaz, 2014). Nonetheless, caution should be taken in considering the findings of the current study in relation to other areas of England, where inevitably the provisioning of substance use services is likely to vary according to local authority. Research from a broader range of services across England could therefore enhance transferability to contexts with more ethnically and culturally diverse populations as well as widening the study to incorporate the inconsistent nature of service provision across England. Application and interpretation of the current data is also limited by the lack of comparable studies in other parts of the UK as well as globally. Research using quantitative as well as

qualitative analysis and studies incorporating a wider geographical scope are needed to solidify implications for NHS policy and practice.

In addition, this study may also have attracted PWUA who were eager to share their stories because of having negative experiences with healthcare services. Those who have managed to access therapy through traditional routes may have felt less compelled to participate in the research, given they had positive experiences. This may have led to response biases. Similarly, participants were giving details of accounts over the lifespan which may be subject to recall biases. Providing accumulative accounts of historic experiences with mental healthcare services may lead to more negative appraisal of current experiences. In terms of transferability, the study also cannot account for the 82% of PWUA who are not accessing any substance use treatment at all (Alcohol Change, 2018). The study only sampled a small number of participants who are currently engaging with a support service. Given the majority of PWUA are not currently in treatment of any kind, further research with these participants may yield different results, perhaps in terms of a desire for psychological therapy and help-seeking in general.

Another limitation of this study is that it incorporates the views of PWUA rather than people who use both drugs and alcohol. This was intentional, given the scope of the current study and the need for a focussed research aim, however the study therefore does not account for the experiences of people who use drugs, who are usually seen within the same substance use services. Furthermore, it was decided not to specify the exact quantity of alcohol and/or other substances that were used by participants. The study instead included participants who identified as having an addiction to alcohol as their primary substance. Future research could perhaps select participants based on more specific drinking levels in order to explore the

extent to which amount of alcohol intake affects therapeutic help-seeking and access to therapy. Similarly, the study does not include the voices of HCPs, who could provide insightful perspectives relating to service delivery, perhaps inviting nuance and balance into accounts of the "system".

4.5 Clinical implications

Given the considerable lack of research surrounding PWUA experiences of the mental health sector in England, this study's dissemination hopes to shed light on the chaotic nature of PWUA's experiences and proposes recommendations for changes in service delivery. This study aims to support not only professionals working within the field of substance use and mental healthcare policy, but also PWUA who may find some reassurance in the knowledge they are not alone in their attempts to negotiate such complexity. Making sense of this complexity in order to support PWUA into treatment is paramount. This study illustrates that at present, the system does not operate in a way that is "grounded'" in PWUA's everyday lives and lived experiences, suggesting that it not appropriately and effectively set up for the people it is meant to support.

The current study provides an initial response to calls across the sector for further research into effective working with co-occurring addiction and mental health problems to address the gap in the literature. In response to the Dame Black report (2021), the NHS Addictions Provider Alliance highlighted a "general need for more evidence to support the whole system response" (NHS APA, 2025) while the publication of the "Better Care…" report (PHE, 2017) specified the importance of integrated care whereby alcohol and mental health needs are addressed at the same time, "delivered in and by mainstream services and

not in specialist dual diagnosis teams" (p. 17). It also called for closer monitoring on providers who often work with patients presenting in mental health crisis whilst intoxicated, who are regularly excluded from services because "their condition is not judged severe enough" (PHE, 2017, p. 27) and to ensure services users are not excluded "based on levels of alcohol and/or drug dependency, or on diagnoses (or lack of diagnoses) of mental illness" (p. 28). Nearly a decade later, however, and such an approach appears yet to be embedded.

Considering this study is the first to explore PWUA experiences of accessing psychological therapy specifically, there is scope for further research to be undertaken to deepen understanding of PWUA trajectories towards therapeutic help-seeking. The current study was broad in its aim to understand "experiences" but narrow in specification of psychological therapy. It would be beneficial to further examine experiences of precise components of the psychological therapy pathway in more detail – such as initial assessments with Talking Therapies services. This could give valuable insight into the specific areas that require improvement across the broader therapeutic pathway.

Further research into the perspectives of professionals who work with PWUA could be beneficial in order to understand the challenges and barriers to supporting PWUA into psychological services, furthering understanding of the areas where staff training may be necessary. Interviews with NHS Talking Therapy practitioners would also be beneficial in this regard and could contribute to the relatively small body of existing literature in the area which so far has focussed on staff perspectives of supporting PWUA within secondary care hospitals (Jackson et al., 2024a). The role of the wider psychological "system" could also be examined in more detail through interviews with policymakers and commissioners in order to

explore the rationale behind current segregations between mental health and substance use services and to better understand perceptions around the barriers to integration.

The geographical inequality in terms of substance use and mental health service provision creates difficulties for researchers when conducting studies that are generalisable or transferable. This was noted during the research process in this study; attempting to establish which services were offered where was challenging and contributed to the sense of chaos in attempting to understand the pathway. For example, some substance use services provided their own psychology therapist for PWUA whilst at others this was unavailable. An up-to-date review of service provision for PWUA across England would be beneficial in order to determine the support that PWUA have access to and to hopefully work towards standardising this across the sector.

Further exploration into the lead up to relapse could be beneficial in order to facilitate appropriate and timely support for PWUA. Often, PWUA spoke about achieving sobriety for a period of time yet still experiencing rejection from services, leading to relapse. Identifying the specific impact of interactions with HCPs and the complexity in terms of PWUA's response to rejection may provide some guidance as to how to make primary care consultations more appropriate for PWUA who may be at risk of relapse. For example, attachment-informed research into the relational components of this study's findings could shed light on the impact of early trauma on forming trusting connections with professionals and whether trauma-informed approaches to GP consultations, for example, could provide better care for PWUA.

The impact of wider social issues on addiction cannot be overlooked. Some studies have explored the complex interactions between the social dimensions of alcohol addiction and PWUA's relationships with health services. For example, PWUA display tendencies for increased reliance on A&E departments in the UK to meet both their health and wider social needs (Parkman et al., 2017a; 2017b). The demographic survey conducted in the current study demonstrated that most PWUA were unemployed at the time of interview, suggesting a possible correlation between mental health difficulties, alcohol addiction and difficulties retaining employment. Future research into interventions for PWUA that provide both psychological therapies alongside targeted psychosocial interventions could be beneficial in order to effectively work with this client group. So far, the UK government has piloted schemes including the "Changing Futures" programme which supports people with addictions and mental health problems, alongside other social, economic and relational circumstances by providing assertive outreach and help coordinate access to care (Jackson et al., 2024). Access to such services, however, remains geographically inconsistent (Jackson et al., 2024).

The proposed theoretical framework provided by the current study can offer contributions to healthcare policy in England. Five specific clinical recommendations as a response to the findings of this study are outlined below:

- The findings suggest that pathways into psychological therapy need to be made clearer and more accessible for those with co-occurring alcohol addiction and mental health problems. This study is in line with existing calls for simplified and accessible healthcare pathways for PWUA across the UK (Gilburt et al., 2015; Haighton et al., 2016; Jackson et al., 2024; Montgomery et al., 2023; Naughton et al.,

2013; Roberts et al., 2020). While specific NICE guidelines (2016) are in place for the support of people with addictions and diagnosed severe mental illnesses, those with undiagnosed or CMDs and co-occurring addictions are yet to be accommodated and can fall through the gaps in treatment provision. NICE guidelines to accommodate those with co-occurring CMDs and alcohol addiction would be beneficial in order to guide treatment providers at all stages of the psychological therapy pathway.

- This study contributes to recent reports that document the challenges associated with current fragmented service provision (Black, 2021; Darzi, 2024; NHS APA, 2025; NHS England, 2024; PHE 2017). Despite changes to NHS Talking Therapies guidelines in 2018 (NHS, 2024), most participants in the current study reported experiences of rejection from psychological services. This was often due to their current alcohol use, or alternatively being informed they did not meet the threshold for mental health support. This study suggests that referral criteria for PWUA and mental health issues should be standardised across all Talking Therapies services and effectively communicated to GPs in primary care settings. Referring or signposting PWUA with mental health problems to NHS Talking Therapies should be standard practice.

- This study supports existing calls from GPs for better quality training in identifying and supporting alcohol-related problems as well as greater awareness of therapeutic services, including referral criteria, available for PWUA (Montgomery et al., 2023). According to the theoretical model presented in this study, the role of the GP and other frontline HCPs can be critical in determining treatment outcome for PWUA. One-off appointments with GPs who are both compassionate and

knowledgeable about referral criteria and pathways can be transformational. GPs may benefit from training regarding relatively recent policy changes in Talking Therapies referral criteria to accommodate those with addictions (NHS, 2024) as well as more generally in supporting PWUA with co-occurring mental health problems. NHS Talking Therapies (NHS England, 2024, p. 58) also states that "clear, accessible and engaging materials" should be distributed in GP practices to publicise available services, and links with local third sector services need to be strengthened in order to provide smoother transitions between services.

- Considering the findings of this study, most PWUA not only struggled with common mental health issues such as anxiety or depression, but most had histories of trauma. Trauma-focussed CBT is also the treatment recommendation for people suffering with histories of trauma and/or symptoms of PTSD (NICE, 2018). Current research has indicated not only the causal effects of poor mental health and traumatic experiences in the development of alcohol addiction (Ford et al., 2007; Khoury et al., 2010; Maté, 2018; Moustafa et al., 2021), but has also documented the broad correlation between mental health issues and alcohol addiction in general (Connery et al., 2020; Debell et al., 2014; Jané-Llopis & Matytsina, 2006; Klanecky et al., 2016; WHO, 2022). It is surprising, therefore, that NICE Guidelines (2014) still recommend CBT that focuses on "alcohol-related cognitions, behaviour, problems" for PWUA, rather than identifying and working with the presenting mental health issue specifically, such as clinically evidenced CBT for PTSD or anxiety. Further research into the impact of targeted therapeutic interventions for PWUA could provide important insight regarding the opportunities for symptom reduction amongst this population.

- Alongside the financial implications of missed appointments or late attendances, working with those who may struggle to build therapeutic relationships due to histories of both trauma and poor experiences with statutory services can be challenging for both the workforce and services more generally. Therapists at NHS Talking Therapies may require further training in order to both up-skill and increase confidence when working with this client group. In response to Dame Black's (2021) report, NHS England (2024) published the 10-year Strategic Plan for the Drug and Alcohol Treatment and Recovery Workforce, highlighting their intention for an increased provision of qualified psychologists within substance misuse services as standard practice. While this study supports such calls for the provision of psychologically qualified staff across the sector, and highlights the need for psychological therapy provision to be standardised in order to avoid geographical inequalities in service provision, the study also suggests that the recommended changes to the substance use sector workforce will maintain the segregation between services rather than integrate PWUA into mainstream Talking Therapies services. Increasing psychological therapist posts within substance use services does not provide an antidote to the divisions between mental health and addiction at the sector level.

Encouraging NHS therapy services to be open to the idea of embracing the complexity associated with working therapeutically with addiction might be challenging, considering current financial constraints. Brown et al. (2011) discuss their pilot model of providing open-door psychotherapy for socially excluded adults, going against the dominant exclusion model. While, with any service, it is important to consider that "a completely open

door can leave nothing left to offer", it is important to also bear in mind that "a totally conditional hospitality risks being nothing more than an exclusionary administration" (Brown et al., 2011, p. 312) and likely contributes to further marginalisation of those already suffering from chronic social exclusion. They argue that in order to fight against bureaucratic gatekeeping and exclusion that upholds so many services, policy changes should work towards the seemingly impossible idea of a truly open-door approach.

Gatekeeping is, of course, functionary in the NHS and serves an important role within the healthcare system in terms of managing referrals and caseloads. For the chronically socially excluded, however, engaging with therapy can be experienced as threatening, triggering a sense of annihilation or being trapped in a relationship, often stirred up by historic experiences of abuse and neglect. Models of seemingly radical flexible working may be preferable, especially for those beginning to work therapeutically for the first time. For example, committing to shorter rather than full-length sessions, or having a brief interaction with a therapist in the corridor, can be the only way that some marginalised service users feel able to engage at first (Brown et al., 2011). Other examples include the notion that the therapeutic process may not necessarily be bound by a rigid "frame" and missed sessions, or late attendance, may be part of the process. This is in line with PHE's (2017) framework for supporting those with co-occurring mental health problems and alcohol use under a proposed approach termed "therapeutic optimism". As with psychoanalytic literature, the therapist and the services they work within may be required to play the role of "indestructible object" (Rodriguez de la Siera, 2002) and adopt a flexible approach to what are perceived as more traditional psychological therapies.

4.6 Reflexive account

My journey into the substance misuse sector began in 2016, a few years after I completed my undergraduate degree. I started working as a health and wellbeing practitioner for a substance use service in London, supporting people with addiction issues, both housed and street homeless. I soon became aware of the extent to which nearly every service user I worked with had some form of mental health difficulty which they believed to be at the root of their substance use. Most of their stories also referenced childhood sexual, physical or emotional abuse, which in turn were the cause of their mental health problems today. Substances, both drugs and alcohol, played a critical role in their lives, often as a way of managing complex emotions and coping with pain. Most of the service users I worked with had never been offered psychological therapy as a way of helping them process their trauma and navigate healthy coping strategies so it made sense that service users turned to substances as a way of managing very difficult feelings.

I was in my early twenties, right at the start of my career, and I struggled with the remit of my role. Most service users I worked with wanted to use their sessions to talk "psychologically" about how they were feeling, about events in the past and current difficulties in their lives. I was undoubtedly not qualified to offer professional psychological support, often leaving me feeling out of my depth in sessions, suggesting service users fill in a "drink diary" as homework, at the same time aware that this merely scratched the surface of how to work effectively with the root causes of addiction. Although nearly ten years ago, I remember attempting to refer service users into NHS therapy services on multiple occasions and always getting the same response – that of rejection. I experienced this alongside the service user, often being a vessel for their general discontent with "services" and the sense of being let down that had characterised their lives from an early age.

Being frustrating for me, I can only imagine what it must have felt like for the service users, many of whom had been stuck in this limbo for years. Reasons for rejection were nearly always that clients needed to engage with a substance use service to get sober before accessing therapy. I could understand the requirement; I myself often shared many of the frustrations that therapeutic services must have experienced as rationale for enacting strict referral criteria. Missed sessions were extremely common and as a Trainee Clinical Psychologist I can now understand the disruption this causes to therapeutic work as well as the relationship between therapist and client. However, there were many clients that I worked with who did engage, attending appointments regularly and who were rarely intoxicated during our sessions, or at least not to the point of it being disruptive. For these service users, I really believed there was a possibility for good, and potentially transformative, therapeutic work. Unfortunately, the rigid rules regarding sobriety were preventing access to therapy and therefore, in my mind, possible recovery.

Considering my work history as well as my current NHS psychological training, I chose to explore this topic for my doctoral thesis. I wondered whether the situation for service users had changed over the past decade. Beginning the research process was challenging. Firstly, attaining ethical approval to interview those in active addiction was difficult, forcing me to negotiate extensive safeguarding measures such as risk assessments in order to speak to participants. I experienced this as further marginalising those with addictions, making it even more difficult to have their voices heard. Secondly, attempting to recruit participants through charities and other third sector services was often characterised by rejection, bureaucracy and red tape. This mirrored what I would find to be the experience of those that I interviewed as I progressed through the research process, giving me a glimpse into their everyday challenges.

I persevered, and was lucky to be granted access from specific community alcohol services. I am incredibly grateful to them for taking a chance on this research and prioritising this opportunity for their service users' voices.

My personal values undoubtedly contributed to my desire to pursue research in this area. A commitment to social justice and equal access to psychotherapy are important to me, undergoing both NHS and private psychotherapy myself in recent years has been beyond valuable to me. Some of the stories I heard during the interviews were overwhelming at times. Participants described lifetime experiences of marginalisation and exclusion, not only within healthcare but across a range of statutory services. I was taken aback by the level of openness from participants – a willingness to share their stories and overt expressions of support for the research project, the majority of whom said they would have happily participated with or without a modest remuneration voucher.

I often wondered what I represented to the participants in the study. Being transparent about my role as a Trainee Clinical Psychologist, affiliated both to the University of Essex and to the NHS, meant that I, on some level, was part of the "system", yet also had a dual identity as a "therapist". At times, I questioned whether my interview was replicating the process of being asked to open up, then being "rejected" all over again, considering the lack of relational follow-up involved in research interviews apart from an email with the remuneration voucher and a statement of thanks. During the transcribing process I found myself sympathising with the PWUA experience and at times it was hard not to lean into the political narrative surrounding the segregating of sectors and underfunding of the third sector. I kept myself as neutral as possible, to enhance the reliability and integrity of the study, but

also to provide readers with the opportunity to make up their own minds and to represent the voices of the PWUA without bias.

My own frustration at certain points of the recruitment process was unavoidable at times. I noticed this both with services, but sometimes with potential participants, who on occasion would schedule an interview and then not show up, even on second, third and even fourth attempts. In psychoanalytic terms, I thought about the projection of this frustration at services being transferred from the participants into myself. I reflected on this, and at the frustration that I imagine some healthcare professionals might feel if and when PWUA disengage or miss appointments.

At points I got lost in the chaos of the data analysis itself, again reflective of PWUA experience. The process of abductive reasoning in CGT was helpful; one of the early theories that I soon discarded was the idea that PWUA simply face rejection from services. I realised that the picture was far more complex than this. While some PWUA were rejected outright, internal psychological processes such as the anticipation of rejection could make approaching services nearly unbearable and the more I progressed with interviews, the more complex the picture became. Attempting to organise and consolidate initial codes and categories was overwhelming and I was pulled into trying to establish a coherent narrative, before realising that this did not exist. Coming to the end of the research process, it became clear that chaos was the overarching theme of the study. The more I could accept this, the more the findings began to take shape. Taking a step back and accepting the chaos rather than trying to disentangle its inherent contradictions and cyclical nature was the beginning of the process of being able to understand PWUA experiences.

4.7 Conclusion

This study aimed to explore the experiences of PWUA in their attempts to access psychological therapy. The systematic review conducted into the experiences of healthcare services for PWUA revealed that prior to the current study, no research to date had explored the psychological therapy pathway specifically. Constructivist GT was employed in order to develop a theoretical model to explain how PWUA negotiate the pathway. The model was developed using rich data, collected from in-depth interviews that were grounded in PWUA experiences. Conducting interviews face-to-face as well as online facilitated and fostered a closer relationship with participants – the length of interviews as well as the researcher's psychological training laid a foundation for good rapport between researcher and participant, who were open and willing to share in-depth stories about what were often very personal issues.

The key findings from the study relate to the notion of chaos that characterised both individual experiences of addiction as well as that of the psychological therapy "system". The two realms interact with one another; PWUA remain in a state of chaos, characterised by repeated patterns of relapse and recovery. The study also highlights the idiosyncratic routes into treatment that PWUA adopt, relying on personal resourcefulness that appeared to be borne out of repeated experiences of disappointment and rejection from HCPs and services across the treatment pathway. In this sense, the fragmented and ambiguous policy surrounding access to psychological therapy for this population is arguably transferred onto PWUA, inadvertently exacerbating the chaos. Whilst this is not done intentionally, current practice is somewhat negligent. Recent public health reports, accounts of interactions with HCPs from participant interviews and research into perspectives of doctors working in the

field of mental health (BMA, 2024) demonstrate awareness amongst professionals that the system is not set up to support PWUA into treatment. However, despite changes being made to referral criteria for PWUA in 2018 (NHS England, 2024), this study suggests that policy has not yet filtered down into everyday practice.

Given that these findings are broadly similar to existing studies related to PWUA's experiences of healthcare services in the UK, it suggests that the theoretical framework is illustrative of chronic and enduring problems within the "system" at large. Themes of uncertain pathways, complexity and tendencies to act independently of services have been documented in other studies relating to the healthcare system, demonstrating that the marginalisation and chronic exclusion of PWUA extends well beyond access to psychological therapy services.

Clinical recommendations have also been presented in this study, namely in relation to the need for more clarity for service users throughout the psychological therapy pathway, for service providers to establish standardised referral criteria and for the provision of adequate training for HCPs regarding support and onward referral for PWUA in primary care settings. In the longer term, this study supports existing calls for integrated mental health and substance use services. Further research incorporating the voices of HCPs, as well as studies that explore various components of the referral pathway such as therapeutic assessments in more detail, could be beneficial in order to determine how and where to target appropriate interventions across the psychological treatment pathway.

References

Albanese, M. J. & Shaffer, H. J. (2012). Addiction: The genesis and evolution of an idea and its consequences. In H. J. Shaffer, D., A. LaPlante, & S. E. Nelson (Eds.), *APA addiction syndrome handbook, Volume 1: Foundations, influences and expressions of addiction* (pp. 3–25). American Psychological Association. https://doi.org/10.1037/13751-001

Alcohol Change UK. (2018, May 1). *The hardest hit: Addressing the crisis in alcohol treatment services*. Alcohol Change UK. https://alcoholchange.org.uk/publication/the-hardest-hit-addressing-the-crisis-in-alcohol-treatment

Alcoholics Anonymous. (2001). *Alcoholics Anonymous: The story of how many thousands of men and women have recovered from alcoholism*. (4th ed.). Alcoholics Anonymous World Services.

Alexander, B. K. (2012). Addiction: The urgent need for a paradigm shift. *Substance Use & Misuse*, *47*(13–14), 1475–1482. https://doi.org/10.3109/10826084.2012.705681

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association. https://doi.org/10.1176/appi.books.9780890425596

American Psychological Association. (2018, April 18). *APA dictionary*. Retrieved March 24, 2025, from https://dictionary.apa.org/recovery

Arribas-Ayllon, M. & Walkerdine, V. (2017). Foucauldian Discourse Analysis. In C. Willig, & R. Stainton Rogers, W. (Eds.), *The SAGE Handbook of Qualitative Research in Psychology* (pp. 110-121). SAGE Publications Ltd.

Atkins, S., Lewin, S., Smith, H., Engel, M., Fretheim, A., & Volmink, J. (2008). Conducting a meta-ethnography of qualitative literature: Lessons learnt. *BMC Medical Research Methodology*, *8*(21). https://doi.org/10.1186/1471-2288-8-21

Banister, P, Burman, E., Parker, I., Taylor, M. & Tindall, C. (1994). *Qualitative methods in psychology: A research guide.* Open University Press.

Bansal, N., Karlsen, S., Sashidharan, S. P., Cohen, R., Chew-Graham, C. A., & Malpass, A. (2022). Understanding ethnic inequalities in mental healthcare in the UK: A meta-ethnography. *PLoS medicine, 19*(12), e1004139. https://doi.org/10.1371/journal.pmed.1004139

Barker, C., Pistrang, N. & Elliott, R. (2015). *Research methods in clinical psychology. An introduction for students and practitioners.* (3rd ed.). John Wiley & Sons.

Bion, W. R. (1963). *Elements of Psycho-Analysis.* William Heinemann Medical Books Ltd.

Birks, M. & Mills, J. (2015*). Grounded theory: A practical guide* (2nd ed.). SAGE Publications Ltd.

Black, C. (2021, February 28). *Independent Review of Drugs.* Department of Health and Social Care. https://www.gov.uk/government/collections/independent-review-of-drugs-by-professor-dame-carol-black

Bowen, A. M., Calder, R., Neale, J., Meynen, T., & Gilchrist, G. (2024). Emotion regulation in the association between posttraumatic stress disorder and substance use: a systematic review with narrative synthesis. *Trauma, Violence, & Abuse.* Advance online publication. https://doi.org/10.1177/15248380241306362

Bowers, B. & Schatzman, L. (2009). Dimensional analysis. In J.M. Morse, P.N. Stern, J. Corbin, B. Bowers, K. Charmaz & A.E. Clarke (Eds.), *Developing Grounded Theory: The Second Generation*. Left Coast Press. https://doi.org/10.4324/9781315430577

Bowlby, J. (1969). *Attachment and Loss: Volume 1. Attachment.* Basic Books.

Braun, V., & Clarke, V. (2022). *Thematic analysis: a practical guide*. SAGE Publications Ltd.

British Medical Association. (2024). *"It's broken": Doctors' experiences on the frontline of a failing mental healthcare system.* British Medical Association. Retrieved March 27, 2025, from https://www.bma.org.uk/media/ddclsiii/bma-mental-health-report-2024-web-final.pdf

British Psychological Society. (2021, April 5). *BPS Code of Human Research Ethics.* British Psychological Society. https://doi.org/10.53841/bpsrep.2021.inf180

Britten, N., Campbell, R., Pope, C., Donovan, J., Morgan, M., & Pill, R. (2002). Using meta ethnography to synthesise qualitative research: A worked example. *Journal of Health Services Research & Policy*, *7*(4), 209–215. https://doi.org/10.1258/135581902320432732

Brown, G., Kainth, K., Matheson, C., Osborne, J., Trenkle, A., & Adlam, J. (2011). An hospitable engagement? Open-door psychotherapy with the socially excluded. *Psychodynamic Practice*, *17*(3), 307–324. https://doi.org/10.1080/14753634.2011.587605

Bryant, A. (2002). Re-grounding grounded theory. *Journal of Information Technology Theory and Application*, *4*(1), 25–42. https://aisel.aisnet.org/jitta/vol4/iss1/7

Bryant, A., & Charmaz, K. (2007). Grounded theory research: Methods and practices. In A. Bryant & K. Charmaz (Eds.), *The Sage handbook of grounded theory* (pp. 1-28). SAGE Publications Ltd.

Campbell, R., Pound, P., Morgan, M., Daker-White, G., Britten, N., Pill, R., Yardley, L., Pope, C., & Donovan, J. (2011). Evaluating meta-ethnography: Systematic analysis and synthesis of qualitative research. *Health Technology Assessment,* 15(43), 1–164. https://doi.org/10.3310/hta15430

Campbell, R., Pound, P., Pope, C., Britten, N., Pill, R., Morgan, M., & Donovan, J. (2003). Evaluating meta-ethnography: A synthesis of qualitative research on lay experiences

of diabetes and diabetes care. *Social Science & Medicine*, *56*(4), 671–684. https://doi.org/10.1016/s0277-9536(02)00064-3

Cazalis, A., Lambert, L., & Auriacombe, M. (2023). Stigmatization of people with addiction by health professionals: current knowledge. A scoping review. *Drug and Alcohol Dependence, 9*. https://doi.org/10.1016/j.dadr.2023.100196

Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research.* (pp. 509-535). SAGE Publications Ltd.

Charmaz, K. (2005). Grounded theory in the 21st century: Application for advancing social justice studies. In: Denzin NK and Lincoln YS (Eds.), *The Sage Handbook of Qualitative Research.* (pp. 207–236). SAGE Publications Ltd.

Charmaz, K. (2006). *Constructing Grounded Theory: A practical guide through qualitative analysis.* SAGE Publications Ltd.

Charmaz, K. (2008). Constructionism and the grounded theory. In J. A. Holstein & J. F. Gubrium (Eds.), *Handbook of Constructionist Research* (pp. 397-412). The Guildford Press.

Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). SAGE Publications Ltd.

Charmaz, K. (2017). The power of constructivist grounded theory for critical inquiry. *Qualitative Inquiry, 23*(1), 34–45. https://doi.org/10.1177/1077800416657105

Charmaz, K. & Henwood, K. (2017). Grounded Theory Methods for Qualitative Psychology. In C. Willig & W.S. Rogers (Eds.), *The SAGE Handbook of Qualitative Research in Psychology* (pp. 238-251). SAGE Publications.

Charmaz, K., & Thornberg, R. (2021). The pursuit of quality in grounded theory. *Qualitative Research in Psychology, 18*(3), 305–327. https://doi.org/10.1080/14780887.2020.1780357

Chun Tie, Y., Birks, M., & Francis, K. (2019). Grounded theory research: A design framework for novice researchers. *Open Medicine, 7*(3), 1–8. https://doi.org/10.1177/2050312118822927

Clarke, A.E. (2005). *Situational analysis: Grounded theory after the postmodern turn*. SAGE Publications Ltd. https://doi.org/10.4135/9781412985833

Connery H.S., McHugh R.K., Reilly M., Shin S., & Greenfield S. F. (2020). Substance use disorders in global mental health delivery: Epidemiology, treatment gap, and implementation of evidence-based treatments. *Harvard Review of Psychiatry*. *28*(5) 316–27. https://doi.org/10.1097/HRP.0000000000000271

Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO: The SPIDER Tool for Qualitative Evidence Synthesis. *Qualitative Health Research*, *22*(10), 1435–1443. https://doi.org/10.1177/1049732312452938

Coolican, H. (2009). *Research methods and statistics in psychology* (5th ed.). Routledge. https://doi.org/10.4324/9780203769669

Corrigan, P. W., Larson, J. E., & Rüsch, N. (2009). Self-stigma and the "why try" effect: Impact on life goals and evidence-based practices. *World Psychiatric Association*, *8*(2), 75–81. https://doi.org/10.1002/j.2051-5545.2009.tb00218.x

Coste, S., Gimenez, L., Comes, A., Abdelnour, X., Dupouy, J. & Escourrou, E. (2020). Discussing alcohol use with the GP: a qualitative study. *BJGP Open*; 4(2) https://doi.org/10.3399/bjgpopen20X101029

Crawford, R. (1980). Healthism and the medicalization of everyday life. *International Journal of Social Determinants of Health and Health Services 10*(3), 365–388. https://doi.org/10.2190/3H2H-3XJN-3KAY-G9NY

Creswell, J.W. (2003). *Research design: Qualitative, quantitative and mixed methods approaches* (2nd ed.). SAGE Publications Ltd.

Crichton, P., Carel, H., & Kidd, I. J. (2017). Epistemic injustice in psychiatry. *BJPsych Bulletin, 41*(2), 65–70. https://doi.org/10.1192/pb.bp.115.050682

Critical Appraisal Skills Programme UK. (2018). CASP checklists for qualitative studies. CASP. Retrieved April 13, 2025, from https://casp-uk.net/casp-tools-checklists/

Crothers, C. E., & Dorrian, J. (2011). Determinants of Nurses' Attitudes toward the Care of Patients with Alcohol Problems. *International Scholarly Research Notices.* https://doi.org/10.5402/2011/821514

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process.* SAGE Publications Ltd. https://doi.org/10.4324/9781003115700

Cunningham, J. A., Sobell, L. C., Sobell, M. B., Agrawal, S., & Toneatto, T. (1993). Barriers to treatment: Why alcohol and drug abusers delay or never seek treatment. *Addictive Behaviors, 18*(3), 347–353. https://doi.org/10.1016/0306-4603(93)90036-9

Darzi, A. (2024, September 25). *Independent Investigation of the National Health Service in England.* Department of Health and Social Care. https://assets.publishing.service.gov.uk/media/66f42ae630536cb92748271f/Lord-Darzi-Independent-Investigation-of-the-National-Health-Service-in-England-Updated-25-September.pdf

Davidson, L., & White, W. (2007). The Concept of Recovery as an Organizing Principle for Integrating Mental Health and Addiction Services. *The Journal of Behavioral Health Services & Research, 34*(2), 109–120. https://doi.org/10.1007/s11414-007-9053-7

Debell, F., Fear, N., Head, M., Batt-Rawden, S., Greenberg, N., Wessely, S., & Goodwin, L. (2014). A systematic review of the comorbidity between PTSD and alcohol misuse. *Social Psychiatry and Psychiatric Epidemiology, 49*(9), 1401–1425. https://doi.org/10.1007/s00127-014-0855-7

Denzin, N.K. & Lincoln, Y.S. (1998). *The landscape of qualitative research: Theories and issues*. SAGE Publications Ltd.

Department for Levelling Up, Housing & Communities (29 April 2022). *From harm to hope: A 10-year drugs plan to cut crime and save lives.* https://www.gov.uk/government/publications/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives#chapter-3--delivering-a-world-class-treatment-and-recovery-system

Department of Health and Social Care (2017). *Guidelines on Drug Misuse and Dependence: UK guidelines on clinical management.* Retrieved January 31, 2025, from https://assets.publishing.service.gov.uk/media/5a821e3340f0b62305b92945/clinical_guidelines_2017.pdf

Department of Health and Social Care (2020). *Common Mental Disorders.* Retrieved March 31, 2025, from https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/adults-experiencing-common-mental-disorders/latest/

Dixon-Woods, M., Agarwal, S., Jones, D., Young, B., & Sutton, A. (2005). Synthesising qualitative and quantitative evidence: A review of possible methods. *Journal of Health Services Research & Policy, 10*(1), 45–53. https://doi.org/10.1177/135581960501000110

Dixon-Woods, M., Fitzpatrick, R., & Roberts, K. (2001). Including qualitative research in systematic reviews: Opportunities and problems. *Journal of Evaluation in Clinical Practice, 7*(2), 125–133. https://doi.org/10.1046/j.1365-2753.2001.00257.x

Dorey, L., Lathlean, J., Roderick, P., & Westwood, G. (2021). Patient experiences of alcohol specialist nurse interventions in a general hospital and onwards care pathways. *Journal of Advanced Nursing*, *77*(4), 1945–1955. https://doi.org/10.1111/jan.14777

Drake R., Mueser K., Brunette M., & McHugo, G. (2004). A review of treatments for people with severe mental illnesses and co-occurring substance use disorders. *Psychiatric Rehabilitation Journal. 27*(4), 360–374. https://doi.org/10.2975/27.2004.360.374

Drożdżowicz, A. (2021). Epistemic injustice in psychiatric practice: epistemic duties and the phenomenological approach. *Journal of Medical Ethics, 47*(12). https://doi.org/10.1136/medethics-2020-106679

Drummond C, Oyefoso A, Phillips T., Cheeta, S., Deluca, P., Perryman, K., Winfield, H., Jenner, J., Cobain, K., Galea, S., Saunders, V., Fuller, T., Pappalardo, D., Baker, O. & Christoupoulos, A. (2005). *The 2004 National Alcohol Needs Assessment for England.* Department of Health and Social Care. Retrieved April 13, 2025. https://www.researchgate.net/publication/258028408_Alcohol_needs_assessment_research_project_ANARP

Eatough, V. & Smith, J. A. (2017). Interpretative Phenomenological Analysis. In C. Willig & W.S. Rogers (Eds.). *The SAGE handbook of qualitative research in psychology* (pp. 193-207). SAGE Publications Ltd.

El-Guebaly, N. (2012). The meanings of recovery from addiction: Evolution and promises. *Journal of Addiction Medicine, 6*(1), 1–9. https://doi.org/10.1097/ADM.0b013e31823ae540

El Hussein, M. T., Kennedy, A., & Oliver, B. (2017). Grounded theory and the conundrum of literature review: Framework for novice researchers. *The qualitative report, 22*(4), 1198-1210. https://doi.org/10.46743/2160-3715/2017.2661

Essex Council (2021). *Census 2021: Ethnicity, Language, and Religion.* Essex Country Council. Retrieved January 18, 2025, from https://data.essex.gov.uk/dataset/ex6gx/census-2021-ethnicity-language-and-religion

Firman, J., & Gila, A. (1997). *The primal wound: A transpersonal view of trauma, addiction, and growth*. State University of New York Press.

Fisher, C. (2022). *The Urge: Our history of addiction.* Scribe.

Fletcher, G. (1996). Realism versus relativism in psychology. *American Journal of Psychology, 109(3)*, 409-429. https://doi.org/10.2307/1423014

Ford, J. & Smith, S. (2008). Complex posttraumatic stress disorder in trauma-exposed adults receiving public sector outpatient substance abuse disorder treatment. *Addiction Research & Theory, 16*(2), 193-203. https://doi.org/10.1080/16066350701615078

France, E. F., Cunningham, M., Ring, N., Uny, I., Duncan, E. A., Jepson, R. G., Maxwell, M., Roberts, R. J., Turley, R. L., Booth, A., Britten, N., Flemming, K., Gallagher, I., Garside, R., Hannes, K., Lewin, S., Noblit, G. W., Pope, C., Thomas, J., Noyes, J. (2019). Improving reporting of meta-ethnography: The eMERGe reporting guidance. *Journal of Advanced Nursing, 75*(5), 1126–1139. https://doi.org/10.1111/jan.13809

Francia, L., Lam, T., Berg, A., Morgan, K., Savic, M., Lubman, D. I., & Nielsen, S. (2022). Putting out the welcome mat - A qualitative exploration of service delivery processes and procedures as barriers to treatment-seeking for people who use alcohol and other drugs. *Drug and Alcohol Review 42*(1) 193-202. https://doi.org/10.1111/dar.13551

Frank, L.E. & Nagel, S.K. (2017). Addiction and Moralization: The role of the underlying model of addiction. *Neuroethics 10*. 129–139. https://doi.org/10.1007/s12152-017-9307-x

Fraser, S., & Moore, D. (2008). Dazzled by unity? Order and chaos in public discourse on illicit drug use. *Social Science & Medicine 66*(3), 740–752. https://doi.org/10.1016/j.socscimed.2007.10.012

Fricker, M. (2007). *Epistemic injustice: Power and the ethics of knowing.* Oxford University Press.

Gasson, S. (2004). Rigor in grounded theory research: An interpretive perspective on generating theory from qualitative field studies. In M.E. Whitman & A.B.

Woszczynski (Eds), *The handbook of information systems research* (pp. 79-102). IGI Global. https://doi.org/10.4018/978-1-59140-144-5.ch006

Giaocomini, M. (2010). Theory matters in qualitative health research. In I.L. Bourgeault, R. Dingwall & R.G. De Vries (Eds.) *The SAGE Handbook of qualitative methods in health research* (pp. 125-150). SAGE Publications Ltd.

Gilburt, H., Drummond, C., & Sinclair, J. (2015). Navigating the Alcohol Treatment Pathway: A qualitative study from the service users' perspective. *Alcohol and Alcoholism 50*(4), 444–450. https://doi.org/10.1093/alcalc/agv027

Glaser, B. (1965). The constant comparative method of qualitative analysis. *Social Problems*, *12*(4), 436-445. https://doi.org/10.2307/798843

Glaser, B. & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Routledge.

Guba, E.G. & Lincoln, Y.S. (2005). Paradigmatic Controversies, Contradictions, and Emerging Confluences. In N.K. Denzin & Y.S. Lincoln (Eds.) *The Sage handbook of qualitative research* (pp. 191–215). SAGE Publications Ltd.

Guest, C. & Holland, M. (2011). Co-existing mental health and substance use and alcohol difficulties – why do we persist with the term "dual diagnosis" within mental health services? *Advances in Dual Diagnosis*, *4*(4), 162-172. https://doi.org/10.1108/17570971111197175

Haighton, C., Wilson, G., Ling, J., McCabe, K., Crosland, A., & Kaner, E. (2016). A qualitative study of service provision for alcohol related health issues in mid to later life. *PLoS ONE, 11*(2), e0148601. https://doi.org/10.1371/journal.pone.0148601

Hale, R. (2013). In search of a reliable container. Staff supervision at a drug dependency unit. In R. Bower, R. Hale, & H. Wood (Eds.) *Addictive states of mind. The Tavistock Clinic series (*pp. 199-210). Karnac.

Hall, W., & Farrell, M. (1997). Comorbidity of mental disorders with substance misuse. *The British journal of psychiatry: The Journal of Mental Science, 171,* 4-5. https://doi-org./10.1192/bjp.171.1.4

Harris, M. (2020). Normalised pain and severe health care delay among people who inject drugs in London: Adapting cultural safety principles to promote care. *Social Science & Medicine, 260*. https://doi.org/10.1016/j.socscimed.2020.113183

Hertfordshire Council (2021) *Diversity profile for Hertfordshire.* Hertfordshire County Council. Retrieved January 18, 2025, from https://www.reports.esriuk.com/viewreport/f589797e29b14c50a0f7cffdaa2c4420/E10000015?clear=true

Hingson. R., Mangione, T., Meyers, A. & Scotch, N. (1982). Seeking help for drinking problems: A study in the Boston metropolitan area. *Journal of Studies on Alcohol. 43*(3), 273-288. https://doi.org/10.15288/jsa.1982.43.273

Holland M. (1998). Substance use and mental health problems: Meeting the challenge. *British journal of nursing, 7*(15), 896–900. https://doi.org/10.12968/bjon.1998.7.15.5619

Hoover, K., Lockhart, S., Callister, C., Holtrop, J. S., & Calcaterra, S. L. (2021). Experiences of stigma in hospitals with addiction consultation services: A qualitative analysis of patients' and hospital-based providers' perspectives. *Journal of Substance Abuse Treatment*, *138.* https://doi.org/10.1016/j.jsat.2021.108708

Improving Access to Psychological Therapies (2012). *IAPT positive practice guide for working with people who use drugs and alcohol.* Retrieved February 9, 2025, from https://www.drugwise.org.uk/wp-content/uploads/iapt-drug-and-alcohol-positive-practice-guide.pdf

Jackson, K., Baker, R., O'Donnell, A., Loughran, I., Hartrey, W., & Hulse, S. (2024a). Understanding the challenges of identifying, supporting, and signposting patients with alcohol use disorder in secondary care hospitals, post COVID-19: A qualitative

analysis from the North East and North Cumbria, England. *BMC Health Services Research, 24*(1), 772–13. https://doi.org/10.1186/s12913-024-11232-4

Jackson, K., Kaner, E., Hanratty, B., Gilvarry, E., Yardley, L., & O'Donnell, A. (2024). Understanding people's experiences of the formal health and social care system for co-occurring heavy alcohol use and depression through the lens of relational autonomy: A qualitative study. *Addiction, 119*(2), 268–280. https://doi.org/10.1111/add.16350

Jakobsson, A., Hensing, G., & Spak, F. (2005). Developing a willingness to change: Treatment-seeking processes for people with alcohol problems. *Alcohol & Alcoholism, 40*(2) 118–123. https://doi.org/10.1093/alcalc/agh128

Jané-Llopis, E., & Matytsina, I. (2006). Mental health and alcohol, drugs and tobacco: a review of the comorbidity between mental disorders and the use of alcohol, tobacco and illicit drugs. *Drug and Alcohol Review*, *25*(6), 515–536. https://doi.org/10.1080/09595230600944461

Kelle, U. (2007). The development of categories: Different approaches in grounded theory. In A. Bryant & K. Charmaz (Eds.), *The sage handbook of grounded theory* (pp.191-213). Sage Publications Ltd.

Kelly, J. F., Magill, M., & Stout, R. L. (2009). How do people recover from alcohol dependence? A systematic review of the research on mechanisms of behaviour change in Alcoholics Anonymous. *Addiction Research & Theory, 17*(3), 236–259. https://doi.org/10.1080/16066350902770458

Khoury, L., Tang, Y. L., Bradley, B., Cubells, J. F., & Ressler, K. J. (2010). Substance use, childhood traumatic experience, and Posttraumatic Stress Disorder in an urban civilian population. *Depression and Anxiety, 27*(12), 1077–1086. https://doi.org/10.1002/da.20751

King's Fund (2021) *Improving drug treatment services in England: Models for commissioning and accountability.* King's Fund.

https://www.york.ac.uk/media/healthsciences/images/research/prepare/reportsandtheircoverimages/Kings%20Fund%20report%20on%20drugs%20commissioning%20and%20accountability%20-%20final%20JULY%202021.pdf

Klanecky, A. K., McChargue, D. E., & Tuliao, A. P. (2016). Proposed pathways to problematic drinking via post-traumatic stress disorder symptoms, emotion dysregulation, and dissociative tendencies following child/adolescent sexual abuse. *Journal of Addictive Diseases, 35*(3), 180–193. https://doi.org/10.1080/10550887.2016.1139428

Lai, H. M., Cleary, M., Sitharthan, T., & Hunt, G. E. (2015). Prevalence of comorbid substance use, anxiety and mood disorders in epidemiological surveys, 1990 - 2014: A systematic review and meta-analysis. *Drug and Alcohol Dependence, 154*, 1–13. https://doi.org/10.1016/j.drugalcdep.2015.05.031

Lamb, J., Bower, P., Rogers, A., Dowrick, C., Gask, L. (2012). Access to mental health in primary care: A qualitative meta-synthesis of evidence from the experience of people from 'hard to reach' groups. *Health*, *16*(1), 76-104. https://doi.org/10.1177/1363459311403945.

Lawrence-Jones, J. (2010). Dual diagnosis (drug/alcohol and mental health): Service user experiences. *Practice Social Work in Action, 22*(2), 115–31. https://doi.org/10.1080/09503151003686684

Lawson, S., & Griffiths, H. A (2023). A grounded theory study: How non-treatment-seeking substance users make sense of their behaviour “I want to be me but I don’t know who me is”. *International Journal of Mental Health and Addiction, 21*, 273–291. https://doi.org/10.1007/s11469-021-00592-1

Lemma, A. (2013). Introduction to the Practice of Psychoanalytic Psychotherapy. Wiley.

Lempert, L. B (2007). Asking questions of the data: Memo writing in the grounded theory tradition. In A. Bryant & K. Charmaz (Eds.), *The SAGE handbook of grounded theory* (pp. 245- 264). SAGE Publications Ltd.

Levers, M. (2013). Philosophical paradigms, grounded theory, and perspectives on emergence. *SAGE Open*, *3*(4). https://doi.org/10.1177/2158244013517243

Leung L. (2015). Validity, reliability, and generalizability in qualitative research. *Journal of Family Medicine and Primary Care, 4*(3), 324–327. https://doi.org/10.4103/2249-4863.161306

Li, H., Glecia, A., Arisman, K., Peternelj-Taylor, C., Holtslander, L., & Leidl, D. (2022). Mental health and addiction related emergency department visits: A systematic review of qualitative studies. *Community Mental Health Journal*, *58*(3), 553–577. https://doi.org/10.1007/s10597-021-00854-1

Lloyd, C. (2013). The stigmatization of problem drug users: A narrative literature review. *Drugs: Education, Prevention & Policy, 20*(2), 85–95. https://doi.org/10.3109/09687637.2012.743506

Lock, C. A. (2004). Alcohol and brief intervention in primary health care: What do patients think? *Primary Health Care Research & Development, 5*(2), 162–178. https://doi.org/10.1191/1463423604pc194oa

Malson, H. (2010). Qualitative Methods from Psychology. In I.L. Bourgeault, R. Dingwall & R.G. De Vries (Eds.) *The SAGE handbook of qualitative methods in health research* (pp. 193-204). SAGE Publications Ltd.

Maté, D. G. (2018). *In the realm of hungry ghosts*. Vermilion.

May, C., Eton, D., Boehmer, K., Gallacher, K., Hunt, K., MacDonald, S. (2014). Rethinking the patient: Using Burden of Treatment Theory to understand the changing dynamics of illness. *BMJ Health Services Research*, *14*(281). https://doi.org/10.1136/bmj.b2535

May, C., Nielsen, A., & Bilberg, R. (2019). Barriers to Treatment for Alcohol Dependence. *Journal of Drug and Alcohol Research 8*(236083). https://doi.org/10.4303/jdar/236083

Moher, D., Liberati, A., Tetzlaff, J., Altman, D.G. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA Statement. *PLoS Medicine, 6*(7), e1000097. https://doi.org/10.1371/journal.pmed1000097

Monks, R., Topping, A., & Newell, R. (2013). The dissonant care management of illicit drug users in medical wards, the views of nurses and patients: A grounded theory study. *Journal of Advanced Nursing, 69*(4), 935-946. https://doi.org/10.1111/j.1365-2648.2012.06088.x

Montgomery, C., Saini, P., Schoetensack, C., McCarthy, M., Hanlon, C., Owens, L., Kullu, C., van Ginneken, N., Rice, M., & Young, R. (2023). Improving access to treatment for alcohol dependence in primary care: A qualitative investigation of factors that facilitate and impede treatment access and completion. *PloS One, 18*(10), e0292220. https://doi.org/10.1371/journal.pone.0292220

Morris, J., Boness, C. L., & Burton, R. (2023a). (Mis)understanding alcohol use disorder: Making the case for a public health first approach. *Drug and Alcohol Dependence, 253*. https://doi.org/10.1016/j.drugalcdep.2023.111019

Morris, J., Boness, C.L., Witkiewitz, K., (2023). Should we promote alcohol problems as a continuum? Implications for policy and practice. *Drugs: Education, Prevention and Policy 31(*2), 271-281. https://doi.org/10.1080/09687637.2023.2187681

Motta-Ochoa, R., Bertrand, K., Flores-Aranda, J., Patenaude, C., Brunelle, N., Landry, M., & Brochu, S. (2017). A qualitative study of addiction help-seeking in people with different co-occurring mental disorders and substance use problems. *International Journal of Mental Health and Addiction, 15*(4), 883–899. https://doi.org/10.1007/s11469-017-9762-y

Moustafa, A., Parkes, D., Fitzgerald, L., Underhill, D., Garami, J., Levy-Gigi, E., Stramecki, F., Valikhani, A., Frydecka, D., & Misiak, B. (2021). The relationship between childhood trauma, early-life stress, and alcohol and drug use, abuse, and addiction: An integrative review. *Current Psychology, 40*(2), 579–584. https://doi.org/10.1007/s12144-018-9973-9

Murray, E., Linke, S., Harwood, E., Conroy, S., Stevenson, F., & Godfrey, C. (2012). Widening access to treatment for alcohol misuse: Description and formative evaluation of an innovative web-based service in one primary care trust. *Alcohol and Alcoholism, 47*(6), 697–701. https://doi.org/10.1093/alcalc/ags096

National Health Service (2019, August 21). *NHS Long Term Plan.* https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

National Health Service Addictions Provider Alliance (2025). *Dame Carol Black's Independent Review of Drugs - Part Two Report is Welcomed by the NHS APA*. Retrieved March 25, 2025, from https://www.nhsapa.org/post/dame-carol-black-phase-2-report

National Health Service England (2010, November 30). *NHS Long Term Plan: Healthy Lives, Healthy People*. Department of Health and Social Care. https://www.gov.uk/government/publications/healthy-lives-healthy-people-our-strategy-for-public-health-in-england

National Health Service England (2016, February). *The Five Year Forward View for Mental Health: A report from the independent Mental Health Taskforce to the NHS in England*. https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

National Health Service England (2019). *The Community Mental Health Framework for Adults and Older Adults.* Retrieved March 25, 2025, from https://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/

National Health Service England (2020). *Advancing Mental Health Equalities Strategy*. Retrieved March 25, 2025, from https://www.england.nhs.uk/publication/advancing-mental-health-equalities-strategy/

National Health Service England (2024, June 19). *NHS Talking Therapies for Anxiety and Depression Manual*. Retrieved March 25, 2025, from https://www.england.nhs.uk/publication/the-improving-access-to-psychological-therapies-manual/

National Health Service England (2024). *10-year strategic plan for the drug and alcohol treatment and recovery.* Department of Health and Social Care. Retrieved February 3, 2025, from https://www.england.nhs.uk/publication/10-year-strategic-plan-for- the-drug-and-alcohol-treatment-and-recovery-workforce-2024-2034/

National Institute for Health and Care Excellence (2014a, February 6). *Anxiety Disorders*. (Quality Standard QS53) Retrieved March 25, 2025, from https://www.nice.org.uk/guidance/qs53/chapter/Quality-statement-1-Assessment-of-suspected-anxiety-disorders

National Institute for Health and Care Excellence (2014, February 23). *Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence.* (Clinical Guideline CG115). Retrieved January 31, 2025, from https://www.nice.org.uk/guidance/cg115

National Institute for Health and Care Excellence (2016, November 30). *Coexisting severe mental illness and substance misuse: community health and social care services*. (NICE Guideline NG58). Retrieved March 26, 2025, from https://www.nice.org.uk/guidance/ng58

National Institute for Health and Care Excellence (2018, December 5). *Post-traumatic stress disorder.* (NICE Guideline NG116). Retrieved March 25, 2025, from https://www.nice.org.uk/guidance/ng116/chapter/Recommendations#management-of-ptsd-in-children-young-people-and-adults

National Institute for Health and Care Excellence (2022, June 29). *Depression in adults: treatment and management* (NICE Guideline NG222). Retrieved March 25, 2025, from

https://www.nice.org.uk/guidance/ng222/chapter/recommendations#treatment-for-a-new-episode-of-more-severe-depression

National Institute on Alcohol Abuse and Alcoholism (2024). *Neuroscience: The Brain in Addiction and Recovery*. Retrieved March 25, 2025, from https://www.niaaa.nih.gov/health-professionals-communities/core-resource-on-alcohol/neuroscience-brain-addiction-and-recovery

National Institute on Drug Abuse (2020, July 13). *Drug Misuse and Addiction*. Retrieved March 31, 2025, from https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction

Naughton, F., Alexandrou, E., Dryden, S., Bath, J., & Giles, M. (2013). Understanding treatment delay among problem drinkers: What inhibits and facilitates help-seeking? *Drugs: Education, Prevention & Policy, 20*(4), 297–303. https://doi.org/10.3109/09687637.2012.745121

Neale, J. (2016). Iterative categorization (IC): A systematic technique for analysing qualitative data. *Addiction*, *111*(6), 1096–1106. https://doi.org/10.1111/add.13314

Neale, J., Bouteloup, A., Getty, M., Hogan, C., Lennon, P., Mc Cusker, M., & Strang, J. (2017). Why we should conduct research in collaboration with people who use alcohol and other drugs. *Addiction, 112*(12), 2084–2085. https://doi.org/10.1111/add.14015

Neale, J., Cairns, B., Gardiner, K., Livingston, W., McCarthy, T., & Perkins, A. (2024). Waiting for inpatient detoxification: A qualitative analysis of patient experiences. *International Journal of Drug Policy, 123*. https://doi.org/10.1016/j.drugpo.2023.104291

Neale, J., Miller, P., & West, R. (2014). Reporting quantitative information in qualitative research: Guidance for authors and reviewers. *Addiction 109*(2), 175–176. https://doi.org/10.1111/add.12408

Neale, J., Tompkins, C., Wheeler, C., Finch, E., Marsden, J., Mitcheson, L., Rose, D., Wykes, T., & Strang, J. (2015). “You’re all going to hate the word ‘recovery’ by the end of this”: Service users’ views of measuring addiction recovery. *Drugs: Education, Prevention & Policy, 22*(1), 26–34. https://doi.org/10.3109/09687637.2014.947564

Nelson, J. (2016). Using conceptual depth criteria: Addressing the challenge of reaching saturation in qualitative research. *Qualitative Research, 17*(5), 554-570. https://doi.org/10.1177/1468794116679873

Nettleton, S., Neale, J., & Pickering, L. (2011). 'I don't think there's much of a rational mind in a drug addict when they are in the thick of it': towards an embodied analysis of recovering heroin users. *Sociology of Health & Illness, 33*(3), 341–355. https://doi.org/10.1111/j.1467-9566.2010.01278.x

Noblit, G. W., & Hare, R. D. (1988). *Meta-ethnography: Synthesising qualitative studies*. SAGE Publications Ltd. https://doi.org/10.4135/9781412985000

O’Brien, C., & Thomas McLellan, A. (1996). Myths about the treatment of addiction. *The Lancet, 347*(8996), 237–240. https://doi.org/10.1016/S0140-6736(96)90409-2

Office for Health Improvement & Disparities (2021). *Alcohol dependence prevalence in England.* Retrieved February 1, 2023, from https://www.gov.uk/government/publications/alcohol-dependence-prevalence-in-england#full-publication-update-history

Office for Health Improvement & Disparities (2023, October 16). *UK clinical guidelines for alcohol treatment: Core elements of alcohol treatment.* Retrieved March 25, 2025, from https://www.gov.uk/government/consultations/uk-clinical-guidelines-for-alcohol-treatment/uk-clinical-guidelines-for-alcohol-treatment-core-elements-of-alcohol-treatment

Office for Health Improvement & Disparities (2023a, December 21). *Adult substance misuse treatment statistics 2022 to 2023: report.* Retrieved August 12, 2024, from https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2022-to-2023/adult-substance-misuse-treatment-statistics-2022-to-2023-report#mentalhealth

Office for National Statistics (2025, February 5). *Alcohol-specific deaths in the UK: registered in 2023.* Retrieved March 25, 2025, from https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/alcoholrelateddeathsintheunitedkingdom/registeredin2023

Oleski, J., Mota, N., Cox, B. J., & Sareen, J. (2010). Perceived need for care, help seeking, and perceived barriers to care for alcohol use disorders in a national sample. *Psychiatric Services, 61*(12), 1223–1231. https://doi.org/10.1176/ps.2010.61.12.1223

Olsen, J.A., Richardson, J., Dolan, P., & Menzel, P. (2003). The moral relevance of personal characteristics in setting health care priorities. *Social Sciences & Medicine*, *(57)*7, 1163–72. https://doi.org/10.1016/s0277-9536(02)00492-6

Orford, J., Kerr, C., Copello, A., Hodgson, R., Alwyn, T., Black, R., Smith, M., Thistlethwaite, G., Westwood, A., & Slegg, G. (2006). Why people enter treatment for alcohol problems: Findings from UK Alcohol Treatment Trial pre-treatment interviews. *Journal of Substance Use, 11*(3), 161–176. https://doi-org.uniessexlib.idm.oclc.org/10.1080/14659890500246540

Padykula, N. F. & Conklin, P. (2010). The self regulation model of attachment trauma and addiction. *Clinical Social Work Journal, 38*. 351-360. https://doi.org/10.1007/s10615-009-0204-6.

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Aki, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., & Moher, D. (2021). The PRISMA 2020 statement: An updated

guideline for reporting systematic reviews. *PLOS Medicine, 18(*3), https://doi.org/10.1136/bmj.n71

Parkman, T., Neale, J., Day, E., & Drummond, C. (2017a). How do people who frequently attend emergency departments for alcohol-related reasons use, view, and experience specialist addiction services? *Substance Use & Misuse*, *52*(11), 1460–1468. https://doi.org/10.1080/10826084.2017.1285314

Parkman, T., Neale, J., Day, E., & Drummond, C. (2017b). Qualitative exploration of why people repeatedly attend emergency departments for alcohol-related reasons. *BMC Health Services Research, 17*(140). https://doi.org/10.1186/s12913-017-2091-9

Peele, S. (1987). A moral vision of addiction: how people's values determine whether they become and remain addicts. *Drug Issues, 17*(2), 187 – 215. https://doi.org/10.1177/002204268701700

Perry, J. C., & Bond, M. (2012). Change in defense mechanisms during long-term dynamic psychotherapy and five-year outcome. *American Journal of Psychiatry 169*(9), 916–925. https://doi.org/10.1176/appi.ajp.2012.11091403

Phillips, D. C. (1987). *Philosophy, science and social inquiry: Contemporary methodological controversies in social science and related applied fields of research.* Pergamon Press.

Phillips, T., Coulton, S., & Drummond, C. (2019) Burden of alcohol disorders on emergency department attendances and hospital admissions in England. *Alcohol and Alcoholism, 54*(5), 516–524. https://doi.org/10.1093/alcalc/agz055

Phillips, T., Huang, C., Roberts, E., & Drummond, C. (2021). Specialist alcohol inpatient treatment admissions and non-specialist hospital admissions for alcohol withdrawal in England: An inverse relationship. *Alcohol and Alcoholism*, *56*(1), 28–33. https://doi.org /10.1093/alcalc/agaa086

Pickard H. (2020). What we're not talking about when we talk about addiction. *The Hastings Center Report, 50*(4), 37–46. https://doi.org /10.1002/hast.1172

Polgar, S., & Thomas, S. A. (2013). *Introduction to research in the health sciences* (6th ed). Elsevier.

Pope, C. & Mays, N. (1995). Qualitative Research: Reaching the parts other methods cannot reach: An introduction to qualitative methods in health and health services research. *British Medical Journal*, *311*, 42-45. https://doi.org/10.1136/bmj.311.6996.42

Poulter, D., Foster, J. & Finch, E. (2021). Addiction services: A new approach is needed. *Health Services Journal*. Retrieved 25 March, 2025, from https://www.hsj.co.uk/service-redesign/commissioning-of-addiction-services-by-councils-has-failed/7030214.article

Pound, P., Britten, N., Morgan, M., Yardley, L., Pope, C., Daker-White, G., & Campbell, R. (2005). Resisting medicines: A synthesis of qualitative studies of medicine taking. *Social Science & Medicine, 61*(1), 133–155. https://doi.org/10.1016/j.socscimed.2004.11.063

Powell S. (2006) Handoffs and transitions of care: Where is the Lone Ranger's silver bullet? *Lippincotts Case Management*, *11*(5), 235–237. https://doi.org/10.1097/00129234-200609000-00001

Priester, M. A., Browne, T., Iachini, A., Clone, S., DeHart, D., & Seay, K. D. (2016). Treatment access barriers and disparities among individuals with co-occurring mental health and substance use disorders: An integrative literature review. *Journal of Substance Abuse Treatment, 61*, 47–59. https://doi.org/10.1016/j.jsat.2015.09.006

Priestley, J., & McPherson, S. (2016). Experiences of adults providing care to a partner or relative with depression: A meta-ethnographic synthesis. *Journal of Affective Disorders, 192*, 41–49. https://doi.org/10.1016/j.jad.2015.12.011

Probst, C., Manthey, J., Martinez, A., & Rehm, J. (2015). Alcohol use disorder severity and reported reasons not to seek treatment: A cross-sectional study in European primary care practices. *Substance Abuse Treatment Prevention and Policy, 10*(32), 1–10. https://doi.org/10.1186/s13011-015-0028-z

Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research & Practice, 19*(3), 276–288. https://doi.org/10.1037/h0088437

Public Health England (2017). *Better Care for people with co-occurring mental health and alcohol/drug use conditions: A guide for commissioners and service providers.* Retrieved January 22, 2025, from https://assets.publishing.service.gov.uk/media/5a75b781ed915d6faf2b5276/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf

Puddephatt J.A., Irizar, P., Jones, A., Gage, S.H., & Goodwin, L. (2022). Associations of common mental disorder with alcohol use in the adult general population: a systematic review and meta-analysis. *Addiction, 117*(6), 1543–72. https://doi.org/10.1111/add.15735

Race Equality Foundation (2023 November 1). *Ethnic Inequalities in Improving Access to Psychological Therapies (IAPT).* Retrieved January 22, 2025, from https://raceequalityfoundation.org.uk/wp-content/uploads/2023/11/Ethnic-Inequalities-in-Improving-Access-to-Psychological-Therapies-IAPT.Full-report.pdf

Rance, J., Gray, R., & Hopwood, M. (2017). "Why Am I the Way I Am?" Narrative Work in the Context of Stigmatized Identities. *Qualitative health research, 27*(14), 2222–2232. https://doi-org.uniessexlib.idm.oclc.org/10.1177/1049732317728915

Recovery Partnership (2015). *State of the Sector 2014-2015.* Retrieved January 31, 2025, from https://www.drugwise.org.uk/state-of-the-sector/

Reed, A. (2002). Psychotherapy with addicted people. In M. Weegmann & R. Cohen (Eds.) *The Psychodynamics of Addiction* (pp. 84-97). John Wiley & Sons.

Resnick, S.M. & Griffiths, M.D. (2010). Service quality in alcohol treatment: A qualitative study. *International Journal of Mental Health and Addiction*, *8,* 453–470. https://doi.org /10.1007/s11469-009-9216-2

Resnicow, K., & Vaughan, R. (2006). A chaotic view of behavior change: A quantum leap for health promotion. *The International Journal of Behavioral Nutrition and Physical Activity, 3*(25). https://doi.org/10.1186/1479-5868-3-25

Rodriguez de la Siera, L. (2000). Counter transference: Our difficulties in the treatment of substance abuse. In M. Weegmann & R. Cohen (Eds.) *The Psychodynamics of Addiction* (pp. 141-151). John Wiley & Sons.

Room, R. (2005). Stigma, social inequality and alcohol and drug use. *Drug and Alcohol Review, 24*(2), 143–155. https://doi.org/10.1080/09595230500102434

Roberts, E., Hillyard, M., Hotopf, M., Parkin, S., & Drummond, C. (2020). Access to specialist community alcohol treatment in England, and the relationship with alcohol-related hospital admissions: Qualitative study of service users, service providers and service commissioners. *BJPsych Open, 6*(5), 1-9. https://doi.org/10.1192/bjo.2020.80

Roper, L., McGuire, J., Salmon, P., & Booth, P. G. (2013). Treatment-seeking for alcohol problems: The influence of mirroring events and windows of opportunity. *Addiction Research & Theory, 21*(6), 479–488. https://doi.org/10.3109/16066359.2012.746318

Roscoe, S., Pryce, R., Buykx, P., Gavens, L., & Meier, P. S. (2022). Is disinvestment from alcohol and drug treatment services associated with treatment access, completions and related harm? An analysis of English expenditure and outcomes data. *Drug and Alcohol Review, 41*(1), 54–61. https://doi.org/10.1111/dar.13307

Rose, A., Winfield, H., & Jenner, J. (2011) National survey of alcohol treatment agencies in England: Characteristics of treatment agencies. *Journal of Substance Use 16*, 407–421. https://doi.org/10.3109/14659891003721125

Rosenthal, R. J., & Faris, S. B. (2019). The etymology and early history of 'addiction.' *Addiction Research & Theory, 27*(5), 437–449. https://doi.org/10.1080/16066359.2018.1543412

Saldaña, J. (2021). *The coding manual for qualitative researchers* (4th ed.). SAGE Publications Ltd.

Sawer, F., Davis, P., & Gleeson, K. (2019). Is shame a barrier to sobriety? A narrative analysis of those in recovery. *Drugs: Education, Prevention and Policy*, *27*, 1-7. https://doi.org/10.1080/09687637.2019.1572071.

Schindler A. (2019). Attachment and substance use disorders: Theoretical models, empirical evidence, and implications for treatment. *Frontiers in Psychiatry, 10*(727). https://doi.org/10.3389/fpsyt.2019.00727

Schomerus, G., Lucht, M., Holzinger, A., Matschinger, H., Carta, M., & Angermeyer, M. (2011). The stigma of alcohol dependence compared with other mental disorders: A review of population studies. *Alcohol and Alcoholism*, *46*(2), 105–112. https://doi.org/10.1093/alcalc/agq089

Sebatindira, W. (2023). *Through an addict's looking glass.* Hajar Press.

Shaffer H. J. (1997). The most important unresolved issue in the addictions: conceptual chaos. *Substance Use & Misuse, 32*(11), 1573–1580. https://doi.org/10.3109/10826089709055879

Shaffer, H. J. (1999). On the nature and meaning of addiction. *National Forum, 79*(4), 9-14. Retrieved April 13, 2025, from https://www.proquest.com/docview/1297806888?parentSessionId=nOJPzIFjxWVObFZYJzWXCbNsozA8Gtgp3%2FM8ggQMiOg%3D&accountid=10766&sourcetype=Scholarly%20Journals

Shaffer, H. J., & Albanese, M. J. (2005). Addiction's Defining Characteristics. In R. H. Coombs (Ed.), *Addiction counseling review: Preparing for comprehensive, certification and licensing examinations* (pp. 3–31). Taylor & Francis.

Shevchenko, S., & Zhavoronkov, A. (2025). Temporal aspects of epistemic injustice: The case of patients with drug dependence. *Journal of Bioethical Inquiry*. Online ahead of print. https://doi.org/10.1007/s11673-024-10404-5

Skinner, H. A. (1989). Butterfly wings flapping: Do we need more "chaos" in understanding addictions? *British Journal of Addiction*, *84*(4), 353–356. https://doi.org/10.1111/j.1360-0443.1989.tb00577.x

Society for the Study of Addiction. (2022). Stigmatising language in academic manuscripts: the view from a reader and peer-reviewer. Retrieved August 7, 2025, from https://www.addiction-ssa.org/features/blog/stigmatising-language-in-academic-manuscripts-the-view-from-a-reader-and-peer-reviewer/

Stock, A. (2017). Barking up the wrong tree: Why and how we may need to revise alcohol Addiction Therapy. *Frontiers in Psychology, 8*, 884. https://doi.org/10.3389/fpsyg.2017.00884

Strauss, A. & Corbin, J. (1990). *Basics of grounded theory methods*. Sage Publications.

Taket, A. R. (2009). *Theorising social exclusion.* Routledge.

Tarp, K., Sari, S., & Nielsen, A. S. (2022). Why treatment is not an option: Treatment naïve individuals, suffering from alcohol use disorders' narratives about alcohol use and treatment seeking. *Nordic Studies on Alcohol and Drugs 39*(4), 437–452. https://doi.org/10.1177/14550725221082512

Teesson, M., Hall, W., Proudfoot, H., & Degenhardt, L. (2011). *Addictions* (2nd ed.). Psychology Press.

Terry, G. Hayfield, N., Clarke, V., & Braun, V. (2017). Thematic Analysis. In C. Willig & W.S. Rogers (Eds.). *The SAGE Handbook of Qualitative Research in Psychology* (pp. 17-37). SAGE Publications Ltd.

Urquhart, C. (2013). *Grounded theory for qualitative research: A practical guide*. SAGE Publications Ltd. https://dx.doi.org/10.4135/9781526402196

Van Boekel, L. C., Brouwers, E. P. M., van Weeghel, J., & Garretsen, H. F. (2013). Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review. *Drug and Alcohol Dependence, 131*(1), 23–35. https://doi.org/10.1016/j.drugalcdep.2013.02.018

Wagner, V., Bertrand, K., Flores-Aranda, J., Acier, D., Brunelle, N., Landry, M., & Brochu, S. (2017). Initiation of addiction treatment and access to services: Young adults' accounts of their help-seeking experiences. *Qualitative Health Research*, *27*(11), 1614–1627. https://doi.org/10.1177/1049732316679372

Warren, K., Hawkins, R. C., & Sprott, J. C. (2003). Substance abuse as a dynamical disease: Evidence and clinical implications of nonlinearity in a time series of daily alcohol consumption. *Addictive Behaviors, 28*(2), 369–374. https://doi.org/10.1016/s0306-4603(01)00234-9

Weegmann, M. (2017). Open space. Life after addiction: Understanding recovery. *Psychodynamic Practice, 23*(3), 293–304. https://doi.org/10.1080/14753634.2017.1333588

Weegmann, M. & Cohen, R. (2000). *The psychodynamics of addiction*. Wiley.

White, W. L. (2007). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment, 33*(3), 229–241. https://doi.org/10.1016/j.jsat.2007.04.015

Williams, A. (2002). Container and contained: The school of Bion. In M. Weegmann & R. Cohen (Eds.) *The Psychodynamics of addiction* (pp 3 – 12). John Wiley & Sons.

Williamson, K. (2006). Research in constructivist frameworks using ethnographic techniques. *Library trends, 55*(1), 83-101. https://doi.org/10.1353/lib.2006.0054

Willig, C. (2012). Perspectives on the epistemological bases for qualitative research. In H. Cooper, P. Camic, D. Long, A. Panter, D. Rindskof, & K. Sher (Eds.), *APA handbook of research methods in psychology (Vol 1: Foundations, planning, measures, and psychometrics* (pp. 5–21). American Psychological Association.

Willig, C. (2018). Ontological and epistemological reflexivity: A core skill for therapists. *Counselling and Psychotherapy Research, 19*(3), 186–194. https://doi.org/10.1002/capr.12204

World Health Organisation (2022). *International Statistical Classification of Diseases and Related Health Problems* (11th ed.). Retrieved March 25, 2025, from https://icd.who.int/browse/2025-01/mms/en#1676588433

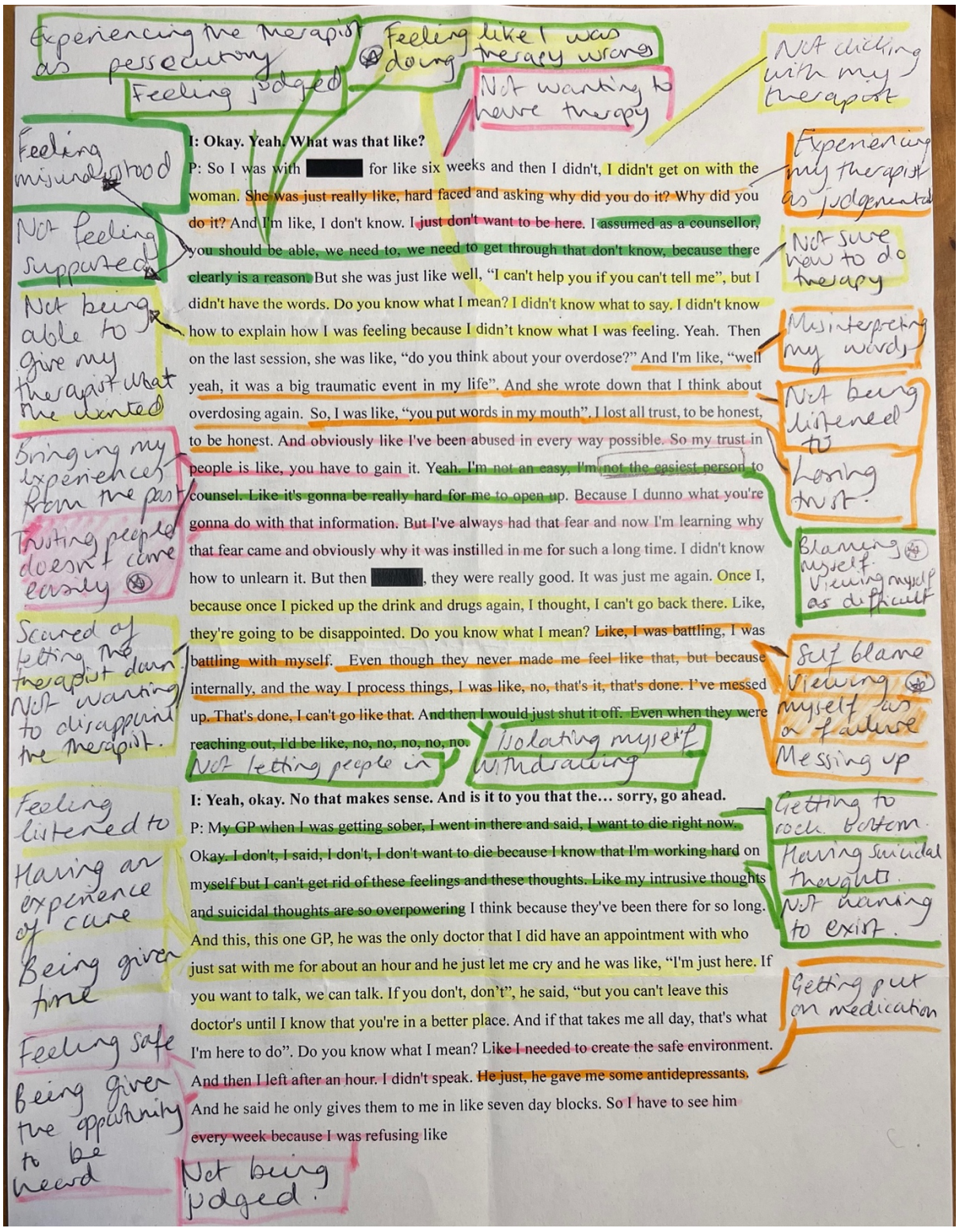
World Health Organisation (2022, June 28). *World Health Organisation fact sheets: Alcohol*. Retrieved March 25, 2025, from https://www.who.int/news-room/fact-sheets/detail/alcohol

Young, R. & Collin, A. (2004). Introduction: constructivism and social constructionism in the career field. *Journal of Vocational Behaviour 64*(3), 373- 388. https://doi.org/10.1016/j.jvb.2003.12.005.

Appendices

Appendix A

Example of line-by-line coding



Appendix B

Example of focussed coding

	A	B	C	D	E	F	G	H	I	J	K	L
1	Colour code	Needing flexibility and struggling to meet demands	Rejection/poor experiences	Losing trust	Fragmented help	Persevering	Complex system	Stuckness	Internalised shame	Anticipating judgement/ rejection	Role of third sector	Anticipating relap
2	P1	Finding it hard to cope with communication	Being treated like a time-waster	Getting let down	Being cut off from therapy	Having high hopes at first	Lack of confidence in the system	Standing still	Sense of failure	Worrying I'll be judged.	Reliance on A+E and Samaritans	Worrying about relaps
3	P2	Accepting I need to drink whilst I'm in therapy	Not being taken seriously	Unwilling to depend on NHS	No sense of progress	Jumping through hoops	Having my time wasted	Can't pay for therapy	Shutting myself away	Anticipating stigma	Leaning on emergency services	Relying on alcohol to s
4	P3	Asking for help doesn't come easy	Feeling let down	Finding counselling too posh	Being passed around between services	Given it my all	Uncertainty about where to get help	Waiting on rehab	Finding myself in a state	Being judged for drinking	Unwilling to depend on NHS	Falling down again
5	P4	Being contacted at the wrong times	Being kicked out of services	Building relationships with staff is difficult	No one takes responsibility	Wanting services to connect with me	Uncertainty about what counselling I got	Having my life put on hold	Feeling too ashamed to ask for help	Not disclosing to my GP	Depending on charities	Not having progressiv
6	P5	When I'm drunk I'm not motivated	Experiencing rude staff	Asking for help is a big deal	Gatekeeping services	Wanting to be cared for and loved	Uncertainty about waiting time	Waiting forever	Wanting to withdraw	Being labelled an alcoholic	Being taken seriously by charity	Getting better then gett
7	P6	Not thinking clearly when drunk	Getting told to pull my socks up	Constantly asking for help, not getting it	Methods of communication are dismissive	Keeping up the trust	Getting help is like snakes and ladders	Feeling like I'm in limbo	Feeling like a fraud	Being put in a box	Getting help from a charity in the end	Giving up without mer support feels impossib
8	P7	Difficulty reaching out	Feeling let down from a young age	Opening Pandora's box for nothing	Back and forth	Holding onto hope	Lack of communication	Endless waiting lists	Thinking I'm not 'bad enough'	Getting labelled	Dependent on substance misuse service	Worrying I'll drink aga
9	P8	Struggling with communication	Being told to get on with it	Getting desperate	Not getting through to the right people	Expecting support despite it all	Not getting through to the right people	Experiencing endless delays	Hiding myself away	Thinking help would be pointless	Relying on third sector in the end	Not wanting to decline
10	P9	Drinking isn't a choice	Being told I was dramatic	Feeling like they wanted to get rid of me	No one following up	White knuckling it	Not knowing who to contact	Waiting for appointments	Feeling embarrassed of my drinking	Uncerainty about professionals	Getting put in a refuge saved me	Anticipating things get
11	P10	Missing appointments is seen as laziness	No one dug deeper	Losing trust in the system	Being in a constant battle	Not being myself	Feeling uncertain about the plan	Sense of delay	Feeling like therapy is stigmatised	Mistrust of psychiatrists	Being referred by Samaritans	Feeling concerned square one drinking
12	P11	Need a more do-able service	Being told I'm not worthy of treatment	Losing faith in humanity	Getting told I had to go to a substance misuse service	Feeling 'too much' for therapists	Being in a constant battle	At crisis point but didn't meet the criteria for help	Ashamed at lack of self-control	They think I'm just another junkie	Charities as a lifeline	Waiting too long
13	P12	Worrying I'll forget things if I'm drunk	Wanting somebody to check in with me	Being made to feel unvaluable	Being told I needed to be sober to get help	Feeling like therapists couldn't handle me	Not understanding the system	Being put in a box	Shame in front of family	Being judged by hospitals	Calling Samaritans in time of need	Waiting for things to h
14	P13	Supposed to get on with it	No one reached out	Predictability of services	Being turned away from services	Not disclosing self-harm to doctors	GPs have difficulty referring	Experiencing delays	Feeling ridiculous for my own state	Fear of being judged	Finally being saved by CGL	White knuckling it
15	P14	Strict rules	Sending me to substance misuse services	Triggering feelings of rejection	Told I need to get sober	Playing the game	Self-referrals are confusing	Endless waiting lists	Ruining things for myself	Fear of not being believed	Calling Samaritans out of desperation	Relying on myself is u
16	P15	Difficult meeting service requirements	GP didn't have time for me	Methods of communication are dismissive	Unclear where to seek support	Patients and doctors playing the game	GPs not sure where to refer	Going round in circles	Feeling like it's my own fault	Wanting to turn it into a joke	Contacting Samaritans when I was desperate	Hanging on by a threa
17		Needing more flexibility	Staff acting last minute	Not trusting my GP	Feeling dismissed	Not wanting to shock the therapist	Not knowing where to get help	Always on waiting lists	Feeling ashamed of my alcohol use	Put into a category	Charity was the only thing that helped me	Timing is everything
18		Not able to stop drinking	Uncaring attitude from staff	Unreliable doctors	Caught in the middle	Leaving out the bad bits	Getting mixed messages	Waiting lists taking forever	Feeling like I am broken	Being judged immediately	Getting help for the first time from charity	Waiting too long make
		Kept moving house, difficult to stay put	Feeling let down	Being rejected via letter	Providing false sense of security	Minimising my experiences	Unsure where my help is coming from	Waiting and waiting for nothing	Feeling not worthy of help	Feeling pessimistic about help	Importance of	Back to square one dri

Colour code	Acting as my own advocate	Anticipating rejection risks relapse	Going round in circles, square 1	Physical risks folliowing rejection: self-harm/ overdose	Misunderstood/ not taken seriously	Learned pessimism	Chance encounters	Not ready to open up/ putting up barriers	Hard to be honest/ playing games	Overly medicated	The role of alcoh
P1	Calling up services	Being all over the place	Relapse is a grey area	Entering a mental health crisis	Cannot be honest about drinking	Losing trust in services.	Being honest with my therapist	Needing to feel understood	Cannot be honest about drinking	Getting put on meds	Giving me warmth ins
P2	Expecting support despite it all	Pointless ness of help-seeking	Going around in circles	Knowing I would overdose	Not taken seriously	Feeling pessimistic about support.	Therapy was the first thing that helped me	Putting up my barriers	Too risky to be honest about my drinking	Taking antidepressants instead	Acting as a remedy
P3	Holding onto hope	Started drinking again	Back to where I was before	Feeling rejected made me spiral	Being lectured by doctors	Bad experiences put me off	Being listened to for the first time in my life	Making myself vulnerable is too risky	Worrying I'll have my medication reduced if I'm honest	Put on medication	Alcohol as a means of feelings
P4	Ball left in my court	Avoiding asking for help	Coming full circle	Self-harming as the only way of coping	Being told I'm too complex for services	Hopelessness about the value of help	Getting taken seriously by one person was life-changing	Easier to avoid talking about it	Hiding my alcohol use	Coping on my own with medication	Drinking to forget
P5	Reaching out for help myself	Learned helplessness	Going round in circles	Knowing I would harm myself	Problems being ignored	Lack of confidence in the system	Being listened to can be a lfiesaver	Wasn't quesitoning anything at the time	Keeping my drinking secret	Putting me on medication instead	Personal life is a trigge
P6	Palmed off to charities	Losing confidence in myself	Ending up back at the beginning	Scarred by my experiences	Services assuming I'm ok	Not trusting counsellors	One GP gave me endless time	Telling strangers my deepest stuff	Thinking drinking was a tabboo	Antidepressants thrown at me	Drinking as a solution
P7	Wanting somebody to take control	Feeling desperate	Going back to square one	Gving up	No one took any notice of me	Avoiding getting help after bad experiences	Getting a rare chance	Difficulty building a relationship	Embarrassed about asking for help	Getting put on meds	Numbing myself
P8	Having to chase up services	Self-harming following discharge	Going back to square one	Wanting to hurt myself	Feeling lonely	Going back to the NHS wasn't worth it	Being offered therapy was life changing	Refusing help to cut down alcohol	Feeling in denial about having a problem	Being medicated has been unhelpful	Drinking as avoidance
P9	Chasing people up	Being discharged led to overdose	Urgency whilst I'm sober	At my lowest point	Drinking isn't a choice	Needing help but not getting it	Getting referred to therapy changed everything	Shutting myself off	Acknowledging a problem is scary	Given antidepressants instead	Alcohol as a means of
P10	Chasing the GP myself	Drinking again	Catch 22	Feeling at my most depressed	Nobody knows me	Carrying on drinking	Feeling listened to	Putting up a barrier	Lying about my drinking out of fear	Being put on meds first	Personal life is a trigge
P11	Referring myself in the end	Worrying about relapse	Feeling caught in the middle	Straight back to self-harming	Not taken seriously by services	Learning to reject help	Being supported by friends	Afraid of being sectioned	Trusting people is difficult	Throwing tablets at me	Alcohol as a crutch
P12	Chasing up services for myself	Waiting too long leads to relapse	Going round in circles	Taking an overdose after discharge	Not feeling heard properly	Not trusting my GP anymore	Financing rehab on my own	Afraid of getting help	Playing games with professionals	Just got put on antidepressants	Distancing myself fro
P13	Peer support saved me	Going on a downward spiral while I wait	Not receiving support when in crisis	Self-harming following discharge	Fearing being sectioned	Pointless asking for help	Relying heavily on family	Not bothering to get support	Difficulty being honest	Thrown tablets at me	Alcohol became a crut
P14	Biggest help is peer support	Becoming isolated	Wishing action had been taken earlier	Going into crisis mode	Feeling unworthy of treatment	Can't be bothered to go through the process	Realising how much was out there	Wanting to leave hospital without help	GPs and patients playing games	Chucking drugs at me	Being drunk all the tim
P15	Being around others who won't judge me	Just existing	Needing help in the moment	Deteroriating confidence	Not feeling understood	Keeping my hopes up is hard	Knowing I could lean on friends	Making me avoidant of help	Undermining the thereapeutic relationship	Assuming the GP was right	Making myself numb
	Finding groups supportive	Waiting for things to happen	Ended up relapsing	**Rejection from services risks relapse**	Begging for help	Not believing therapy would work	Finding help in unexpected places	Taught to have a stiff upper lip	Worrying I would upset my therapist	Not questioning being put on meds	Making myself uncons
	Trying to manage myself	Being rejected made me suicidal	Not making progress	Being all over the place	Being told the drink is the problem	Expecting to be shunned anyway	Getting forced to seek help was the best thing	Not wanting to acknowledge the problem	Not telling my therapist I had relapsed	Feeling like I didn't have a choice	Self-medicating

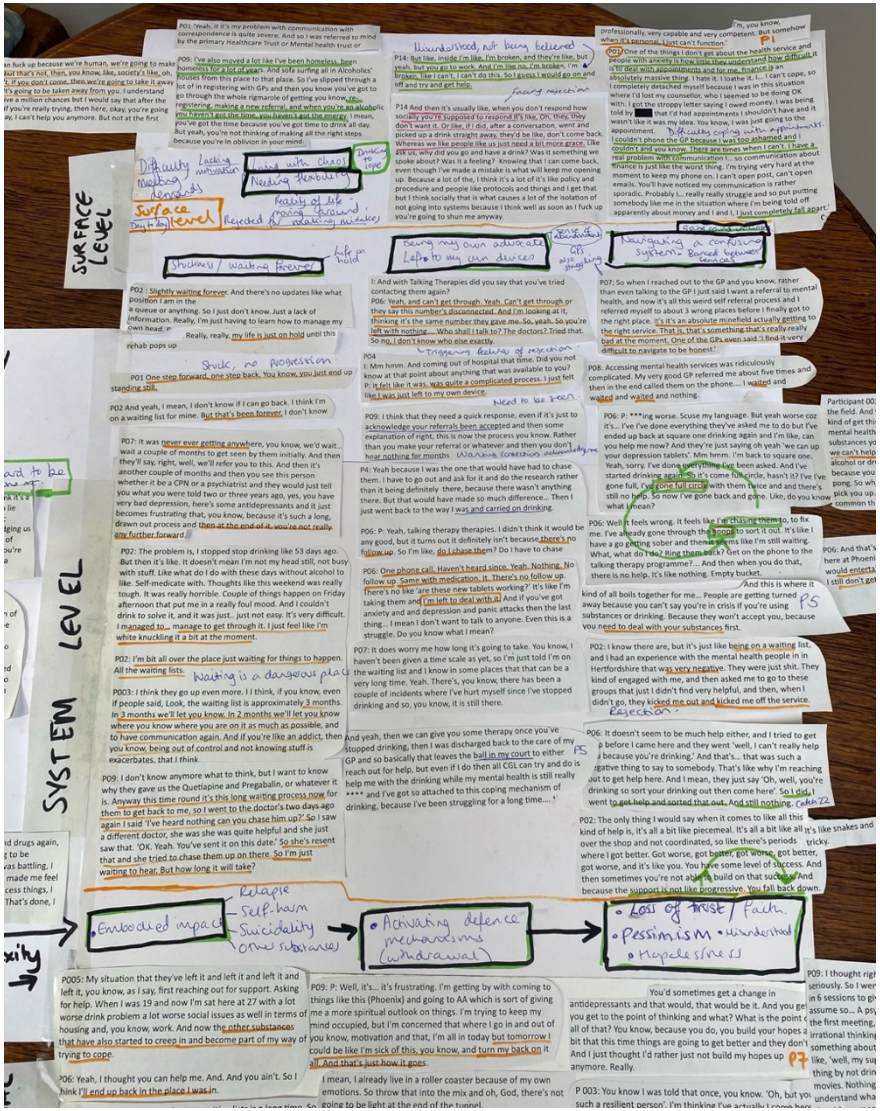
Sheet1 Sheet2 +

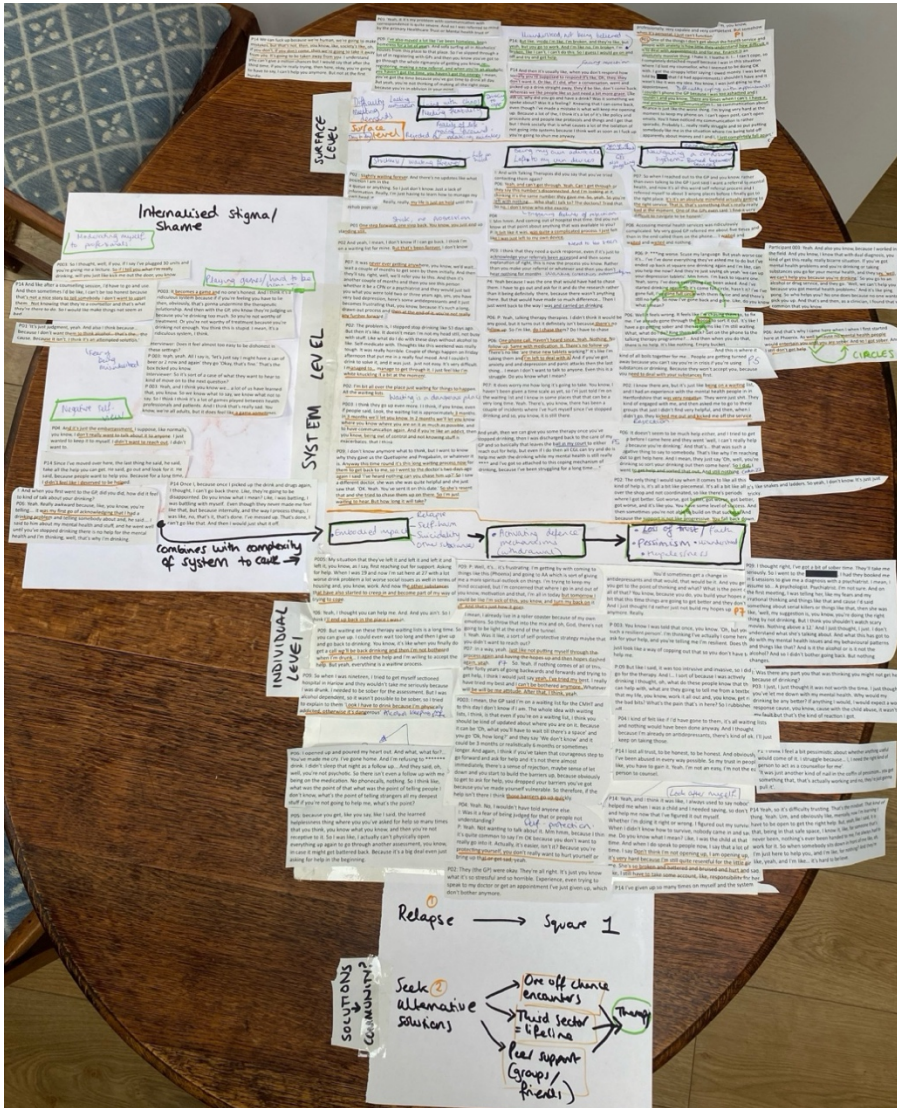
Participant colour code	Category and Sub-categories	Occurrence	Focussed codes	Transcript segment
P1	**Embodied experiences:** risk of relapse; deterioration in mental health	**Risk of relapse** (17) Participants (10): 2, 3, 5, 6, 7, 9, 11, 13, 14, 15	Anticipating relapse prevents treatment-seeking	The problem is, I stopped stop drinking like 53 days ago. But then it's like. It doesn't mean I'm not my head still, not busy with stuff. Like what do I do with these days without alcohol to like. Self-medicate with. Thoughts like this weekend was really tough. It was really horrible. Couple of things happen on Friday afternoon that put me in a really foul mood. And I couldn't drink to solve it, and it was just... just not easy. It's very difficult. I managed to... manage to get through it. I just feel like I'm white knuckling it a bit at the
P2			Anticipating relapse prevents treatment-seeking	I'm concerned that where I go in and out of you know, motivation and that, I'm all in today but tomorrow I could be like I'm sick of this, you know, and turn my back on it all. And that's just how it goes.
P3			Anticipating relapse prevents treatment-seeking	Yeah, I don't want to relapse, I don't want to lose my marbles again, I can't afford to, mentally, physically, everything. And there's a feeling that if you do talk about stuff, things will get worse before they get better.
P4			Rejection from services leads to relapse	I: Mm hmm. And what did that feel like, stopping the counselling? P: Well then literally, I was straight back into addiction, and I cut all my resources off.
P5			Rejection from services leads to relapse	Got worse, got better, got worse, got better, got worse, and it's like you. You have some level of success. And then sometimes you're not able to build on that success. And because the support is not like progressive. You fall back down. It's like snakes and ladders. So yeah, I don't know. It's just just tricky.
P6			Rejection from services leads to relapse	These people ain't helping me. I'm unhelpable. Well, there's no help out there, you know. So then I left the rehab and then went back to being street homeless. And that was. And then that was for a couple of years. And then I got with CHESS homeless. And then they referred me to here. This was a couple of years back. And then I was doing everything right and then trying to get a GP again and then start it all over. Since then I haven't done anything mental health wise until this time again because I I started on smoking crack quite
P7			Rejection from services leads to relapse	So I tried to get help from that again from the NHS. And they just said 'There's nothing we could do. It's just dementia.' So a couple of years ago, it really sent me into a dark place. So I went right back and started drinking heavily and started self-harming again. And felt really suicidal.
P8			Rejection from services leads to relapse	So you're asking them to just throw that substance to the wayside, but without the mental health support there yet. So obviously I just relapse straight away.
P9			Rejection from services leads to relapse	I clearly remember the last time I left the doctors, uh, you know, I, I was that bad. I, I left that surgery after he's said there was nothing they could do, and I was, well I was gonna, it sounds mental, I was gonna drive my car through a wall. And I remember going home, and I was drinking more, and I was just so angry.
P10			Rejection from services leads to relapse	But yeah worse coz it's… I've I've done everything they've asked me to do but I've ended up back at square one drinking again and I'm like, can you help me now? And they're just saying oh yeah 'we can up your depression tablets'. Mm hmm. I'm back to square one. Yeah, sorry. I've done everything I've been asked. And I've started drinking again.
P11			Rejection from services leads to relapse	I: Do you think if you got mental health support before, you might not have relapsed? P: 100%. Yeah, but because you're drinking they go… They don't take it seriously.
P12			Rejection from services leads to relapse	If nothing comes of all of this, after forty years of going backwards and forwards and trying to get help, I think I would just say yeah, I've tried my best. I really have tried my best and I can't be bothered anymore. Whatever will be will be me attitude and I won't even try to stop anymore.
P13			Anticipating rejection risks relapse	I'm just drinking more and doing less and it starts impacting you and things like that. But so, yeah, but I, In terms of like trying to get help, I did, I tried over the years and it was, I just felt like every time I went there, it was like I'm being a pain for them, like go
P14			Anticipating rejection risks relapse	So you know, I I couldn't see any benefit, really, of going to see anyone. So I just started turning back to drinking, and the GP said, 'Are you drinking?' and I sort of said, 'Well yeah, a little bit.'
P15			Waiting too long risks relapse	But waiting on these therapy waiting lists is a long time. So you can give up. I could even wait too long and then I give up and go back to drinking. You know, it's like when you finally do get a call we'll be back drinking and then I'm not bothered when I'm drunk… I need the help and I'm willing to accept the help. But yeah, everything is a waiting process.
			Waiting too long risks relapse	Yeah, yeah. I had to pack up all my life. Yeah, pack up all my life in boxes in my flat. Yeah, 2 weeks ago, after you know, I thought I was going to prison. So I'm still like, really, I'm still recovering from that haven't really unpacked my life in the flat yet. So... Yeah. Limbo is the word for it. I'm just. I don't know. I'm bit all over the place just waiting for
			Waiting too long risks relapse	I went straight to the doctor and they said, well, we can make you an appointment, but there was nothing. There was a three month wait or something. To process the trauma. But by that time I started drinking.
		Deterioration in mental health (32) Participants (14) (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15)	Risk of overdose following rejection	And obviously I was also anxious, like obviously you know, there were also feelings of abandonment. Not saying they did actually abandon me, it's just that's how you know you get those emotions at the time of abandonment. Unfortunately, I think that led to drinking quite a bit of rum and I'd also taken some pills. I didn't want to but then I ran out of pills so I went to the village and I went into the shop, just to buy something. I can't remember what? But when I came out of this shop, I suppose the combination of the pills and alcohol and what had just happened with the discharge, I just felt very strange and I went

Sheet1 Sheet2 +

Appendix C

Example of theoretical coding





Appendix D

CASP checklist and quality assessment of studies

CASP Criteria	Dorey et al. (2021)	Gilburt et al. (2015)	Haighton et al. (2016)	Jackson et al. (2024)	Montgomery et al. (2023)	Naughton et al. (2013)	Parkman et al. (2017)	Parkman et al. (2017a)	Roberts et al. (2020)	Roper et al. (2013)
1. Clear statement of research aims	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2. Qualitative methodological appropriateness	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3. Research design appropriateness	Yes	Yes	Yes – although could have benefitted from reflection of conducting focus groups.	Yes	Yes – although inclusion of staff and service user opinions reduced quality.	Yes	Yes	Yes	Yes – although inclusion of staff and service user opinions reduced quality.	Yes
4. Recruitment strategy appropriateness	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No – vague recruitment criteria and use of breathalysers.
5. Data collection addresses research issue	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

6. Relationship between researcher & participants adequately considered	No	No	No	Yes	No	No	No	No	Yes – although brief and could provide more detail.	No
7. Ethical issues considered	Yes	Yes – although no discussion regarding ethical interviewing for those under the influence of alcohol	Yes – although no discussion regarding the ethics of interviewing those likely under the influence of alcohol	Yes	No – only a short reference to ethical approval body.	Yes – although no discussion regarding ethical interviewing for those under the influence of alcohol	Yes	Yes	Yes	No
8. Data analysis sufficiently rigorous	Yes	Yes	Yes	Yes	No – results combined staff and service user perspectives.	Yes	Yes	Yes	Yes	Yes
9. Clear statement of findings	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
10. How valuable is the research?	Findings support	Provides evidence	Findings suggest	Study draws attention to	Provides detailed	Study demonstrate	Recommen dations for	Provides insight	Clinical implications	Implicatio ns for

	justification for alcohol specialist nurse role and intervention in hospitals	that PWUA are required to be self-efficacious in sourcing alcohol treatment	changes in training provision for GPs and better aftercare to adequately support PWUA in later life.	lack of formal care provision for PWUA with depression.	clinical and future research implications for more timely and appropriate support for PWUA in primary care.	s rationale behind treatment seeking is largely due to health and psychosocial factors rather than stopping drinking.	case management and assertive outreach to support broader psychosocial needs of PWUA.	into rationale behind A&E attendances amongst PWUA.	of the Health and Social Care Act provided in terms of access to specialist alcohol treatment.	clinical practice regarding motivations to seek alcohol treatment.

Appendix E

Example of memo-writing process

Subcategories	**Memos**
Confusion around mental health services	**20th February 2023 – recruitment stage.** Frustrating feeling to be liaising with services and not getting anywhere. Feeling like there is so much red tape around protecting service users, but is this for their benefit or for the charity? I feel sure that participants would want to have their voices heard about this subject. But sense of participants being silenced by the process of not being allowed to recruit. Told by one substance use service: *The challenges are well known within the sector but solutions for overcoming them are less so and are less likely to be identified by speaking to service users alone.* This feels counterintuitive. **23rd June 2024 – memo written after interview 5.** Noticing myself feeling confused while the participants are talking about which service they're waiting for. Is this their confusion being transferred into me? Trying to understand what routes participants are talking about is confusing. Trying to map them out visually following the interview, but seem to be complicated. Even if the 'reality' that I know as a professional is less complex than what participants are describing, they are still experiencing this confusion everyday – to them this is the system. I was aware of myself attempting to clarify service names or which service exactly they have been accessing. Perhaps this is something I'm being caught up in, and actually accepting that the accounts of which services they have been involved in might be confusing is not something I need to clarify or try to understand fully? Am becoming aware of the language used – confused, unsure of who they had been seen or assessed by, where they were on the waiting list. Sense of waiting endlessly. Frustrating, feeling of being stuck. Feeling surprised so far no one has heard of IAPT or NHS talking therapies. Some had received therapy but weren't sure what service or how they had been referred. I am noticing that lots of participants view charities as a form of saviour, thinking this was the only route into therapy. Some had called Samaritans, reached a crisis point and then been referred. Most seemed to have found unusual routes into treatment, not the usual self-referral to NHS Talking Therapies or referral from a GP. Noticed that concept of 'active addiction' is hazy for a lot of people, includes patches of sobriety. Doesn't seem to be clear cut drinking or sober. Discuss with supervisor about changing inclusion criteria to that of also short term period of recovery?

Loss of faith in services Putting a guard up Getting on with things myself Finding my own sense of agency Let down by services	**20th May 2024 – memo written before potential interview 5 (cancelled)** I am feeling let down after one participant arranged and cancelled the interview 3 times, each time I joined the call, she didn't arrive. Feeling ashamed at my own feelings of frustration and aware I should be more understanding. Thinking about whether I have the right to feel let down? Sense of chaos in my own attempts at organising the interviews and wondering whether this is mirroring the process of how PWUA feel about being let down by services and left to try and cope with the chaos. On times where I have been let down by participants before, then they have rearranged and attended I'm reminding myself that it was worth it, participants have been so open and trusting with me. **30th July 2024 – memo written after interview 7** Sense that participants had to chase up services themselves when they were at their lowest and lacked any motivation. Often they would be referred to a service but then never heard back, ended up having to chase up the service and were confused about who to call/ how to contact. Wasn't a clear method of referral or waiting list. Feeling like the timing is so important, to be picked up in that moment of reaching out, making the connection, being followed up – can be a critical point in recovery. One good interaction with a health professional could be life changing. But often things were let slide and then people relapsed. **9th September 2024 – memo written after interview 9** Finding myself surprised at the harsh terminology used about themselves - 'just another junkie'. Every single person so far has recounted childhood or adult trauma and had felt let down by services in the past. This contradicted somewhat what I imagined initially? That the process might be more black and white - people would have approached the GP and been turned away and told to get sober first before getting mental health support. Noticing that lots of participants had not even gone to their GP and had felt put off before even trying. Sensed some reluctance in this interview of [redacted] feeling that she had to attend - coming to the interview when I'm based in the service rather than online. As though I'm also representing part of the 'system', am demanding something of her?

Appendix F

Participant information sheet

Participant Information sheet

Research title: What are the experiences of people with alcohol addictions in attempting to access psychological therapies?

Are you currently experiencing an alcohol addiction whilst also struggling with a mental health problem? Have you accessed, or tried to access, psychological therapy at some point during your experience of addiction? Are you over 18 years of age and currently engaged with your local substance misuse service (or other relevant support service)?

If you answered yes to these questions, I would like to invite you to participate in this research study. Before you decide whether or not to participate, it is important to understand why the research is being carried out, and what it will involve. Please read the following information carefully and feel free to ask me if you would like any more information, or if there is anything you do not understand. **I would like to remind you that participation is entirely voluntary, and you do not have to accept this invitation.** You should only agree to take part if you want to. Thank you for taking the time to read this.

1. What is the purpose of this study?

I am carrying out this study as part of my doctoral training in Clinical Psychology at the University of Essex. I am interested in exploring the journeys that people with alcohol addictions have undertaken when trying to access psychological therapies (such as counselling or psychotherapy). The study aims to explore the range of experiences people have had when attempting to seek help for their mental health issue, and what this was like for them. The study is concerned with exploring the lived experience of people's journeys, which means I would like to understand more about the views and experiences of people with alcohol addictions and mental health issues at an individual level.

2. Why have I been selected to take part?

I would like to speak to people who are currently experiencing alcohol addictions and are engaging with their local substance misuse service (or other relevant support service), and who also feel that they have a mental health issue such as anxiety or depression (for example). Your mental health issue does not need to have been formally diagnosed. I would like to speak to those who have at some point felt they would like to seek mental health support in the form of psychological therapies including counselling or psychotherapy, either through the NHS or a mental health charity. I am interested in understanding your experience of what this journey was like – whether you received psychological therapy or you were not able to. Don't worry if you are not sure if you fit the criteria, I will arrange an initial conversation with

all interested individuals to double check whether this research is suitable for you before we go ahead with the interview.

3. Do I have to take part?

No. Taking part in this research is entirely voluntary and you are free to decide to withdraw from the study at any point if you change your mind. You do not need to give a reason for choosing to withdraw, it is entirely up to you.

4. What will happen if I take part?

After an initial conversation, if we both agree that the research project is right for you and you would like to participate, I will give you an idea of what we will discuss in the interviews. We can then discuss any questions you might have and, if you are happy to go ahead, we will set a date, time and place for the interview. This is likely to be face-to-face within your local substance misuse service (or other support service) where possible and it is up to you if you would like to let your keyworker (or service lead/ support worker) know that the interview is taking place. If it is not possible to meet face-to-face for any reasons, or you are concerned about somebody finding out you are participating in the interview, we would then be able to conduct the interview via Microsoft Teams using a video call. The interview will be with myself and will last about 1 hour. I will always try to fit around your schedule and preferences. The interview will be recorded using a Dictaphone if face-to-face, or using Microsoft Teams if conducted online. The interview will feel more like a conversation where you will be invited to talk through and reflect upon your personal experiences of accessing psychological therapies.

5. How will my data be used?

The University of Essex processes personal data as part of research under the lawful basis of 'public task' in accordance with the University's purpose to 'engage in scholarship and conduct research.' Under the UK's General Data Protection Regulation (UK GDPR) and the UK Data Protection Act 2018 (DPA) the University acts as the 'data controller' in relations to any personal data gathered as part of University research. Any questions relating to the handling and storage of your data can be sent to the University Information Assurance Manager via [redacted]. Further information about how your data will be used can be found below:

How will my data be collected?	Using an encrypted Dictaphone for audio recording or via Microsoft Teams if conducted online.
How will my data be stored?	All data will be stored securely via the host server at University of Essex, all files will be password protected and held in accordance with UK GDPR requirement. Any identifiable data (including the signed consent form and demographic survey) will be redacted and labelled with the participant ID number. This will then be stored on the secure University server. The paper form will be securely disposed of.
What measures will be put in place to keep my data secure and confidential?	At transcription stage all identifiable information will be anonymised (e.g. names, locations). Participants will be assigned an ID number in

	place of their name. Interview recordings will be permanently deleted once the data has been transcribed and moved to the secure University system. This will be stored on a password protected laptop.
Will my data be anonymised?	Yes, your data will be anonymised. This means that your real name and any identifiable information will not be included. A pseudonym will be used for the purposes of the final report.
How will my data be used?	Your data will be used for the purposes of this study only with the potential for future publication of the research paper in academic journals.
Who will have access to my data?	The lead researcher– Madeleine Wickers and research supervisor – Dr John Day.
Will my data be archived for use in future research projects?	No.
How will my data be destroyed?	Data will be securely held by the University for 10 years and then will be permanently deleted.

6. Exceptions to anonymity

The only exception to maintaining anonymity would be if you disclosed information to suggest yourself or another person were at risk of serious harm or engaging in serious criminal activity. In such cases I may be legally required to disclose your confidential information to the relevant authorities. Such a situation is highly unlikely to occur, but please ask for more information if you have any concerns.

7. Expenses

I will provide each participant with a £20 voucher as a thank you for your time. The voucher will be in the form of an Amazon gift card. Travel expenses will not be reimbursed, however I hope to conduct interviews at your local substance misuse service (or other support service) therefore long-distance travel is unlikely. If this is inconvenient to you, the interview can take place online in the comfort of your home.

8. Are there any risks to taking part?

It is possible that thinking and talking about your story may bring up some strong emotions and memories. This is not unusual but has the potential to cause distress. It is hoped that having a telephone call with myself prior to the interview to talk through the questions that will be asked will help you feel informed and comfortable about the content of the interview. You do not have to answer any questions that you don't want to. Together we will agree on steps we can take if you feel distressed at any point. This may involve pausing, discussing what may help you feel more comfortable and then deciding if you would like to continue or end the interview. We can also discuss services or resources that may be helpful to you and I will provide you with a signposting sheet at the end of your interview that will identify various support services available to you if you are to feel distressed following our interview.

Where possible, refraining from being intoxicated prior to the interview would be helpful, although this will not necessarily prevent the interview from taking place. Although it is unlikely, if I am to sense that a participant is intoxicated to the extent

that it feels difficult to continue with the interview, I will likely end the interview and discuss with the participant whether it is possible to reschedule for a different date.

9. Are there any benefits to taking part?

The interview provides a space for you to share and reflect on parts of your story and who you are as an individual and as a person experiencing both an alcohol addiction and mental health difficulties. This experience may feel helpful to you, however everyone processes life events differently and so it is not possible to predict if you will find participating personally beneficial or not. It is hoped that the experiences shared in interviews will help move towards a better understanding of the experiences of accessing psychological therapies for those with addictions and how this may be different in the future.

10. What is the legal basis for using the data and who is the Data Controller?

The legal basis for using the data will be your informed consent. This will be a statement signed by all participants. The Data Controller will be the University of Essex. Further details regarding data controls can be directed to the University Information Assurance Manager ([redacted]

11. Who has reviewed the study?

The study has been reviewed and approved by the Science and Health Ethics sub-committee at the University of Essex.

12. What will happen to the result of the study?

An overview of the results will be sent to everyone who participants. The final research project will be submitted to the University of Essex for marking. The results may also be published in an academic journal(s). It would not be possible to identify you in the result of either of these as your information will be anonymised.

13. What will happen if I want to stop taking part?

You can withdraw from the research at any point before or during the interview without providing a reason got your decision. You can withdraw your data up to two weeks following the interview by contacting myself and asking to withdraw. After this point, your data will be anonymised and combined with a larger set of results so it will not be possible to withdraw it.

14. What if I'm unhappy or there is a problem?

If you have any concerns about any aspect of the study or you have a complaint, in the first instance please contact myself, or the research supervisor, Dr. John Day, using the contact details below and we will try to help. If are still concerned, you think your complaint has not been addressed to your satisfaction or you feel that you cannot approach us, then please contact the University's Research Governance and Planning Manager, Sarah Manning-Press (email: [redacted]). Please include the ERAMS reference which can be found at the bottom of this page.

The University of Essex strives to maintain the highest rigour when processing your personal data, however it is important that you are aware of your right to submit a

complaint to the University Data Protection Officer via email at [redacted]

Lead Student Researcher: **Maddy Wickers**	**Lead Research Supervisor:** **Dr John Day**
Email: mw22307@essex.ac.uk	Research Co-Lead for University of Essex Doctorate in Clinical Psychology Email: [redacted]

Appendix G

Participant consent form

Consent Form for participants

Title of the Project: What are the experiences of people with alcohol addictions attempting to access psychological therapies?

Research Team: Madeleine Wickers (primary researcher, University of Essex, mw22307@essex.ac.uk) and Dr John Day (research supervisor, University of Essex [redacted]).

Please initial box

1. **I confirm that I** have read and understand the Information Sheet dated **19.12.2023** for the above study. I have had an opportunity to consider the information, ask questions and have had these questions answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw from the project at any time without giving any reason and without penalty. I understand that I can withdraw my data up to **two weeks** following the interview by contacting the lead researcher (Madeleine Wickers) and asking to withdraw. After this point, my data will be anonymised and combined with a larger set of results so it will not be possible to withdraw it.

3. I understand that, due to the nature of the research, I may be asked questions relating to both my current experiences with alcohol addiction as well as my mental health issues. I understand that I may stop the interview at any point without explanation and withdraw consent from the study.

4. I understand that the identifiable data provided will be securely stored and accessible only to the members of the research team directly involved in the project, and that confidentiality will be maintained.

5. I understand that my fully anonymised data will be used for the doctoral thesis for Clinical Psychology at the University of Essex, titled ‘What are the experiences of people with alcohol addictions attempting to access psychological therapy?’

6. I understand that my data will be stored for up to 10 years and that the researcher may seek publication of the research project within a range of academic journals. I understand that my data will remain entirely anonymised in the case of publication.

7. I agree to the use of audio recording of my interview. This will be in the form of Dictaphone recording or via Microsoft Teams. The audio data will be stored securely via the host server at University of Essex, all files will be password protected and held in accordance with UK GDPR requirement. Only the lead researcher (Madeleine Wickers) and supervisor (Dr John Day) will have access to this data.

8. I agree to take part in the above study.

Participant Name	Date	Participant Signature
_____	_____	_____

Researcher Name	Date	Researcher Signature
_____	_____	_____

Appendix H

Participant demographic survey

Participant demographic survey

1. Participant ID number:

   .....

2. What is your age?

   .....

3. What is your gender?
   a. Female (inc trans women)
   b. Male (inc trans men)
   c. Non-binary
   d. Other (please specify)

   .....

4. Sexual orientation
   a. Bisexual
   b. Gay
   c. Lesbian
   d. Straight/Heterosexual
   e. Queer
   f. Questioning
   g. Other (please specify)

   .....

5. Ethnicity
   a. Black/ African / Caribbean / Black British
   b. White British/ White Other
   c. Mixed/ Multiple ethnic groups
   d. Asian/ Asian British
   e. Other (please specify)

   .....

6. Employment status
   a. Employed (full time)
   b. Employed (part time)
   c. Unemployed (seeking work)
   d. Unemployed (long term sick)
   e. Other (please specify)

   .....

7. Employment type (if applicable)
   a. Higher managerial, administrative and professional occupations
   b. Intermediate occupations
   c. Routine and manual occupations

8. First part of post code

   .....

9. Which county/borough do you live in?

   .....

10. Which support service are you currently engaged with?

    .....

11. How long have you been engaged with this support service?

    .....

Appendix I

Participant signposting sheet

Signposting: Support services available to you

If the event that you are to feel upset or distressed by any of the themes we have discussed during our interview, I would like signpost you to a **range of support services** that you can contact for support. These include a range of telephone, text messaging and in-person services.

1. To talk about anything that is upsetting you, you can contact Samaritans 24 hours a day, 365 days a year. You can call 116 123 (free from any phone) or email jo@samaritans.org

2. Shout 85258 is a 24/7 text service for anyone in crisis. You can get free, confidential mental health support by texting 'SHOUT' to 85258.

3. SANEline. If you're experiencing a mental health problem or supporting someone else, you can call SANEline on 0300 304 7000 (4.30pm–10.30pm every day).

4. For information on further support services, you can contact the Mind Infoline on 0300 123 3393
5. You can call NHS 111 Option 2 for the NHS Crisis Response service. This is open 24/7.

6. In an emergency, for example if you feel you are at risk of suicide, you can call 999 for an ambulance or go straight to A&E, if you can.

7. If you feel comfortable to, you are welcome to let your support service and/or relevant keyworker know that you are undertaking this interview. They might be able to offer follow up support after your interview in future keywork sessions.

Appendix J

Dynamic risk assessment

Dynamic risk assessment checklist

This risk assessment has been written in order for myself, as primary researcher, to have a checklist both prior to and during interviews to maintain safety both for myself and participants. The risks below are areas in which I will be assessing beforehand via phone call with participant (as outlined in my main risk assessment) but also to be continually dynamically assessing during the interview. The need for this additional risk assessment is because I plan to conduct interviews with service users who are likely to be experiencing alcohol addictions.

The risks below (and subsequent actions prior and post interview) highlight the areas that I believe need to be focussed on and will be paying close attention to during the interviews. During the interview I will be dynamically conducting this risk assessment mentally and observing participant behaviour using the skills I have developed during my extensive experience working with people with addictions.

Risk		
Level of intoxication	**Prior to interview (phone call)**	**During/post interview**
- lack of capacity to consent to interview	Check with participant how they feel about attending interview without consuming alcohol. Risk assess for suitability based on initial phone call.	Check with participant how they are feeling today Terminate interview if deemed client unable to consent, aim for client agreement. Reschedule if appropriate
- lack of capacity to engage in interview	Check with participant regarding appropriate time of day to conduct interview to avoid intoxication.	Involve participant in discussion if client appears to be under the influence of alcohol and unable to continue with interview. Discuss options: 1. Would client be willing to reschedule and could feasibly attend another interview not under the influence? 2. If client is at their 2nd interview and attends under the influence again, inform client that the interview cannot go ahead. Client to still be reimbursed for their time.

		GDPR: Consent and demographic surveys destroyed.
Behaviour change	**Prior to interview (phone call)**	**During/post interview**
- Escalation	Discuss mental health issue with participant, any formal diagnoses. Risk assess for stability.	Terminate interview if abusive/aggressive behaviour is identified/ escalates.
- Distress	Discuss mental health issue with participant, any formal diagnoses. Risk assess for stability.	Check with client if they would like to terminate interview. Terminate the interview if client is noticeably distressed. Reschedule if appropriate.

Appendix K

Interview schedule

University of Essex

Interview topic guide (amended).

Research questions

- What are the experiences of attempting to access psychological therapies through various access and referral pathways amongst PWAA?
- What is the psychological and/or embodied impact of either rejection from or long waiting lists for therapy?
- If a participant did receive therapy, what was the experience?

1. **Welcome and introductions**

2. **Instructions regarding interview set up**

3. **Confidentiality recap and verbal discussion of participant information sheet. Obtain consent verbally (second occasion). Demographic data form collection.**

4. **Topic 1**

a) History taking – what is your experience of alcohol addiction? (How long have you been using alcohol? Engagement with substance misuse services in the past?)
b) What is your experience of mental health problems? (How long have you had mental health issues? How would you describe these issues and how do they impact your life?)
c) How do you think the two are connected, if at all?

5. **Topic 2**

a) What has been your experience so far of seeking psychological support whilst using alcohol? If you chose not to seek help, why not?
b) How easy or difficult has it been to access psychological therapy?
c) What route did you take in your attempts to seek therapy? Why did you choose this route?
d) What was your journey regarding making a decision whether to pursue therapy or not? How useful do you perceive therapy to be?
e) What other services have you got help from, if any?

6. **Topic 3**

a) What was the outcome of your decision to seek psychological therapy (waiting lists, treatment, rejection)?
b) Psychological and embodied impact of the outcome of your decision to seek or not seek psychological therapy?
c) What was your experience of staff and services?

Appendix L

Ethics application and approval letter

University of Essex

09/02/2024

Miss Madeleine Wickers

Health and Social Care

University of Essex

Dear Madeleine,

Ethics Committee Decision

Application: ETH2324-0824

I am pleased to inform you that the research proposal entitled "What are the experiences of people with alcohol addictions attempting to access psychological therapies?" has been reviewed on behalf of the Ethics Sub Committee 1, and, based on the information provided, it has been awarded a favourable opinion.

The application was awarded a favourable opinion subject to the following **conditions**:

Extensions and Amendments:

If you propose to introduce an amendment to the research after approval or extend the duration of the study, an amendment should be submitted in ERAMS for further approval in advance of the expiry date listed in the ethics application form. Please note that it is not possible to make any amendments, including extending the duration of the study, once the expiry date has passed.

Covid-19:

Please note that the current Government guidelines in relation to Covid-19 must be adhered to and are subject to change and it is your responsibility to keep yourself informed and bear in mind the possibility of change when planning your research. You will be kept informed if there are any changes in the University guidelines.

Yours sincerely,

REO Research Governance team

Ethics ETH2223-0993: Miss Madeleine Wickers

Date Created	04 Mar 2023
Date Submitted	23 Jun 2023
Date of last resubmission	15 Aug 2023
Date forwarded to committee	29 Aug 2023
Date of committee meeting	09 Aug 2023
Academic Staff	Miss Madeleine Wickers
Category	Postgraduate Research Student
Supervisor	Dr John Day
Project	What are the experiences of people with alcohol addictions attempting to access psychological therapies?
Faculty	Science and Health
Department	Health and Social Care
Current status	Approved after revisions made

Ethics application

Project overview

Title of project

What are the experiences of people with alcohol addictions attempting to access psychological therapies?

Do you object to the title of your project being published?

No

Applicant(s)

Miss Madeleine Wickers

Supervisor(s)

Dr John Day

Proposed start date of research

04 Sept 2023

Expected end date

30 Apr 2025

Will this project be externally funded?

No

Will the research involve human participants?

Yes

Will the research use collected or generated personal data?
Yes

Will the research involve the use of animals?
No

Will any of the research take place outside the UK?
No

Project details

Summary of the project

My research aims to explore the experiences of people with both an alcohol addiction and a common mental health problem when it comes to accessing psychological therapy in the UK. My research involves interviewing 15-20 adult service users (18+) around the southeast of England who are currently engaged with a drug and alcohol service.

I aim to conduct semi-structured interviews face-to-face (or on Microsoft Teams in instances where this is not possible) with individual service users in order to gain a deeper understanding of service users' lived experience in navigating and accessing their local psychological therapy services.

In the UK, health providers often treat people with alcohol addictions in specialist substance misuse services, increasing segregation from both mainstream healthcare as well as mental health support.

Talking therapies, including counselling and psychotherapy provided by the NHS, often remain largely out of reach for those with alcohol addictions.

Such exclusion is thought to compound existing stigma and social isolation experienced by people with alcohol addictions, as well as creating a gap between mental health need and service provision for this population. This is especially important given the high rate of mental health issues amongst people with addictions, a phenomenon commonly termed dual diagnosis. Current NHS England talking therapies guidance suggests that substance misuse issues should ideally be 'treated' before accessing therapy. While there are valid reasons behind this rationale, there is also evidence to suggest talking therapies can be highly effective in treating alcohol use disorders. Despite such evidence, the lived experience of people with alcohol addictions' interactions with therapy remains largely under-researched, with the majority of current literature being either US-based, exploring segregation of addiction services from physical healthcare, or focussed on illicit drug users rather than alcohol users.

As a result of this gap in the literature, this research aims to explore the lived experience of people specifically with alcohol addictions and a mental health problem, and gain a deeper understanding of their interactions with psychological therapy services in the UK. It will primarily focus on people with alcohol addictions' experiences of accessing psychological therapies for common mental health problems, such as anxiety and depression, that are normally provided by NHS talking therapies and other third sector providers such as mental health charities. It hopes to gain an understanding of the sense of inclusion or exclusion and the impact of these phenomena as experienced by people with alcohol addictions in relation to psychological treatment, or to understand how they experience(d) therapy if they are engaged in treatment.

Psychological therapies in this context refers to talking therapies provided by a qualified professional within the NHS or third sector, incorporating modalities such as psychodynamic, CBT, DBT and EMDR. The population of interest is people who identify as having a common mental health problem and are currently experiencing an alcohol addiction. I hope to inform and contribute to current research surrounding mental health provision for people with alcohol addictions which I understand to be a gap in the literature.

The key questions I hope to answer throughout the research will be:

- What are the experiences of attempting to access psychological therapies through various access and referral pathways amongst people with alcohol addictions?

- What is the psychological and/or embodied impact of either rejection from or long waiting lists for therapy?

- If a participant did receive therapy, what was the experience?

In order to undertake this research, I plan to conduct one-to-one semi-structured interviews with people who are currently experiencing an alcohol addiction as well as identifying as having one of a range of common mental health problems but may or may not have an official diagnosis. I will not specify that participants must be receiving mental health treatment or not, as I would like to capture the experience of a selection of people with alcohol addictions and their experiences attempting to access, or accessing, psychological therapies. I will be recruiting participants who are currently engaged with a substance misuse service.

So far, I have contacted a range of drug and alcohol services across southeast England (largely from services in London and Essex) in order to assess interest in supporting the study. The study location is largely for pragmatic reasons due to researcher's location combined with the intent to interview participants in person in order to prioritise quality face-to-face encounters and encourage openness. I will recruit

directly through these services but also use snowball sampling techniques to widen my recruitment strategy as the population group will potentially be difficult to engage.

A qualitative approach will be used in order to conduct this research. Interviews will be recorded and transcribed. Data will likely be analysed using Grounded Theory Analysis as this gives rise to the option to develop a new theory generated from the data itself. Interviews will take place either in the participants' local drug and alcohol service where possible, or online via Microsoft Teams or telephone call as secondary options. Local drug and alcohol services are likely to be third sector, fully staffed organisations where service users attend for weekly groups or one-to-one meetings with their allocated keyworker. I plan to request the use of a room within these bases in order to conduct interviews. This means staff will be present on site, and the service user will be familiar with the setting.

I will be supervised by Dr John Day at the University of Essex. Regular meetings, including informal progress meetings approximately once every 2 months as well as annual formal supervisory panels, will take place throughout the course of the research.

Research project proposal

Will the participants, either the subjects or the investigators, be involved in any activities that could be considered to be unlawful in the UK?

No

If the project is being undertaken outside the UK, will the participants, either the subjects or the investigators, be involved in any activities that could be considered to be unlawful in the country overseas?
No

Participant details

Who are the potential participants?
15-20 adult participants (over the age of 18) who are currently engaged with an addiction service for alcohol misuse (these services are commonly called drug and alcohol services or substance misuse services, I will be seeking interviews with people engaged with these services for alcohol use only) in the UK. I am seeking participants who identify as having an alcohol addiction and who also identify as having a common mental health problem such as anxiety or depression that would be treated under primary care services such as NHS Talking Therapies, third sector charities or private psychotherapy. This is not limited to depression or anxiety (these are just 2 common examples) but a participant can be experiencing any mental health conditions (including mood disorders) that a participant would likely to be seeking primary mental health support for i.e. those conditions that are not managed by a psychiatrist or care coordinator and therefore participants are not currently receiving secondary mental health care). This does not have to be formally diagnosed by a medical professional, but the participant will have considered seeking psychological support for their mental health problem at some stage during the course of their alcohol addiction.

I will be taking self-reported statements of mental health problem at face value for this research, i.e. if a participant states they have symptoms of depression/anxiety (for example) and have considered seeking psychological therapy at some point during their addiction, they will qualify for participation.

On the flyer I have specified that an official diagnosis for a mental health problem is not a requirement, but that the mental health problem can be self-reported, i.e. an individual who identifies as having anxiety but has not yet sought treatment or diagnosis. This will not include participants who have sought psychological treatment for their alcohol use only, I am looking for participants who have a mental health issue as well as experience of alcohol addiction.

I will clarify this criteria with any interested participants during the initial phonecall when I will be assessing suitability for participation in more detail (as outlined on my additional risk assessment).

I will clarify if individuals have a mental health condition/issue during my initial phonecall with the participant. I believe that many individuals will likely be suffering with a mental health issue that they have not yet had diagnosed, potentially due to the difficulty in seeking treatment and diagnosis when experiencing alcohol addiction. This is key part of my research as I believe mental health conditions are likely to go undiagnosed as a result of marginalisation from talking therapies due to addiction. I therefore will take participants' self-reporting of a mental health issue at face value. For example, if a potential participant states that they suffer with anxiety and have not yet received any psychological therapy for this, I would be interested to interview them about their experience of seeking treatment or what has stopped them accessing support so far.

How will they be recruited?

I will be recruiting participants through various drug and alcohol organisations (third sector charities) across south east England. I will be recruiting via word of mouth through organisational leads as well as a flyer which will be sent round to participating organisations.

I will also use snowball sampling techniques in order to recruit participants who may be eligible via word of mouth. Participants will be contacted via telephone prior to setting up an interview in order to assess for eligibility.

Recruiting materials

Will participants be paid or reimbursed?

Yes

If yes, please provide details and justification for this payment.

I will provide a one-off Amazon voucher of £20 for participants' participation in the research. This will be funded via my Proficio student budget. This will be the same amount for every participant.

Travel expenses will not be reimbursed, however I hope to conduct interviews at participants' local substance misuse service therefore long distance travel is unlikely. If this is inconvenient to any participant, the interview can take place online in the comfort of their home.

How much will the participants be paid?

£ 20

Could potential participants be considered vulnerable?

Yes

If yes, please explain how the participants could be considered vulnerable and why vulnerable participants are necessary for the research.

Recruiting participants with both an alcohol addiction and mental health problem means that participants may be vulnerable which requires consideration regarding setting up the interview and supporting the participant both during and after. Participants may find it difficult to discuss certain topic areas especially when it comes to alcohol addiction. There is the chance of certain topic areas being triggering to clients, however I believe it possible to reduce harm to participants in numerous ways in the interview process (as outlined in my risk assessment) and I am aware that to avoid interviewing participants about their experiences may in fact serve to re-enact some of the silencing that people with addictions can regularly experience especially when it comes to psychological support. The lived experience of service users in this field is therefore particularly valid in order for change to be enacted in future service provision for this population.

I have 6 years' experience working professionally with clients with alcohol addictions and am experienced in navigating sensitive conversations regarding alcohol use and mental health concerns.

I have also compiled a list of various support services to signpost clients to after the interview. Those who wish to seek further support will be able to contact a range of services. This will be made clear before and after the interview to all participants. I will provide a 'signposting sheet' to all participants detailing contact details of local support services. The Signposting sheet has been uploaded to this application, I will also detail them below:

Signposting:

Support services available to you

If the event that you are to feel upset or distressed by any of the themes we have discussed during our interview, I would like signpost you to a range of support services that you can contact for support. These include a range of telephone, text messaging and in-person services.

1. To talk about anything that is upsetting you, you can contact Samaritans 24 hours a day, 365 days a year. You can call 116 123 (free from any phone) or email jo@samaritans.org

2. Shout 85258 is a 24/7 text service for anyone in crisis. You can get free, confidential mental health support by texting 'SHOUT' to 85258.

3. Shout 85258 is the UK's first 24/7 text service for anyone in crisis. You can get free, confidential mental health support by texting 'SHOUT' to 85258.

4. You can call NHS 111 Option 2 for the NHS Crisis Response service. This is open 24/7.

5. SANEline. If you're experiencing a mental health problem or supporting someone else, you can call SANEline on 0300 304 7000 (4.30pm–10.30pm every day).

6. For information on further support services, you can contact the Mind Infoline on 0300 123 3393

7. In an emergency, for example if you feel you are at risk of suicide, you can call 999 for an ambulance or go straight to A&E, if you can.

8. If you feel comfortable to, you are welcome to let your substance misuse service and/or relevant keyworker know that you are undertaking this interview. They might be able to offer follow up support after your interview in future keywork sessions.

Could potential participants be considered to feel obliged to take part in the research?
No

If yes, please explain how the participants could feel obliged and how any possibility for coercion will be addressed.

Will the research involve individuals below the age of 18 or individuals of 18 years and over with a limited capacity to give informed consent?
No

Is a Disclosure and Barring Service (DBS) Check required?
Yes

If yes, has the DBS check been completed?
Yes

If your project involves children or vulnerable adults but does not require a DBS check, please explain why.

Informed consent

How will consent be obtained?
Written

If consent will be obtained in writing, please upload the written consent form for review and approval.

If consent will be obtained orally, please explain why.

In some cases where participants are only able to be interviewed via MS Teams, I will obtain verbal consent and electronically sign the consent form on the participants' behalf. I will share my screen with the participant and go through the Consent form online. I will then obtain consent and follow the data storage procedure as outlined on the participant information sheet.

Please upload a copy of the script that will be used to obtain oral consent.

If no script is available to upload please explain why.

Who will be obtaining and recording consent?

Myself as primary researcher - Madeleine Wickers. Research supervisor - Dr John Day.

Please indicate at what stage in the data collection process consent will be obtained.

I will read through the consent form over the phone before I meet participants as an initial step in gaining consent. I will ask clients at this stage if they consent and gain verbal agreement. Prior to conducting the interview, I will ask participants to read through and sign the consent form in person, or verbally over MS teams, upon meeting, giving participants the option to read through the information again.

By obtaining consent on more than one occasion, I am minimising the risk of participants giving consent when under the influence of alcohol and who may have fluctuating capacity. Similarly, if I have not been able to determine that the participant is under the influence of alcohol over the phone, asking them to read through and sign the consent form at the start of the interview will provide another opportunity for me to ascertain whether the participant has capacity to consent.

If I believe the participant is under the influence and cannot consent or partake in the interview, I will follow the steps laid out in my 'Additional Risk Assessment' that has been uploaded. This involves rescheduling the interview to a time when the participant will not be under the influence and involving the participant in a discussion of the importance of them trying to attend the interview sober. If the participant attends a second interview under the influence, and I deem it unsuitable to continue with the interview process, they will be informed that the interview cannot go ahead and will be thanked for their time. I will still provide the Amazon voucher regardless as they will have allocated time out of their day to attend the appointment.

The Mental Capacity Act in relation to working with clients suggested that best practice relating to fluctuating consent is to ensure the client has the information needed (as will be provided in the Participant Information Sheet and Consent form). It recommends seeking consent on more than one occasion, as I plan to do. It also recommends seeking consent at a specific time of day where the client is most able to give consent. During my initial phonecall with participants, I will discuss with them the time of day that is most suitable for them to be interviewed, i.e. in the morning when they are less likely to be under the influence.

If informed consent will not be obtained, explain why.

Please upload a participant information sheet.
Have you reviewed the information provided by the REO on participant information and consent?
Yes

Confidentiality and anonymity

Will you be maintaining the confidentiality and anonymity of participants whose personal data will be used in your research?
Yes

If yes, describe the arrangements for maintaining anonymity and confidentiality.
I will be using an a password protected dictaphone for audio recording or alternatively recorded via Microsoft Teams if conducted online. This will be automatically uploaded to the secure University of Essex cloud system.

All data will be stored securely via the host server at University of Essex, all files will be password protected and held in accordance with UK GDPR requirement.

At transcription stage all identifiable information will be anonymised (e.g. names, locations). Participants will be assigned an ID number in place of their name. Interview recordings will be permanently deleted once the data has been transcribed and moved to the secure University system. This will be stored on a password protected laptop.

A pseudonym will be used for the purposes of the final report.

Participants' data will be used for the purposes of this study only with the potential for future publication of the research paper in academic journals.

Audio files and transcripts will be accessed solely by the lead researcher.

Data will be securely held by the University for 10 years and then will be permanently deleted.

If you are not maintaining anonymity and confidentially, please explain your reasons for not doing so.

Data access, storage and security

Describe the arrangements for storing and maintaining the security of any personal data collected as part of the project.
Interview recordings using a password-protected dictaphone and Microsoft Teams will be permanently deleted once the raw data (the recording) has been transcribed and moved to the secure University system. All data will be stored securely via the host server at University of Essex, all files will be password protected and held in accordance with UK GDPR requirement. Transcriptions will be saved as password protected files and will be stored on a password protected laptop using assigned ID numbers to preserve anonymity.

Please provide details of all those who will have access to the data.
Only myself as lead researcher.

Risk and risk management

Risk Assessment documents

Are there any potential risks (e.g. physical, psychological, social, legal or economic) to participants or subjects associated with the proposed research?

Yes

If yes, please provide full details and explain what risk management procedures will be put in place to minimise the risks.

Study subject welfare: Participant becomes distressed following interview content.

Risk management procedures:

To stop the interview immediately upon noticing signs of participants' severe distress. To inform lead research supervisor immediately and any available staff within substance misuse service (if conducting interview in person).

I have created and will circulate a mental health signposting support sheet with relevant services participants can contact in the case of feeling distressed post-interview.

I plan to conduct interviews either in the substance misuse service that the participant is engaged with, or in the comfort of their own home via Microsoft Teams. This is to ensure participant is in a familiar environment and maximise chances of being around people they know following the interview.

Researcher aware to remain in role of researcher not trainee psychologist.

Researcher to debrief with lead supervisor following a distressing interview.

Ensure that I go over the signposting sheet with participant in person prior to the start of the interview as they might not have read it upon initial sending. This is especially important when meeting over zoom as I will not be physically present with the participant to show them the signposting sheet.

I will go over the consent form and reiterate that clients can stop the interview at any time if they feel distressed by any of the content we are discussing.

Interviews will be largely participant led and will not ask probing questions relating to mental health or alcohol use. The interview is focussed on participants' experiences accessing psychological therapies.

I will telephone participants prior to interview to discuss questions I will be asking and checking they are happy with the content.

If the participant appears to be becoming distressed, I will suggest we terminate the interview.

Risk of client intoxication and inability to consent. Risk management procedures:

Participant info sheet makes participants aware the interview will be terminated if participant is too intoxicated to consent or continue with interview.

Participant information sheet makes participant aware that it is preferable to come to the interview sober where this is possible.

Seek consent on 2 occasions to maximise likelihood of client consenting with capacity. Consent verbally on the phone prior to interview. Signed consent at interview.

Researcher to be conducting dynamic risk assessment mentally at all times (see attached separate risk assessment).

Participants selected on basis of having 'common mental health problem such an anxiety or depression' therefore screened during selection process using researcher judgement that participant unlikely to be high risk (i.e. history of suicide attempts).

Breach of confidentiality and anonymity

Risk of data breach due to theft or loss of Dictaphone or Laptop where participant data is stored. Risk management strategies: I will use an encrypted EPUT Dictaphone for audio recording or record securely via Microsoft Teams if conducted online.

All data will be stored securely via the host server at University of Essex, all files will be password protected and held in accordance with UK GDPR requirement.

Laptop is password protected and data stored on the University secure server.

If theft or of an item was to occur, this would be reported immediately to police and lead supervisor and participants informed.

Participant data is anonymised and participants assigned an ID number during the transcription process.

Protection of privacy

Clients attending interviews in their local substance misuse charity. Risk of being identified in person by staff against participants' wishes.

Risk management strategies: Participants are not obliged to inform their keyworkers or substance misuse services that they are participating in the research.

If participant is concerned about attending an interview in person at the substance misuse service and does not wish to be identified, the option will be given for the interview to take place over MS Teams.

Fire, first aid and local emergency arrangements.

Researcher and participant not familiar with local emergency arrangements. Harm escalates due to delayed response.

Risk management strategies: Researcher is briefed on the emergency arrangements by the substance misuse service contact before the research starts.

Researcher imparts knowledge of emergency procedures to participant prior to commencing the interview.

Travel to and from interview location

Risk of road traffic accidents, pedestrian accidents, incidents on public transport. Risk management strategies: Participants will travel independently to their local substance misuse service and will very likely have undertaken the journey before.

Are there any potential risks (e.g. physical, psychological, social, legal or economic) to the researchers working on the proposed research?

Yes

If yes, please provide full details and explain what risk management procedures will be put in place to minimise the risks.

Risk of physical violence and verbal abuse: Participant attends interview highly intoxicated. Researcher subject to physical or verbal abuse.

Risk management procedures:

Conduct interviews at staffed substance misuse services or online via Microsoft Teams to ensure researcher safety.

Researcher is trained in de-escalation techniques, lone working procedures, interview technique and personal safety.

Researcher to have meetings with substance misuse leads prior to conducting interviews to ensure response to high level of intoxication and set up of interview rooms.

Interviews conducted between the house of 09:00-17:00 when substance misuse services are staffed.

Dynamic risk assessment checklist to be mentally noted at all times by researcher regarding interview termination.

Participant information sheet makes participant aware that it is preferable to come to the interview sober where this is possible.

Participant info sheet makes participants aware the interview will be halted if participant is intoxicated.

Risk: Participant becomes distressed following interview content. Researcher experiences vicarious trauma and/or emotional fatigue following outcome of display of distress.

Risk management procedures:

Researcher aware to remain in role of researcher not trainee psychologist.

Researcher to debrief with lead supervisor following a distressing interview.

Participants selected on basis of having 'common mental health problem such an anxiety or depression' therefore screened during selection process using researcher judgement that participant unlikely to be high risk (i.e. history of suicide attempts).

I will telephone participants prior to interview to discuss questions I will be asking and conducting an initial risk assessment (attached separately) regarding participant risk (including history of suicide attempts, current mental health diagnosis if any). Researcher to discuss with lead supervisor any concerns regarding participant suitability.

If the participant appears to be becoming distressed, I will suggest we terminate the interview.

Are there any potential reputational risks to the University as a consequence of undertaking the proposed research?

No

If yes, please provide full details and explain what risk management procedures will be put in place to minimise the risks.

Are there any other ethical issues that have not been addressed which you would wish to bring to the attention of the reviewer(s) of your application?

I believe it is important that being under the influence of alcohol is not a automatic exclusion criteria from participation in my research. I do not want to re-enact the sense of dismissal that I imagine

participants may feel in relation to mental health services, which is the focus of my research project. As I have 6 years' professional experience working with clients with addiction issues, I believe I will be able to make a judgement call regarding the participants' ability to consent and proceed with the interview as well as their vulnerability to risk in terms of distress, depending on level of intoxication.

I will be seeking consent on 2 separate occasions to minimise risk of client consenting whilst under the influence of alcohol. I will also be conducting a dynamic risk assessment in real time as the interview takes place which is outlined in the additional Risk Assessment attached. The purpose of this is to monitor the behaviour and responses of the participant during the interview and to elicit appropriate conversations with the participant if I were to feel they are too intoxicated to be consenting to the interview or too intoxicated that it were to cause a risk to either themselves or myself as researcher. At that point I would terminate the interview and, if appropriate, try to reschedule it for a different date.

It is also important to go over the signposting sheet with clients in detail at the start of the interview so they do not have a re-enacted experience of being shifted onto other services, something that is the focus of my research. I will also be conducting an initial phonecall with participants prior to the interview in order to get a better understanding of both their mental health difficulties as well as their current difficulties with addiction. This will help me to get a fuller picture of the participants' capacity to consent and to ensure that participants are happy with the interview process.

I would like to refer the ethics team to the following link which was some guidance on safeguarding alcohol users written by Alcohol Change UK in 2020 (https://proceduresonline.com/trixcms2/media/14068/safeguarding-vulnerable-dependent-drinkers.pdf).

Myth number 10 in their lists states that 'Ten: People can't be assessed if they are always intoxicated' and is something that needs to be challenged (p. 9). It is a long-standing concern that people with addiction issues are often excluded both from safeguarding procedures and support services in the UK. I hope that my research can challenge this issue as well as providing evidence through my research of the lived experiences of people who are seeking support for mental health problems.

Page 25 refers to the idea of 'fluctuating capacity' which although is linked to the mental capacity act, I believe has relevance to the notion of conducting interviews with people who are currently experiencing an alcohol addiction. It is something that can and should be assessed on a dynamic basis, and as the report states adjustments should be made according to the participant - such as conducting interviews early in the morning to increase the likelihood of a participant being sober. As page 26 states, if the rules surrounding alcohol use continue to rule out anyone who is not sober, then it means care for alcohol users will be almost impossible to provide, as 'when a person is a chronic alcohol user it could be argued that they are never sober' (p.26). I believe that to hear the voices of people who are experiencing alcohol addictions, this sort of research is critical because we should be aiming to avoid what is a chronic issue in terms of silencing alcohol users' perspectives for risk of them being intoxicated.

Furthermore, a report from Gov.UK in 2017 (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf) states that 'evidence from service user and provider surveys suggests that people with co-occurring conditions are often unable to access the care they need from both mental health and addiction services. Individuals

experiencing mental health crisis may experience difficulty in accessing care due to intoxication (in spite of the heightened risk of harm that this brings)' (p.10). This demonstrated the recognition that people with co-occurring mental health and substance misuse issues are often unable to access the support they require, reiterating my concern that by turning participants away who are currently experiencing alcohol addictions may re-enact what is already a chronic issue amongst this service user group.

The report also highlights that 'alcohol/drug use ... and levels of dependence fluctuate.

Local services need to respond in a way that reflects this variability, particularly when

developing effective responses to intoxication in people... trying to engage with services' (p. 13). The additional, dynamic risk assessment that I have produced (and attached) aims to provide me with a tool that I can use to dynamically assess levels of intoxication on the day of conducting the interview, which recognises that alcohol-use fluctuates but that the decision to proceed with or cancel the interview should be made with acknowledgement of this nuance and recognition that alcohol addiction in itself should not be a blanket rule for turning service users away from participation opportunities.

Other documents

Attached files

Thesis proposal.docx

MW Flyer.pdf

MW Consent form participants.docx

MW Signposting.docx

MW Participant demographic survey.docx

MW Interview topic guide.docx

MW Participant information sheet.docx

MW Risk assessment .docx

MW Additional risk assessment.docx

MW Emails from service providers.pdf

Appendix M

Example of transcript

P 014

Microsoft Teams

Thursday 3rd October 2024

Start time 2.07pm

End time 3.42pm

I = Interviewer

P = Participant

I: Um sorry. Tech isn't my strong point. Okay, record. Okay. Amazing. All right. So the first question, if you're okay to answer, is just if you would be able to tell me a little bit about the history of your drinking and when it started and how you think that relates, if at all, to mental health?

P: Okay, so, um, I started, I started using drugs first before I started drinking. Um, so I started smoking weed when I was about 11. Um, and then as I got older, probably around 13, I kind of started drinking, and then by the time I was 15, I was on, um, I don't know if you know it, but it's called MCAT. It's like methamphetamine.

I: Yeah, yeah. I've heard of it.

P: Yeah. And I was like, I was taking loads of prescription drugs. Like, I'd go to the doctors and say, I've got really bad migraines. Just for them to give me some sort of tablet. And then I'd drink loads of alcohol. That kind of carried on until when I was 12 when I tried to take my own life. I took like 64 amitriptyline and I was in a coma for three months, three weeks, sorry, I was in hospital for three months. But, um, yeah, so that happened when I was 12, and then when I woke up, Obviously I was really angry that I woke up, um, but I didn't get the right support then. So it was kind of like 'oh, that was stupid, don't do it again'. Nobody asked why, nobody asked how really. It was just kind of like brushed under the carpet. But after that, I, I always wanted just to die. Like I could never see anything getting any better. You know?

I: Mm-Hmm. So it sounds like you started drinking and taking drugs pretty young? Do you remember why you started?

Yeah. Well when I found drugs and alcohol I was like, well, this takes that feeling away. And I'm not hurting anyone by dying and I don't feel like I want to die. So that carried on. And by the time I was 18 that's when I started to take cocaine. And I was obviously still drinking. And then, yeah, it's just only kind of just left me. But in kind of a sense, so I grew up… I was born three months premature. So I had no human contact, no like family contact until I was about three months old. And, um, that was my older brother, he's smaller than me now, but my older brother was the first person I had skin to skin contact with, like properly. And he was only 11 at the time. My mom didn't want me. So my dad was really abusive to her. And around the time I was conceived, it wasn't consent. My dad then got put in prison for rape. Not from my mum, but from another woman. Um, so by the time my mum realised she was pregnant with me, she was still thinking about whether to keep it because at the time you could still be like 28 weeks or something and me being impatient I came at 27 weeks so, um, she didn't really have a choice after that, so yeah, I came, and then for the first five years my dad was in prison. So other than being back and forth from prisons we had quite a nice life. Like all my family, like my mum's family, were really good. They were all really involved. We had, good relationships and things like that. Um, and then my dad came out of prison when I was 6 and by then he was a heroin addict. So he moved in, he kicked my brother out. And for like the next… up till I was 11, he like abused me and my sister, my mum in like every way possible. Then when I was 11, my mum, we finally, we went in and out of

refuges and as well during that, those couple of, those, those long years. Um, and then the last refugee we went to, my sister was 13 and she was like, I'm not going back home. Like he's going to kill us. So I think because my sister made a stand… and it took a lot of convincing because by then me and my sister were like, we'll just stay in this refuge. Like, if you want to go home, that's up to you, but we don't want to go anywhere near him. Um, so, with, like, with that strength, the people at the refuge helped us put a criminal case together for domestic violence, because it's the same, kind of, for all of us. And he did get put away, and our house got completely like, we had like security alarms, cameras, bolted doors and things like that. But, um, because my mum didn't press charges, he was released within three months. And he came back to the house, but obviously because he saw all the doors and stuff, and me and my sister had the alarm boxes in our room, they looked like big sound decks. So he knew that he couldn't come back there. Um, so then he moved to [redacted] and he was quite heavily on crack at this point. Heroin, crack, drinking. He was horrendous. Then he got with this woman and he like, he was abusing her children, abusing her, and then he got back in contact with us. Then my granddad passed away, his dad, so we started seeing him again, but he obviously pretended like nothing ever happened and we pretend, we also pretended like it was the fear, I think, at that time. Then yeah, one night I went and spent the weekend with him because I knew if I was there he wouldn't hurt those kids.

I: That must have been really terrifying?

P: Yeah and they were only like three and ten at the time, like they weren't his children or anything. So I would try and go there every weekend to just give them a bit of like relief from him. And at that time he was making me like hold crack for him. So I had like massive balls of crack in all my dressing gown pockets, in my socks and things like that. Then the last weekend, basically, this is when I was 12, the little boy was, was rude to me. Obviously he's a toddler so I didn't take it personally, but my dad was on drugs. So he was like… out to get them. So he dropped me home and then he drove them to, like, the edge of a hill, like a cliff kind of thing. And he rang me, and he was like, 'Can you go into a room on your own?' And I was like, 'Alright'. And he was like, 'Don't act like anything's happening.' But obviously I was scared of him, so I literally just did what he said. And he was like, 'I'm gonna kill them'. And I was like, 'What?' And then I could hear screaming, like, and he was like, 'I'm gonna kill them. Like, they were horrible to you.' And I was like, 'Dad, they weren't, it's okay, like, he's three years old, I didn't expect anything.' I was like, 'Please just get them out of the car, let the kids get out of the car'. Like if I could save someone, my first thought was obviously to save them. Anyway, he did let the kids out of the car but then he did stab their mum in front of them while I was on the phone, I was like, this is all because, this is all because of you. Like, that's her kid, and he was horrible to you, and I was like, it's my fault.

I: Sounds like you had a lot to deal with on your own. Where was your mum at this point, and your sister?

P: My mum was in the bedroom next door. My sister was, by that time my sister, she was out on drugs, doing anything to not be at home. By that time my mum wouldn't get out of bed, so my mum was like,

I don't want to do that because she was traumatised, but she lost all sense of being a mother because we looked like our dad. She just couldn't cope. She didn't know what the right or wrong thing was to do. My big brother hadn't been in contact with us, he wasn't allowed to be in contact with us. My dad would have killed him. So she was just so lost, I can see that now. And she just had another kid so my baby brother was like a year old at this point.

I: Were social services involved at any point if they kind of knew about you being at the refuge and that your mum had gone back?

P: Yeah, yeah, yeah, so they were involved but um, my dad's a really good narcissist so when they're around, everything's perfect. You know, like it was really hard, like the social worker, he had charmed the social worker, she couldn't believe the things that we would say because then she was like, why are you so nice in the meetings when you see him? I said, because we don't have a choice. Like, the fear that that man instilled in us is indescribable and we knew that if we ever stepped out of line, he might hurt, or he might hurt somebody else. Like, a lot of our punishment would be like, if I did something wrong, it'd hurt my sister. If my sister did something wrong, it'd be me. If mum did something wrong, it'd be us.

I: Yeah, so it sounds like you were in an impossible position.

P: Yeah, yeah, so once I had to, then he put the phone down and I went into my mum and said, Mum, I said, you need to ring dad. I don't, I don't know what to do. She was like, what, what? And… but she just seemed so unbothered. So I didn't say anything. So all night I was just trying to ring my dad, trying to ring my dad, trying to ring my dad. I think I fell asleep at some point and then woke up in the morning. My mum's like, get up, get up. Your dad's on the run. Your dad's on the run. And I was like, I was like, he killed them. And my mum's like, what? I was like, he killed them, didn't he? And my mum's like, what are you talking about? She was like, how'd you know that? And I was like, he told me he was gonna do it on the phone. And then obviously I just ran out of the house. Because I thought, I've killed them, like, at that age, I thought it was my fault. And at that moment I could see no way out of here. I didn't listen to the end of the story. Like, I thought they were dead. It's insane. That was the moment that I was like, right, I need to die now. Like, I can't live any longer knowing that that was my fault kind of thing. Yeah. So that's when I started, like, preparing for my suicide for about eight weeks. And because I was handling my mum's medication and stuff at the time. So I would just steal her medication as I was doing her Dossett box. So she didn't know.

I: Yeah I mean… And you say were feeling this extreme guilt at the time and unable to cope with that feeling, like it was your fault?

P: Yeah, and there was just nobody to speak to. Because obviously, like, we had cried out for help in so many different ways. But it was like, it was like we was invisible. That's how I felt growing up. Like, we were just invisible. Like, I found a school photo of me, and I've got a black eye. And my hair's not done. I'm in like a dirty jumper. And I'm like, how invisible are we? Like, do you know why that is? Yeah, yeah. So obviously that's, um, It's actually, she did survive. Like, she did survive. The kids

weren't hurt that night. But my dad was on the run. He was on the run for, like, six weeks. So I took the overdose. Obviously went into, like, cardiac arrest and stuff. And my mum was like, this is all Dad's fault, she was just blaming my dad.

I: Mm hmm.

P: But she knew he was on the run but wasn't telling anyone where he was. Mm hmm. And my, it was my dad's mum that was like, if you don't tell them where he is and you let your daughter die, I don't know what sort of woman you are, that kind of thing. Um, and then he turned up to my, turned up to my mum's house and my mum called the police on him. And in that time as well, when I was at hospital, my brother, my big brother found him and got a gun and was like, took him for a drive and was like, if my sister dies, I'm going to kill you. Like, what the, what, what the fuck have you done kind of thing.

I: And did you think your life, was there a feeling that your life was at risk at this point? Was he threatening you?

P: Yeah. Like where, like, because I had to be like brought back to life, defibrillated and stuff like that, um, and that nobody knew what was going on, nobody knew what was wrong.

I: Oh, so they were blaming your dad for the overdose, okay.

P: Yeah, yeah, yeah. But that was, like, the first, because my brother started to be back involved in our lives, but he didn't know anything that had gone on, like, he literally knew, like, we had to keep it, I don't know why we had to keep it a secret, but we did, we kept it a secret, do you know what I mean?

I: Yeah. So this is when you were 12, you were then in hospital for three months and you're in a coma for three weeks?

P: Yeah, and then as I woke up, um, the doctor was like, you shouldn't be awake, like when we were doing your brain scans and stuff when you were in the coma, like your brain is just so active, like, it would not let you die. And I was like, okay, well that gives me some hope. Something's working up there. Yeah. Um, but obviously at the time I didn't want to be alive. Yeah. So after that, that's when I, like, when I come out, my mum didn't really change. My dad was then put in prison for like, eight years? seven years?

I: Mm hmm.

P: Something like that. He came back out when I was 17. So, oh five, seven, I don't know. Anyway, my dad's been in prison so many times it's hard to keep up. Yeah. So yeah, but during my secondary years, my mum just wasn't a mum. She was angry, hurt, like traumatised. And my sister by then was like, on kind of hard drugs, in and out, kind of all over the place. And I was just left to look after, raise my little brother. So it would be like, I would have to get up at like 5am, do breakfast, get our school uniforms ready, make sure that I was ready for school. Yeah. Then I'd have to take him to school and then I'd always be late for school and I had to leave school early to pick him up. It was just quite a lot, like my mum didn't get out of bed for about three years. Like she got out of bed like to go to the toilet and stuff but my mum just wasn't there, do you know what I mean? She wasn't functioning. Yeah and that changed when my brother… his girlfriend was a social worker and she came round the house once and

the house was infested with fleas. We were like, not malnourished, but I was… I'm a teenager trying to navigate my own personal hygiene, everything. Plus having like a little baby brother that was just like a baby kind of thing. And mentally I'd shut everything away, so I never really felt anything. I had to do what I had to do to keep me and my little brother alive. And my mum alive, to be fair.

I: So you'd kind of, you were just kind of coping at that age?

P: Yeah, yeah, yeah. Okay. Um, and then obviously the drinking drugs just become more and more. And because I knew my mum wasn't really there, she didn't really notice.

I: Mm hmm. So it was around that time, did you say, that you first started drinking and taking drugs? To cope with everything that was going on by the sounds of it.

P: Yeah, so I smoked weed when I was 11. That's when my sister started smoking weed and she's three years older than me. So I watched how the weed would make her and be like, oh my god. I'd just go in her room when she was in the toilet and like, get off on the joints and smell weed and things like that. But even at that time, I mean, I shouldn't have touched drugs at all, but at the time on the weekend, I'd be like, Oh my God, guys, I've got weed, like, I was like the cool friend kind of thing. Do you know what I mean? And then I think I was about 13 when I had, as a teenager, I'd go out to the park with friends, someone's got a bottle, and I was like, give me that, had a little bit, and then I was like, Oh my God. I need it. Gimme more. Gimme more. Gimme more.

I: Mm-Hmm. What was that 'oh my god' moment? What was, what was happening for you at that point?

P: It was like, um, I just felt free. Free of kind of thoughts and feelings. Yeah, yeah, yeah. Memories. Like my mind, I didn't have no responsibilities. I didn't even, I wasn't me like I wasn't the little girl [redacted] that has had that horrific time. I was fine. Do you know what I mean? Like, I had a good time. Anyway, so that lasted… that lasted forever. That's lasted up until now. But, over time, obviously I started, um, experimenting with more drugs. Um, and I had quite a hold on it. I could, I could get drunk on a bench. Like, once I put my little brother to bed and knew that he was alright, I'd go to mum's purse. It just became like a bit of my routine. Um, then I've got to my A levels in school I did really well because I thought that's the only thing that's going to be able to set us free, as long as I have some education me and my little brother, we can go anywhere, we can do anything, like, it'll be fine. And the school kind of had an idea of what was going on, but because I never said it, they could never intervene. Like, I would talk around things, but I would never say what they needed to hear to be able to do something. But by the time I was in year 11, they did ease up on me, so like, my behaviour like, they wouldn't let male teachers tell me off or anything like that. I had, like, a good relationship with a couple of the pastoral team that were women and I would speak to them. And obviously, like, the social worker, when my dad came out of prison, the time before he went back in they had contact with the social worker and she kind of gave them a bit of a debrief. But obviously, their version was, my dad's in prison now, so she's fine.

I: Mm hmm.

P: Not knowing about my mum. Do you know what I mean? So that went on and by the time I was 17 I was drunk in school all the time.

I: And was that a way of coping with something going on at school? How was alcohol helping you at that point?

P: Yeah, yeah, yeah. Just everything really. The same stuff. I mean by then my little brother was getting older, so I didn't have as much responsibility. Um, and by then my mum, by the time I was 17, my mum had gone and got a job back. So she then was working like 18 hours a day to, because she didn't want to face what was really going on. And then when I was 18, I went to uni. I didn't want to go, I mean I wanted to go to uni, but I didn't know what I wanted to do. I didn't know who I was. I was just doing what I thought the next thing was to do. Um, but obviously I went to university, got given all this money and then realised that I don't actually have to go to a lecture. Nobody's checking up on me. There's drink and drugs everywhere. So there's nobody to go and speak to, like, there was nobody for me to go and speak to if I was struggling. Yeah. And, or there, there was, but I just didn't know how to navigate that. I never had known how to navigate that.

I: So that was like a, was that like a University counsellor or something?

P: Yeah, yeah. My lecturers let me know that we do have support, like, because obviously I wouldn't go in for weeks, I'd be drunk. And I was sexually assaulted in Uni, so that also, that put another block on me like, I just didn't care. I didn't have any fear, like, I didn't have any feelings. I'd repressed so much that it was, I was just literally get up, get a drink, do what you might have to do, get out of feeling like you, and you'll be all right. That was literally my routine. Um, so yeah, once I was sexually assaulted I came home because that weekend I blacked out. I completely blacked out because I was on so many different drinks, drugs, everything. And then I woke up on the Sunday and all I remember is going out on the Friday. But when I woke up there was like blood everywhere. Sorry to be crude, but my bum was bleeding, my vagina was bleeding. And I hadn't lost my virginity yet either. I hated boys, I was like, no, disgusting. I, like, I hated men. Anything like that. Um, so yeah, I ran home and I said, 'I think I need to go to the hospital'. And my flatmate was like, [redacted], he was like, 'Have you had a mental breakdown?', like, I didn't know what to do. And I was like, 'What do you mean?' He was like, 'I didn't know what to do. You smashed up the kitchen, you smashed your head against the wall, you were trying to kill yourself when you came in Friday, Saturday lunchtime, you were covered in blood and you couldn't tell me what was wrong. You couldn't tell me what happened, you were just crying'. On Saturday night I'd apparently gone and got more alcohol and was just like in a pit of oblivion, but I don't remember. But on Sunday, by the time I'd sobered up, I was in pain. There was blood all over my sheets. It was like, this is not a very nice thing. But even then, it was like, it's alright. Literally, like, I just shrugged it off. I just shrugged. So yeah, by that time, um, I had to come back home, sorry. I left, no, I carried on with Uni, but I just lived at home. Still drinking every day, like all the time just like…. Yeah. But by then, because I'd had a sense of independence, and my mum still hadn't dealt with her shit, we were just clashing. Um, so I moved in with my brother. My brother was selling drugs, so I started

selling drugs. Um, and that's when I started taking, sniffing cocaine because I was selling it. So, I didn't have to buy it, it was just there all the time. Again, my brother didn't know that I was an addict by then. Because I still had, like, by then I had a full-time job. Like, I was really well put together, like, on the face of it. How I dressed, how I looked. You wouldn't think anything, do you know what I mean?

I: Yeah. So you were able to cover it up. Why do you think you did that?

P: Just wasn't proud of myself at that time I guess. And I was thinking this… it will change soon, it had to end at some point. Couldn't keep on like that. But again, being addicted to drink, it just took over, like I was going out every night and then, and how old was I, well probably it was about 23, um, and I was sleeping around with anyone. I literally had no feelings. I had no, nothing. I was just like, looking back, I was just like a zombie. But if you spoke to me and looked at me, you'd think, oh, she's, she's fine.

I: Yeah. And when you were going out, was there, cause you had no feeling kind of during the day and then you would go out drinking, what were you seeking do you think?

P: Um, I was by that point, like, numb. And that's, I think that's why, that's what my, I use my body for a lot of the time because that's the only time I could feel something. **I: Okay, yeah.**

I: And obviously when taking drugs as well that would make me feel something.

Whether it was like great euphoria, or I'd be like, I want to die, I could feel something.

I: Okay, so it's getting away from the numb, the numbness that you had chronically, I guess, at that age?

P: Yeah. Yeah. Well obviously I, I never knew who I was by the time. From the age of six, I've lived like in turmoil. I never got to be who I thought I might be or who I wanted to be, like, and by, like, by the time I was 23, it was, I was like, it's inevitable. The drugs will kill me sooner or later. So I, like, and because I didn't know who I was and who my friends are, I guess that carried on and I got into some really awful relationships. I got with a girl because I thought, oh well I hate men, maybe that's better. Um, and she like really badly abused me.

I: When was that?

P: From when I was 24 till I was 26. Physical abuse, everything, um, sexual abuse, all of it.

I: Right, right. Was she, was she drinking and using drugs as well? Was that something you did together?

P: Yeah, yeah, yeah. Um, but by that time, by the time I was about 26 because I had my own flat by then and I was like, maybe there's a chance I can, I can save myself. And so after like six months of being with her, I was like, I don't want to use much anymore. Like maybe we should just, it should just be at the weekend. So, I stopped, I managed to wean myself off of it. I wouldn't drink until it was the weekend. I wouldn't use unless it was the weekend, but obviously by, by Thursday, I'm like gagging for it, I'm like, I need to get to the weekend. I need to get to the weekend. And the less drugs and drink I used, the more she used. So the abuse got more and more and then again, it just reaffirmed my belief that this is it. This is just going to be my life. So I then started using more again. So then… Um we

broke up, then I got, I got a job as a head of year in a secondary school which gave me like quite a lot of purpose because there were so many kids like me and I was like, oh my god, I can help these kids. Do you know what I mean? So that job was one thing that kind of saved my life to be honest. Like it gave me a vision. I knew that there was something I could do. And it gave me a feeling. I started to get feelings back. Like I was excited about going to work. I was excited to do things for my kids like oh, we're gonna have a fun day Friday. Do you know what I mean? Like what… what did I need? What would I want if I was 11 again and somebody said, what do you need from me?

I: Yeah, yeah. And how was your mental health at this point, when you were back at work?

P: I guess a bit better, I was more… grounded if you know what I mean. So when I started that job, and I had, I've got amazing friends from that job. They're still my friends now, um, and they, like, I started to find, like, a sense of sisterhood… friendship that wasn't based around drinking, because they're all teachers. I mean, they drank but didn't drink like me, like, we loved a bottle of prosecco, but I, I was like, oh my god, there's an opportunity. I might not have to be this fucked for the rest of my life. So with them girls, I got the strength to leave my partner that I was with. Um, it took a lot of, it took a lot, a lot of work on their part, bless them. And they still never judged me for drinking, but it would be like, oh, maybe you should only have one bottle tonight. Like, we're only going here. So it was like I was starting to get a bit of control back. But yeah, my demons were obviously still there. That stuff doesn't go away.

I: Mm hmm. And at any point in this time, did you think you needed any mental health support of any kind?

P: Yeah, so I reached out a lot. I reached out a lot. But, because I would go to appointments and be like, yeah I'm really struggling with my mental health, but I'd be there with a smile on my face and I'm well put together, because that's how I was raised, like we had to be washed and dressed before 7am. Those are things that I can't, like, undo. But like, inside I'm like, I'm broken, and they're like, but yeah, but you go to work. And I'm like no, I'm broken, I'm broken, like I can't, I can't do this. So I guess I would go on and off and try and get help.

I: Yeah, yeah. So on the outside maybe it looked like you were coping?

P: Yeah. But to be fair when I started my job as a head of year, I had a mental breakdown in school. Um, and it was the head teacher that got me a private counsellor because I said I said like 'I'm just a broken child and I don't know what to do. I'm so lost in that…. I'm so lost I don't know what I'm doing. I don't know. I don't know. I don't even know what I'm doing'. And it was kind of like I was just whimming. Everything was on a whim. And my headteacher, she's amazing. So she got me in touch with a counsellor. And that really worked. Because it was, like, specific. She was like, do you have a drink problem? And I was like, if I tell you that, are you going to fire me? And she was like, no, you're such an amazing part of our school that I don't want to lose you. So I'm going to do everything I can to get you better but we need to start with being honest.

I: And how did you find that counselling, that, that private counselling?

P: So for the last six months I was there, like, I'd had some really good counselling, um, I started to work through some trauma, but even then, I couldn't remember a lot. So I've got quite a lot of gaps. And like after a counselling session, I'd have to go and use. And then sometimes I'd be like, I can't be too honest because that's not a nice story to tell somebody. I don't want to upset them. Not knowing that they're a counsellor and that's what they're there to do. So I would like make things not seem as bad. And another thing was that I was so worried about my job, I was like well I can't say that, I can't say that, oh god, do you know what I mean. But even so, like the counsellor was amazing, and I was sober for like 8 months with them.

I: Is this a couple of years ago did you say, when you were around 26?

P: Yeah, yeah. They, they pointed me to meetings and things like that. I left my partner and I was quite in a good place in terms of getting ready to deal with the trauma. But then I lost my nan, like really suddenly, and that literally just set me back. Because both my nans were the only two maternal people in my life that I could trust and trust that they loved me. So I didn't know how to live a life without them. So as soon as my nan died and I had to wheel her out in the black bag and stuff. I was like there like every minute. Obviously not knowing what that does to somebody, especially someone that's already as traumatised as I am. So straight away I went back to the bottle. But by then even drinking and sometimes the cocaine wasn't enough. So, this was last year, May last year, I started taking ketamine as well and I was drinking so much alcohol. Like, I was drinking six bottles of wine a night, just to even go to sleep. And I was smoking so much weed by then because weed made me sleep, and if I slept I didn't have to deal with nothing.

I: And were you working at this point?

P: No I wasn't, so obviously I took, they'd give me some time off for grieving and then I just, one day, no, actually it was after a five day bender, I just handed in my reservation and then I turned my phone off, turned all my emails off and nobody could get a hold of me for like weeks. So they sent the police round obviously for welfare checks and stuff, but they were like… I was like uncontactable basically.

I: What do you think made you do that? Turn off…

P: Just…

I: The, your phone. Sorry.

P: Yeah, yeah well wanting to shut everyone out. Like, knowing I'd spiralled so badly. So yeah, that's kind of what led to me coming here really. I then lost my flat. I was sleeping with people for drugs, but I just wanted to die. I like, I just wanted to die. I was like, I can't, there's no good that's going to come out of this. At that point I couldn't see it. And the drugs had fucked me up already. I was so paranoid and like weird. I like, I was completely and utterly fucked. Um, and then yeah in May, I ended up in a hostel. And there were guys in there that were really abusive, um, like sexually and like I, I was like covered in bruises. I was giving blow jobs in parks for a bit of cocaine and ketamine and yeah, yeah I was down for it and um, I was like adamant that I wanted to die, the drugs weren't killing me, nothing was killing me, like I was in a battle, I was like okay clearly there's a reason for me to be here but I just

can't see it. So yeah I got in touch with Oxygen and I was like I can't see my purpose, but I can't die. Like, I've tried. It's not happening. And then in March this year, I, um, I found God. I re-found God. Because my nans were, like, really, like, old school Christian women. And I thought, like, if I want to feel close to my nans, maybe I should go to church. Because they would always take me to church. So I started doing that. And I was sober up until May and then because I was like living with family and stuff, my sister lives in my childhood home, so I lived with her, but I couldn't live in the home, too many memories. And then obviously my mum still battles with her demons, so we were clashing. So then I got put in the hostel and I was sober when I went in there. Like, I was really trying but obviously I was just, I just was, all I'd ever known or been doing I guess was drinking and taking drugs. I wasn't doing any other work and wasn't having counselling. I was literally going to church, I was praying, but I didn't really know what I was praying for. Do you know what I mean? I was just kind of like floating about really. But thought I was doing amazing because I wasn't taking drugs and drinking. So mentally, it was just like, I was just existing.

I: And you said there were a couple of times that you, well, a certain amount of times that you asked for help and you were told, oh, you're presenting well, going to work, doesn't look like you're struggling. Was that at the GP or where was it that you were asking for help?

P: Yeah, it was the GP mainly. Yeah it was just the GP because I didn't know where else to go and then, like I'd end up texting the Samaritans sometimes when I was like really low and it's really helpful but only for that moment because it's the action that I need to put in to carry on with the support and I think like in those moments I just did, I had nothing left in me so it was like I can't keep begging for this help. And the GP even when I went it was just it was shit, they were like, 'Yeah, you're drinking and using. So that's probably what it is. That's why you're feeling like this'.

I: Okay. How did that affect how you felt about asking for help?

P: Yeah well I was like, 'but I can't stop. I can't stop'. So how am I ever going to get help? It felt pointless to be honest. So I worked, when I was over in [redacted], I worked, um, with an agency called [redacted]. A charity.

I: Mm hmm. Yeah, I've heard of them, I think.

P: I found them online, and I was like because they're drug and alcohol based, I thought, okay, they'll get me anyway. They might not be able to get me sober, but they'll understand. Um, so I worked with them, their help was amazing. I did counselling through them. And I, I stayed sober. I was clean until… it wasn't until I moved into the hostel because I thought I was getting support in the hostel and I didn't get it.

I: So there was no, what happened to the counselling you were getting in the hostel, did that end?

P: No but, um, I was in a different town.

I: Oh, you moved, okay. Why did it stop then?

P: Couldn't keep going once I'd moved. So I was having trouble going back and forward, I was in Hertfordshire at this point, miles away. Yeah. And then I got a chest infection one week, so I literally

was poorly, but because I was poorly, the addict came back in me and was like, oh, just take that, that'll make you feel better.

I: Mm hmm. And what did that feel like, stopping the counselling?

P: Well then literally, I was straight back into addiction, and I cut all my resources off. Although this time round again, I'm quite lucky. I've come over here and they've been amazing. I think it's because all the little people that helped this year. And like, I've got loads of, now I've got loads of people in fellowships and I've got friends that are like eight years sober that I can actually speak to and not feel like, oh my god I can't actually say that out loud because it's, do you know what I mean? I think that's enabled me to be able to sit here today and accept help and go and find help for myself and argue with the GP. Like, no, I'm sober and something's still not right and things like that. I mean that was probably a really long answer to your first question.

I: No, it's really helpful. You've covered so much, so much. So there's so much that's happened. I just was wondering, so there was a private counselling and, and then there was a counselling from [redacted]. Was there anything else you ever got at any point in term of psychological help?

P: When I turned out of hospital when I was 12, I got sent to CAMHS.

I: Okay. Yeah. What was that like?

P: So I was with [redacted] for like six weeks and then I didn't, I didn't get on with the woman. She was just really like, hard faced and asking why did you do it? Why did you do it? And I'm like, I don't know. I just don't want to be here. I assumed as a counsellor, you should be able, we need to, we need to get through that don't know, because there clearly is a reason. But she was just like well, 'I can't help you if you can't tell me', but I didn't have the words. Do you know what I mean? I didn't know what to say. I didn't know how to explain how I was feeling because I didn't know what I was feeling. Yeah. Then on the last session, she was like, 'Do you think about your overdose?' And I'm like, 'well yeah, it was a big traumatic event in my life'. And she wrote down that I think about overdosing again. So, I was like, 'you put words in my mouth'. I lost all trust, to be honest, to be honest. And obviously like I've been abused in every way possible. So my trust in people is like, you have to gain it. Yeah. I'm not an easy, I'm not the easiest person to counsel. Like it's gonna be really hard for me to open up. Because I dunno what you're gonna do with that information. But I've always had that fear and now I'm learning why that fear came and obviously why it was instilled in me for such a long time. I didn't know how to unlearn it. But then [redacted] [counselling via charity] they were really good. It was just me again. Once I, because once I picked up the drink again, I thought, I can't go back there. Like, they're going to be disappointed. Do you know what I mean? Like, I was battling, I was battling with myself. Even though they never made me feel like that, but because internally, and the way I process things, I was like, no, that's it, that's done. I've messed up. That's done, I can't go like that. And then I would just shut it off. Even when they were reaching out, I'd be like, no, no, no, no, no.

I: Yeah, okay. No that makes sense. And is it to you that the… sorry, go ahead.

P: Sorry yeah. Well my GP when I was getting sober, I went in there and said, I want to die right now. Okay. I don't, I said, I don't, I don't want to die because I know that I'm working hard on myself but I can't get rid of these feelings and these thoughts. Like my intrusive thoughts and suicidal thoughts are so overpowering I think because they've been there for so long. And this, this one GP, he was the only doctor that I did have an appointment with who just sat with me for about an hour and he just let me cry and he was like, 'I'm just here. If you want to talk, we can talk. If you don't, don't', he said, 'but you can't leave this doctor's until I know that you're in a better place. And if that takes me all day, that's what I'm here to do'. Do you know what I mean? Like I needed to create the safe environment. And then I left after an hour. I didn't speak. He just, he gave me some antidepressants. And he said he only gives them to me in like seven day blocks. So I have to see him every week because I was refusing like any help. So he was like, 'fine then. Come to me. I'm your GP. I have a duty of care to you'. Um, so he was really amazing. Even now, like, he's still like, like, he'll check in. Because he's my mum's doctor now, so he'll be like, 'oh, how's [redacted] doing?' And things like that. So it's like, for me, I needed a safe space to be created. Even in the first session, if I don't say a word, I just need to know that I can sit comfortably in silence with you. Because then I feel like you've got space for me. Do you know, like, that's, I'm just like, like, that's how I, that's how I see it because nobody ever has, nobody's ever had space for me to be. Like, if you can sit in silence with me for an hour while I'm processing what we're talking about and you understand that that's how I work, then I will tell you everything. Now I'm in a better place.

I: Yeah. And did he, did he refer you to any counselling?

P: I was refusing it, you know. But um, he made our appointments every week, an hour long.

I: Okay, wow.

P: So that if I needed to speak, there was the space and time. And he would let me stay there for an hour, even if we only spoke about just stuff. Because there would always be a way where he would get something out of me that would make me feel a bit better leaving. Do you know what I mean?

I: Yeah, I see, yeah. How did it feel to have that time and someone just listening?

P: Yeah it was good, he was like 'I don't know how else to help you and you deserve, you deserve a life better than what you've had'. It was like, yeah, I was very lucky in terms of him doing that and he then, like, because he would teach me things, he'd be like, 'you disassociate'. Like, he would be able to tell, like, explain to me what I'm doing and then I'd be able to tell him why. Because I couldn't understand what I was doing because it was just normal to me. Do you know what I mean? So it was really, he gave me the insight to be able to now, like now I remember a lot of the things he said, I'm like, Oh, that's what I'm doing right now. And I do that when I feel like this, do you know what I mean? I can like navigate it. Um, and since I've moved over here, the last thing he said, he said was 'take all the help you can get, go out and look for it, because people want to help you'. Because for a long time, I didn't feel like I deserved to be helped. He was the first person, oh and like people from like the meetings and like the fellowship and stuff that made me feel like I had a space to be helped. And they weren't doing

it just to get paid or they weren't doing it to make like, do you know what I mean? Like for their own stuff. They were doing it because they actually saw potential in me and knew that I could do something. Um, and they have that approach here at [redacted] [substance use charity]. Like it's very, open like that. A lot of the people are like ex-addicts and things like that. So we already have those things in common where nothing is too hard to talk about. Yeah. Or it might be hard to talk about, but then I happen to sit in the room for an hour and help me process whatever I'm trying to process or whatever might've come up or things like that. And I'm obviously, I've, I've seen the massive transformation in myself by allowing people to do that, letting people in. Because it's not my family or friends and I know they can't go back to my family and friends, I feel a lot safer now. Before, because I was at home with my family and that, I always thought that they're going to find out and a lot of the things would hurt them or be about them or, do you know what I mean?

I: Yeah. So, yeah. Yeah, so that's interesting as well that you didn't want to take up that offer of counselling. Why do you think that was?

P: Wasn't ready for one. But I always used to say nobody helped me when I was a child and I needed saving, so don't try and help me now that I've figured it out myself. Whether I'm doing it right or wrong. I figured out my survival. When I didn't know how to survive, nobody came in and saved me. Do you know what I mean? Like, I was the child at that time. And when I do speak to people now, I say that a lot of the time. I say 'Don't think I'm not opening up, I am opening up, but it's very hard because I'm still quite resentful for the little girl in me. She's so broken and battered and bruised and hurt and sad'. Like, I still have to take some account, like, responsibility for her. Yeah. But I feel like over time, I will lose that kind of protective, because I'm, I as an adult, am really protective of that little girl. And that's hard to explain to people that you don't know. And I found like because some people suggest that I go to counselling and I'm like, it's not just about going to counselling. It's about finding someone that I can sit down with and open up to, that relationship. And especially for someone like me, who's never been able to you know, see a healthy relationship, never been in a healthy relationship, never known a healthy relationship, not even with my mum and my sisters and my brothers. I can't go and have a healthy relationship with a random stranger and tell them all my secrets. Yeah, so it's difficulty trusting. That's the mindset. That kind of thing. Yeah.

I: And are you having therapy at the moment?

P: Yeah, yeah. So obviously with [redacted] [substance use service] that's who I'm with now.

I: Right. Yeah, so that was through [redacted] you got that? And how have you been finding that?

P: Um, obviously like, mentally, now I'm learning I have to be open to get the right help. It's taken a long time. But, yeah, like I said, it is that, being in that safe space, I know it, like, for someone that's never been, nothing's ever been handed to me, I've always had to work for it. So when somebody sits down in front of me like, oh, I'm just here to help you, and I'm like, for nothing? And they're like, yeah, and I'm like… it's hard to believe. Yeah. Like, it sounds crazy, but because of all the hurt and the pain, I have that sinister sense of, oh, you're going to do the same? Are you going to throw it in my face? Or

are you going to sell it to the news? I don't know. Like, crazy thoughts. And obviously where I smoked weed for so long, I still have a lot of paranoia. So there's like loads of little things that, that you know, I think counsellors and stuff have to consider before even getting to the reason as to why we're sat there. Do you know what I mean?

I: Yeah. Yeah. Um. So it sounds like, from what you've said, addiction and mental health, they are connected for you, do you think?

P: Yeah. Yeah. Yeah. Yeah. Because as soon as I mentally shut down, and I think that was probably around the age of like eight. It was eight. I watched my dad get stabbed in front of me. In front of me. I watched him bleed out and I was like, I was standing in his blood. That, that's the last moment I remember feeling something as a child. Because that was so painful that my brain just literally had to be like, no, no, that's, that's it. Do you know what I mean? So it's only now that my brain's kind of opening back up to being more aware of things, of feelings and stuff. But without my addiction, I don't think I would have survived as long as I have. Because in addiction, my mental health wasn't a problem. So it's a survival strategy. It relieves all the pressure that is going on mentally for me. Do you know what I mean? So, without one, like, if I didn't feel like that, I wouldn't have had to go, I wouldn't have had to go and find drinking drugs to feel something. Like, for me, they are literally like twins. As soon as I put the drink and drugs down and I've opened up, my mental health is really slowly, like a tortoise, but slowly, I can differentiate between an intrusive thought and how I feel. I now know that if I'm having a bad day, there's better ways to cope than to go and buy a drink, go and have a bath, or when I feel like, because when I can't cope, I go, it's the numbness, there's like nothing, it's like nothingness. So I'm like, go and do something that makes you feel something, whether that's eating, going for a walk, stand outside just to feel something physically will then wake my mental brain back up. I don't know. Sorry. I've said way too much haven't I.

I: No, no, it's so helpful. Yeah, it makes sense, allow you to feel. I'm just aware of the time because we've spoken already for over an hour so you might be tired! How are you doing, how…

P: Oh fine, fine, fine.

I: Ok, great. I mean… But it's, you've given me so much helpful information. And it's like you said drinking, was it a way of keeping yourself protected?

P: And yeah the trauma, I think because I'm… because we're not, well because I'm an adult and I'm coming into a counselling room as an adult then the inner that child's forgotten about. But as I'm coming into that room, the only person I'm thinking about is that little girl. Do you know what I mean? I think, I don't, I don't, I'm not, I'm not a counsellor, obviously not, but as a counsellor, I don't know if that's something that is spoken about or like addressed. Do you know what I mean? Like, I know, I know it's probably part of the training and stuff, but I feel like that should be like, you could have those conversations. You should have those conversations before like, being like, right, what's your problem? Why do you feel like this? I just need you to know that I'm quite fucked. So I just need to know that you're aware that this isn't going to, this is going to be hard, really hard for me. And the little girl inside

doesn't want them to come out. So as much as I, as an adult, really want all this help and support, that little girl still plays a big part in, in my life. Do you know what I mean? For someone like me who's just, it's always been about survival, her first thought is, well, how are we going to fucking survive this? Don't open your mouth, don't open your mouth. And then it's usually like, when you don't respond how socially you're supposed to respond it's like, Oh, they, they don't want it. Or like, if I did, after a conversation, go and pick up a drink straight away, they'd be like, 'don't come back'. Whereas we like people like us just need a bit more grace. Like ask us, why did you go and have a drink? Was it something we spoke about? Was it a feeling? Knowing that I can come back, even though I've made a mistake is what will keep me opening up. Because a lot of the, I think it's a lot of it's like policy and procedure and people like protocols and things and I get that but I think socially that is what causes a lot of the isolation of not going into systems because I think well as soon as I fuck up you're going to shun me anyway. But you have to remember that I've never been taught how to… how to speak, how to… do you know what I mean? I had to teach myself in a, in a matter of survival. Sorry, I'm just trying to help give some wisdom about how you feel.

I: Yeah. It's really helpful. It's really helpful. I mean, that's all my questions that I wanted to ask. But is there anything else that you think is important for me to know, or anything else that you think is relevant here?

P: No, I think it, it was really, it's, it's been really nice for me to be able to like speak to you, because that's what I wanted to do. I said I've, I've, I've given up so many times on myself and the system that maybe I should go in and just speak to people in the system and be like, this is what we need. This is what we actually need. Do you know what I mean? I think people that read a book think they can tell us, but unless you're living it, it's so hard to know. And I think, I just want to represent people like me that are where I was six months ago. Do you know what I mean? I thought there was nobody, but it is like we're, we're still so protective of ourselves and our inner child that it takes, it takes a while to break in and to know that. We can fuck up because we're human, we're going to make mistakes, but society's like, oh, if you don't, if you don't come, then we're going to take it away from you. It's going to be taken away from you. I understand you can't give a million chances but I would say that after the third time, if you're really trying, then here, okay, you're going to have to say, 'I can't help you anymore'. But not at the first hurdle. And I think that's like when I was in the hospital in March this year, the mental health nurse came in and she went, 'Oh, you've been here before, ain't ya?' And I thought, what? Like, that's not how I need to be spoken to right now. Do you know what I mean? Like, and I know that's not everyone, and you do get the select idiots in everywhere you go, but it's just like I don't know. And obviously because addiction, when you say somebody's an addict, they're so judged, you forget why they're an addict. You just, people that aren't addicts just think, you just think, oh, they chose drinking, drugs. I never chose, I never in my life wanted to be giving blowjobs for a bit of cocaine, ever. I didn't choose to do that, but in my mind, I had no other means of survival. And I just think it's like breaking like down that fourth wall, yeah, it's not a choice. Okay, it is a choice in terms of, you know, that you're

hurting people and stuff, but I don't know how to stop it. Because by now my brain and body are craving for the next drug and that's painful. That's more painful than me seeing my mom cry in that moment. Do you know what I mean? So I just think, yeah, it's like, I'm, I feel, I feel like it's a bit like my purpose to just try and kind of like break the fourth wall. Yeah. Um, and kind of like get, because my story, my story is absolutely awful and horrendous and traumatic, but now knowing that I've got people that just want to help me because they feel sad for that little girl, just as sad as I do, means I'll let them in to help me because we've all got the same. We've all got the same end goal. I'm not just here to be a statistic. I'm not just here so you can get paid. Do you know what I mean? And I think addicts, addicts are really good at it because of the survival instinct, like we can, like the energies, we read energies really well. Like we know if a person's going to be genuine or not straight away before, because we're so manipulative and like, like I was like that because I knew how to work my way around things. So I know if you're not being genuine with me or not if you're just there because oh, you gotta be and it's my job. Do you know what I mean?

I: Yeah, that's interesting.

P: You're expecting me to expose the deepest things about me and you're just like, not you personally, but you're just like, yeah write it down. All right. Now knowing that you're gonna clock off at five o'clock and go to your happy family in your nice warm house. And I'm gonna I don't know where I'll be by five o'clock. Do you know what I mean?

I: Mm hmm. So it's a real sense that you have to trust the other person in the room to be able to open up?

P: Yeah, it's making a safe space and, and knowing like, because drug addicts are really good at being like, oh no, nothing's wrong. So if you, so if you said to me like, [redacted], what would you want your child to say right now? Straight away I'd be like, you care. And all we want is to be cared for and loved. Do you know what I mean? And that's a human, that's a human thing. Everybody just wants to be loved. So yeah, I feel like that's, I feel like I'm preaching now and I don't want to be preaching.

I: No, it's so, so helpful. Thank you so much. I, I'll stop the recording now.

End time 3.42pm

Appendix N

The eMERGe meta-ethnography reporting guidance (France et al., 2019)

No.	Criteria Headings	Reporting Criteria
Phase 1—Selecting meta-ethnography and getting started		
Introduction		
1	Rationale and context for the meta-ethnography	Describe the gap in research or knowledge to be filled by the meta-ethnography, and the wider context of the meta-ethnography
2	Aim(s) of the meta-ethnography	Describe the meta-ethnography aim(s)
3	Focus of the meta-ethnography	Describe the meta-ethnography review question(s) (or objectives)
4	Rationale for using meta-ethnography	Explain why meta-ethnography was considered the most appropriate qualitative synthesis methodology
Phase 2—Deciding what is relevant		
Methods		
5	Search strategy	Describe the rationale for the literature search strategy
6	Search processes	Describe how the literature searching was carried out and by whom
7	Selecting primary studies	Describe the process of study screening and selection, and who was involved
Findings		
8	Outcome of study selection	Describe the results of study searches and screening
Phase 3—Reading included studies		

No.	Criteria Headings	Reporting Criteria
Methods		
9	Reading and data extraction approach	Describe the reading and data extraction method and processes
Findings		
10	Presenting characteristics of included studies	Describe characteristics of the included studies
Phase 4—Determining how studies are related		
Methods		
11	Process for determining how studies are related	Describe the methods and processes for determining how the included studies are related: - Which aspects of studies were compared AND - How the studies were compared
Findings		
12	Outcome of relating studies	Describe how studies relate to each other
Phase 5—Translating studies into one another		
Methods		
13	Process of translating studies	Describe the methods of translation**:** - Describe steps taken to preserve the context and meaning of the relationships between concepts within and across studies- Describe how the reciprocal and refutational translations were conducted- Describe how potential alternative interpretations or explanations were considered in the translations
Findings		
14	Outcome of translation	Describe the interpretive findings of the translation.

No.	Criteria Headings	Reporting Criteria
Phase 6—Synthesizing translations		
Methods		
15	Synthesis process	Describe the methods used to develop overarching concepts (“synthesised translations”)Describe how potential alternative interpretations or explanations were considered in the synthesis
Findings		
16	Outcome of synthesis process	Describe the new theory, conceptual framework, model, configuration, or interpretation of data developed from the synthesis
Phase 7—Expressing the synthesis		
Discussion		
17	Summary of findings	Summarize the main interpretive findings of the translation and synthesis and compare them to existing literature
18	Strengths, limitations, and reflexivity	Reflect on and describe the strengths and limitations of the synthesis: - Methodological aspects—for example, describe how the synthesis findings were influenced by the nature of the included studies and how the meta-ethnography was conducted.- Reflexivity—for example, the impact of the research team on the synthesis findings
19	Recommendations and conclusions	Describe the implications of the synthesis