A qualitative longitudinal study of the first Dual Diagnosis Anonymous (DDA) in the UK

Purpose

Dual Diagnosis Anonymous (DDA) is a peer-led programme developed in the USA which aims to address mental and addictive disorders in an integrated manner. This study is part of a mixed methods evaluation of the first DDA pilot in the UK, its purpose was to explore the impact and mechanism of change of the programme through the perspective of DDA attendees, facilitators, and the funding commissioners.

Methodology

Six DDA members were interviewed three times over a period of 12 months, the facilitators were interviewed twice and the commissioner once. The qualitative longitudinal data were analysed using a trajectory thematic analysis.

Findings

DDA attendance was perceived to have had a positive impact on five main areas: (1) acceptance of self, of others and from others; (2) social functioning; (3) self-development; (4) recovery progression; (5) feeling of hope. The possibility of addressing both mental health and addiction at the same time was a key factor in the recovery process. The facilitators observed that DDA had contributed to integrate members into employment and education, while the commissioner stressed the importance of joint commissioning and sustainability.

Value

The longitudinal approach provided a unique insight into the recovery process of DDA members. Being able to address the mental health as well as the substance use problems was considered to be a fundamental strength of DDA in comparison to the single purpose peer support fellowships.

Research Paper

Introduction

Comorbidity of mental and substance use disorders (SUD) (known as "dual diagnosis") is highly prevalent. In their systematic review, Carrà & Johnson (2009) have estimated 20-37% prevalence rates of comorbid substance misuse and psychosis in secondary mental health services and 6-15% in substance misuse settings. Anxiety and mood disorders are particularly common in people

with Alcohol Use Disorders (AUD) (Kushner et al., 2012). For example, research showed that up to 50% of individuals receiving treatment for problematic alcohol use also met diagnostic criteria for one or more anxiety disorders (Chunk et al., 2008) and a systematic literature review showed that presence of either AUD or Major Depression doubles the risks of the second disorder (Boden & Ferguson, 2011). Bipolar Disorders are also associated with high rates of AUD and SUD (Merikangas, *et al.,* 2008), in a meta-analysis of 22 large multicenter studies and 56 individual studies of comorbid bipolar disorder and substance use disorder, it was found that alcohol use was at 42%, followed by cannabis (20%), illicit drugs (17%), cocaine and amphetamine (11%) (Hunt, et al., 2016).

This is concerning as individuals with dual diagnosis experience some of the worst health, well-being and social outcomes. Both mental illness and substance use disorders are the leading causes of non-fatal burden of disease globally (Whiterford *et al.,* 2013), and are risk factors for injury (Wan *et al.,* 2006), suicides and criminal offences (Appleby *et al.*, 2018). There is also growing awareness of the overlap between mental disorders and behavioural addictions, for example Haydok *et al.* (2015) found that the risk of problem gambling in psychiatric patients is four times higher in patients than the general population.

Despite the extent and the severity of the problem, mental health services often lack appropriate knowledge and capacity to deal with substance use and behavioural addictive disorders, while substance misuse services fail to recognise and respond to mental health problems (Rethink, 2007). Research has consistently demonstrated that the best outcomes are obtained when conditions are treated simultaneously (e.g. Drake *et al.,* 2007; Ducharme *et al.*, 2007), yet current practice focuses on treating the "primary need first"; for example, individuals can be denied access to therapy until their alcohol problems are resolved. In a survey of 140 services operating across the UK, co-existing conditions are often employed as exclusion criteria, preventing many individuals access to vital care and support (MEAM coalition, 2015). Vulnerable individuals are then left unsupported and isolated within their own community (Public Health England, 2017).

Historically, peer support groups have been playing an important role in addiction treatment with the 12-step programme (e.g. Alcoholic Anonymous or AA) being the most widely used approach (Tracy & Wallace, 2016). In the recent years there has been an increase in peer support models in the mental health sector, ranging from independent support groups, one to one support, support networks or peer supporters working in statutory mental health services (Hardy *et al.*, 2019;

Gillard *et al.*, 2016; Gillard *et al.*, 2019). Research suggests that peer support groups can lead to improved outcomes including symptom reduction, improved quality of life, increased hope and motivation, better community engagement and sense of belonging (Repper & Carter, 2011). There is growing evidence that individuals with co-existing mental disorders can benefit from 12-Step involvement (Bogenschutz, 2007; Laudet *et al.*, 2004), however, individuals with comorbidity often face greater stigma, challenges and poorer outcomes than those with only a substance use disorder (Laudet *et al.*, 2000) when attending 12-step groups. In addition, mental health issues and the use of psychotropic medications are often discouraged topics of conversation in traditional single pourpose12-Step fellowships (Bogenschutz *et al.,* 2006; Magura *et al.*, 2002; Roush *et al.* 2015). In the UK there are limited peer support groups specifically designed for people with concurrent disorders. One of the best known is Dual Recovery Anonymous (DRA), based on the traditional 12-steps (Cameron, 2009), however, to our knowledge, there is limited evidence of its effectiveness.

Dual Diagnosis Anonymous (DDA)

This programme was founded by Corbett Monica in 1996 in California, and relocated to Oregon in 1998, with the aim of meeting the needs of individuals with concurrent disorders (Roush *et al.*, 2015). Corbett was a Vietnam Veteran who endured alcohol and mental health problems. He observed that individuals with concurrent disorders often failed to benefit from existing peer–support groups like Alcoholics Anonymous (AA) and after gaining permission from AA to use the 12 Steps, he added 5 additional steps to tackle mental health issues (Monica *et al.,* 2010). The additional steps include: "acknowledging both illnesses, accepting help for both conditions, understanding the importance of a variety of interventions, combining illness self-management with peer support and spirituality, and working the program by helping others" (Monica *et al.,* 2010, p. 738). Contrary to traditional AA meetings, DDA encourages participants to give and receive feedback and ask questions; more details about the meeting format can be found in Monica *et al.* (2010). The DDA programme also includes a workbook with reflective exercises to guide its members through the 12 plus 5 steps approach (Monica, 2015). DDA Oregon currently has over 3,000 meeting contacts per month in 36 Oregon counties. It has established meetings in various correctional, hospital, mental health treatment, and community settings within Oregon and is an integral part of state, county, and local healthcare service provision (DDA, 2019). The first DDA in the UK was set up in West London in 2016, jointly funded by the commissioners of Ealing Mental Health and Drug and Alcohol Services commissioners. This paper presents the findings of the qualitative part of a larger mixed method evaluation (Milani & Nahar, 2018).

Method

A longitudinal qualitative trajectory analysis was adopted. This model is often utilised in health services research to measure transitions in recovery (Calman *et al.*, 2013; Bélanger *et al.*, 2017). Unlike other qualitative approaches, the longitudinal approach focuses on duration, time, and change; and allows these changes to be analysed at multiple time points. "Data source triangulation" (Carter *et al.*, 2014) was employed to cross-validate data and to produce comprehensive findings (Noble & Smith, 2015). Interviews with DDA members were conducted 3 times in total, first at 3 to 4 months after they started attending DDA (T1), approximately 4 months (T2) and 9-10 months (T3) after the first interview. The DDA facilitators were interviewed twice: at 1 year and 2 years after the first DDA meeting. The drug and Alcohol Services Commissioner was interviewed once at 1 year and 6 months after the beginning of the DDA-UK programme.

For the DDA members, the interview comprised of 3 primary questions: (1) "Has your life changed in any way since you started attending DDA. If so, what changed and how?" (2) "Has DDA helped your recovery in anyway, if so, what helped?" (3) "What recommendation would you make to improve the programme, if any?" At T2 and T3 participants were asked whether and how their life had been since the last interview and what role DDA had played. For the facilitators, the interview focused on exploring their background, their observation regarding the progress of DDA members, the status of the programme at the time of interview and whether they felt their involvement in DDA had helped them on a personal level. The commissioner's interview explored her point of view regarding the usefulness, feasibility, and future directions of DDA.

Participants

Six DDA members (2 females) took part in the qualitative study, this represented 20% of the total number of people (30) who were attending the group at the time of the interviews. The sample size was agreed upon after "inductive thematic saturation", meaning that two independent researchers upon analysing the recurrence of codes or themes at T1, decided that further data collection would yield similar results (Saunders *et al.*, 2018). All those who were interviewed at T1 completed the three interviews, although one participant halted attending DDA intermittently between interviews. The main DDA facilitator (MF) was a peer supporter with 12-years' experience of group facilitation and a history of co-existing mental health and addictive disorders, he facilitated most meetings, especially at T1 and T2. Facilitator 1 (F1) was a manager of a homeless service, and held a qualification in substance use and addiction studies; Facilitator 2 (F2) had a history of active drug and alcohol addiction spanning 32 years and at the time of the

study was working as peer supporter in a mental health service. Furthermore, F1 and F2 founded DDA-UK.

Procedure

The study was approved by the University of West London ethics committee. Prior recruiting participants, investigators attended several DDA meetings during which they introduced themselves, explained the purpose of the interviews and handed out an information sheet with the details of the study. All attendees were offered the opportunity to take part in the interview. DDA attendees who expressed interest in participating contacted the investigator at a later stage and arranged a time for the interview. All interviews were carried out, recorded, and transcribed by the same investigator who was a female Research Assistant, and Psychologist with work experience in psychiatric and drug treatment settings. All interviews were carried out in the venue where DDA meetings took place. Participants signed the consent form and agreed to being audio-recorded. Participation was voluntary, and no monetary reward was given.

Data analysis

Thematic Analysis (TA) was used to analyse the data. Two investigators worked independently to code the interviews; additionally, data were analysed using NVivo 10 for Windows (release 2014). Data were also analysed using longitudinal matrixes by themes and by participants (Grossoehme & Lipstein, 2016). Themes were compared, discussed, and agreed between the investigators. Finally, the identified themes and the longitudinal analysis were anonymously presented in a DDA group meeting, which provided feedback and further insight into the interpretation of the data.

Results and Discussion

DDA members

As shown in table 1, the group was diverse in demographic characteristics, level of education, employment status, addictive disorders, and mental health diagnoses. One participant was the father of a young person with mental and substance use disorders, who never attended the DDA group himself. Attendance at DDA meetings varied between each participant and between time-points, with an average attendance of 1-2 meetings per week.

< Table 1 about here >

Themes and sub-themes for DDA members are displayed in Table 2 (the trajectory analysis matrixes by participant and by themes can be provided on request).

<Table 2 about here>

The section below presents and discusses the findings divided by questions and themes.

Question 1: Has your life changed in any way since you started attending DDA; if so, what changed and how?

Acceptance

Participants reported that acceptance in DDA meetings led to lower self-stigmatization, and lower stigmatization of others experiencing the same condition. This could be due to public support through the DDA group, and as a result an increase in positive internalisation. Self-help groups have previously been shown to replace a poor social identity with valued personal identities, increasing feelings of self-worth and self-acceptance (Corrigan *et al.*, 2005). By becoming more accepting, DDA members expressed 'self-forgiveness' and 'self-compassion'. Though limited, growing research suggests self-acceptance can play a crucial role in recovery (Webb & Toussaint, 2018); Kang *et al.* (2018) identified "embracing the essence of one's own existence" as pivotal in addiction recovery. Feeling accepted is particularly crucial for individuals who are affected by the double stigma associated with both mental illness and addiction (Stott & Priest, 2018). As participant C explains:

"*You have to learn to accept yourself for who you are, and you just have to accept your life is the way it is. You can't just keep dwelling on the past and thinking I made all these mistakes and I wish I could change them*" (Participant C/T1)

For participant D, self-acceptance lessened negative feelings surrounding their son's diagnoses and pushed him to become more introspective and self-compassionate.

"*Seeing the emotions and universal struggle, you know, that it's not just my son but thousands struggling in similar ways made me feel less anger and stress towards myself and my son*" (D, T1)

The importance of feeling accepted was present also in T2, where some of the participants felt acceptance from others, despite being in a bad place or attending sporadically.

> "*When I felt suicidal and depressed and shutdown the DDA has still accepted me and made me feel cared for*" (G/T2)

Social functioning

Poor social functioning was cited amongst participants as problematic during T1, however there was a significant increase in social activities during T2 and T3. Problems were often disclosed as inter-personal conflict, financial difficulty, housing difficulty, abuse and isolation, factors which often accompany substance use and mental health problems (Turner, 2018; Davidson & Roe, 2007). Experiencing positive social interactions within the DDA group increased members' confidence in their social skills, which led to improved social interactions with relatives and friends outside the DDA group.

> "*This group has allowed me to reconnect more often with friends outside the DDA...I feel more able to go out for coffee, pick up the phone*" (A/T1)

This positive change was maintained or increased from T1 to T3 by most participants, although participants B and F experienced some difficulties with their family members at T2, which the group had helped to overcome at T3.

Self-development and *hope*

Participants reported that attending DDA helped them develop coping strategies by providing them with a "toolbox" that they could utilize in instances where they felt vulnerable. The encouragement participants received from the group led to an increased sense of "self-efficacy". This refers to an individual's belief in his or her capacity to execute behaviours or 'tools' necessary to produce specific performance attainments (Bandura, 1977); particularly, more confidence in their ability to identify triggers, manage relapses, manage their mental health symptoms, fulfill day to day responsibilities, (similar to responsibilities) and interact with others. As a result, there was ~~also~~ an increase in altruistic and pro-social behaviour, with some participants taking up voluntary work. Alongside this new-found motivation "to do more", was an improvement in attending to responsibilities both within and outside the group (e.g. "paying the bills, doing the shopping, cleaning the house"), better self-care, increased educational pursuits and a move towards paid employment. Increased self-esteem and sense of purpose contributed to a renewed sense of hope for the future, hope that they can recover from addiction, manage their mental health issues and live a fulfilling life:

"*…more belief in myself, confidence to do things I couldn't do before. I visit more places now and work more hours, feel I have something to contribute and feel I've learnt to go out and do these things and be confident from being part of the DDA*" (A, T3)

The increased ability to identify and recognize triggers associated with their co-occurring conditions were a skill that appeared to develop over T1, T2 and T3, due to sharing and learning from the experiences of others. This appeared to increase self-awareness and self-regulation (Hull, 1981; Baumeister, Heatherton & Tice, 1994).

In the second and third interviews, the theme of Spirituality emerged, with most participants explaining that they had discovered a new spiritual dimension through meditation and prayer. Previous research has found the experience of 'spiritual awakening' to be a critical element to the increase sense of hope and sustained positive behaviour change (Kakutas *et al.,* 2003; Tonigan, 2007). Self-development and self-improvement were also experienced by the carer, which had a positive impact on his relationship with his children and his colleagues:

 "*As I've gotten myself into a better frame of mind, I am able to be a better father and carer. The time I spent in the DDA helped not just with understanding my son's issues but also my daughter and the guilt, anger which permeated every facet of my life so the benefits of DDA are felt everywhere even with colleagues.*" (PD, T2)

Recovery progression
Changes in acceptance, self-development and social interaction all appeared to contribute towards reduced psychiatric symptoms (including reduced rumination and suicidal ideation) and sustained sobriety:

 "*I often want to kill myself. But when I feel that way everyone here points out...the good things I don't see...helped give me self-respect and dignity*" (G, T1)

"*The DDA makes life so much less painful as I have a group I can be myself with…Going to DDA meetings means less time experiencing pain and a reduction in symptoms.*" (A, T2)

"*Going to the DDA meetings keeps me sober therefore it's vital to me doing anything. And that's what I've been doing. I've been clean from alcohol since October 2016 and it's thanks to this programme.*" (F, T1)

These changes led to overall improvement in quality of life (Magura, 2008; Magura *et al.*, 2002), with participants reporting improvements in adherence to medications, sleep hygiene and healthier eating.

As show in table 2, during the second interview, five out of six participants experienced relapses in either their mental health symptoms or/and addictive behaviours, however, all of them reported that DDA was instrumental in managing, containing and overcoming their crisis.

"*Things can take over and become overwhelming, … I can fall into self-neglect. Don't want to brush my teeth or get out of bed. But here when I get that way I still feel accepted. In other groups I felt self-rejected and destructive.*" (F, T2)

Question 2: Has DDA helped your recovery in anyway, if so, what helped?
Integrated approach
DDA's acceptance of coexisting mental health and addiction was a fundamental reason for attendance to the group. DDA members valued a space to discuss both conditions and the issues related to taking prescribed psychiatric medications as part of their treatment, something that they felt uncomfortable doing in other groups. These findings support the usefulness of the extra five steps proposed by the founder and are in line with previous research on DDA of Oregon (Roush *et al.,* 2015), 'Double Trouble in Recovery' (DTR) and 'Dual Recovery Anonymous' (DRA) (Bogenschutz, 2005, 2007; Magura, 2008; Moos & Timko, 2008).

"*The most important thing about the DDA is that it fills a gap where other fellowships are lacking. It's a reassuring place where you can talk about your addiction issues but also your mental health*" (F, T1)

"*A lot of the time if you go to AA or NA... they've said they don't want me to use any drugs, whether they're prescribed drugs or not…*" (B, T1)

The group and *the main facilitator*

Consistent with previous research on DDA (Roush *et al.*, 2015) and other mutual aid groups (e.g. Baumeister, & Leary, 1995; Chou *et al.,* 2011), a motivating factor toward attendance to DDA was social connectedness. Participants described a sense of belonging and community within the DDA fellowship, with one participant referring to the group as an 'alternative family' (C, T2). Previous research has shown that positive social interactions in recovery communities can support individual recovery by developing "recovery capital". This encourages members to bind to groups, such as DDA, reducing the risk of seeking value and identity from 'substance using' social groups (Dingle *et al.,* 2015):

> "*I've cut contact with a lot of friends who were triggering me...If they really cared…they wouldn't keep asking me to smoke weed with them or to go out and get drunk.*" (B, T3)

As a peer-led programme, participants gained insight and knowledge from 'peers' and 'peer-facilitators' in the group who had undergone similar experiences with their mental health and addiction. This was consistent over T1, T2 and T3. Additionally, through sharing subjective experiences about recovery, participants established *role models* to aspire towards (Humphreys *et al.*, 2004). Moreover, through group 'bonding' participants were able formulate aspirations for the future; therefore, providing structure and goal-directed dialogue (Dingle *et al.,* 2015; Donovan *et al.,* 2013). For this process to occur, participants had to identify with the life stories of other members and with the values and aims of the group. For many, the DDA group provided a new "social identity" (Tajfel, 1974). This sense of belonging was reinforced from T1 to T2:

> "*Everyone is there for a particular purpose to either reach sobriety or remain sober and that similarity helps me connect more and have conversations with them as I struggle to connect with people normally.*" (B, T2)

Increasingly peer support is being delivered within mental health services, whereby "poor mental health is the product of a disordered pathological mind that needs to be "fixed" (Gillards, 2019, pp. 342). In contrast to the medical model, DDA members valued the opportunity of normalizing, nontreatment-based relationships (Gigudu *et al.*, 2015)

> "*With DDA you are seen as more than your diagnosis*" (E, T1)

The process of identity change is one that has gained increasing focus within the alcohol and drug field. Research by Dingle *et al.* (2015) showed how during the recovery process, individuals move from a "substance user" identity to a "recovery" identity. For some participants, the development of a recovery group identity connoted a sense of purpose and a positive identity encountered for the first time in their life.

> "*Being here made me realised I'm not a bad person.*" (F, T2)
>
> "*I started volunteering for the first time in my life and it gave me the confidence to look for employment*" (C, T3).

Throughout the three interviews, participants also felt that DDA provided them with a safe environment which made it possible for them to attend and be their true selves whatever mental state they were in. The diversity of the group was experienced as a strength, with participants reported focusing more on the similarities they shared with others, as opposed to the differences, which used to make them feel alienated. Participants spoke of the DDA's openness, as it embraced people affected by any kind of addictive behaviours. They were able to connect for example, with issues experienced by members suffering from gambling or sex addiction:

> "*I benefit more when I look for the similarities I share with other members rather than the differences*" (A, T2)

Additionally, more experienced members of DDA adopted a mentoring role and offered feedback and advice:

> "*Most of them are a bit older than me, so they give life advice and life lessons…*" (B, T3)

The *main facilitator*'s competence and lived experience were very important to participants; they regarded him as a role model and an inspiration, someone who was always available to help, within and outside the group meetings:

> "*He's very knowledgeable. He's been through it and he understands the patterns of my illness and how to deal with them.*" (E, T2)

Participants also mentioned that facilitators' compassionate attitude made them feel "*accepted no matter what*" and were a *"solid strength to reach out to"* in moments of crisis (F, T2).

The format of the programme

For most of the participants, the use of the *DDA workbook* helped reduce and manage mental health symptoms and relapses. Participants additionally found it helped develop their self-insight, as they looked deeper into where their substance misuse may have stemmed from.

> "*I wouldn't have done those things without the book so in that way it's been good because I searched deeper and thought about why some things have turned out the way they have, and it's been useful in that way.*" (A, T1)

The *five additional steps* resonated with participants' experience and were found particularly useful in addressing their mental health problems. Previous research also suggests that self-efficacy can increase when members transform from the role of 'one who is helped' to 'one who helps others' (Carpinello & Knight, 1991), this relates well to DDA's step on "service to others" and the opportunity the DDA offers for taking on tasks and responsibilities.

Question 3: What recommendation would you make to improve the programme, if any?

Views on how DDA should move forward remained consistent, with most participants focused on the necessity of supplementary sessions in more locations and additional facilitators to enable this. During T1, female participants also wanted to see more female facilitators and attendees, as the group is predominately male. Women only groups could be an option, having been successful when employed by Alcoholics Anonymous (Kaskutas, 1994) and DDA in Oregon.

> "*I also wish there were more woman facilitators and women attending the sessions as it is mainly male, and I feel it would be easier to talk about relationships and boundaries.*" (G, T1)

Participants also wanted a stronger social media presence, more social outings, and more responsibilities within the group, which could further help foster positive social relationships and reduce isolation (Kelly *et al.*, 2011 and 2012).

> "*I would also like it if there were more gatherings and trips outside of the session because everyone has social issues and it could strengthen this.*" (E, T2)

"*I am now secretary for the Saturday group and collect and look after money, by making an expense sheet which I send to [the facilitator] and I nominate a chair for the next meeting. We can't rely on one person to do all the work*..." (F, T3)

Two participants expressed the importance of collaborating with external agencies when dealing with trauma, and the need for support when working through challenging steps. This was offered to some participants at T2 and T3.

<u>The DDA facilitators</u>

The three interviewees agreed that they had witnessed a "*huge"* difference for individuals after they had begun attending the DDA. They reported that "*people are in a much better place*" (Facilitator 1), more adherent to their medication, returning to employment or volunteering, socialising more and creating more support networks. All facilitators emphasised the importance of being able to discuss both mental health and addiction problems, F2 added that single purpose fellowships prevented people with co-existing conditions "*fully benefit from the process of identification",* because such mental health issues could not be openly discussed. Facilitator 2 also emphasised how the inclusiveness and openness of DDA enables its members to identify with each other regardless of their differences:

"*If you and I were alcoholics and I was brought up in "Park Lane" and you were brought up on "a park bench" our lives couldn't be more different, but if we speak about our alcoholism you will hear my story echoed in yours, and where we find our identification is not with the details of our stories, they couldn't be more different, but it's with how it felt, it's with the mind-set, the emotion…how it felt living in the throes of alcoholism, in the throes of addiction…*" (T1)

In line with what was reported by the DDA members, the main facilitator acknowledged that "being of service to others" was integral to the format of the programme:

"*I experienced health problems…which meant I was having to delegate my duties to others…it got other people involved and doing a service. It took some of the burden off my shoulder as I was running a lot of the meetings at that time. The mutual support which is the ethos of the DDA was evident during this time, as members took part in facilitating.*"

The facilitators echoed the DDA members in expressing the need for more social activities, having observed how instrumental this has been to the success of DDA in Oregon.

When asked how DDA helped them personally, the facilitators said that, similarly to other members, helping others was rewarding and by doing so, it helped dealing with their own mental health issues.

> "*I find joy in helping others in the group and that's great when you have mental health issues because it takes your focus away from your problems and onto something positive. …It's good for me to socialise and participate in meetings as it reinforces my abstinence and allows me to be around people on a similar path and journey.*" (Main facilitator, T1)

The above statement underlines "reciprocity" between the main facilitator and the group, and how the benefits of the DDA were mutual for both members and facilitators (Stratford et al., 2017).

F1 and co-founder of DDA UK explained that challenges for the future include having the capacity to develop a system of governance to monitor standards, train new facilitators and engage with more external services and the community on a local and national level:

> "*Despite demand, meetings need to be governed and overseen properly...More funding would allow us to train more facilitators. We'd also like professionals involved so members can be signposted to and from other services, such as housing, employment and so on. More funding would also mean more social outings out in the community helping to tackles the loneliness and isolation many dual diagnosis sufferers experience.*"

The Commissioner

The commissioner explained that DDA having been commissioned jointly by the drug and alcohol and mental health commissioners was a success in itself:

> "*There is a need for joined up working, people with multiple problems are let down by the system, they fall in between the gaps and their needs are not addressed. It is important that services and commissioners from different sectors work together*".

She supported the necessity of the group and regularly informs other services so that referrals to DDA can be made. She identified long-term sustainability as the main challenge for the future.

Summary, recommendations, and conclusions

The themes which emerged from the interviews with the DDA members converged with the accounts of the facilitators and the feedback from the overall group. The findings demonstrated that DDA was instrumental in achieving and maintaining sobriety as well as reducing psychiatric symptoms. Crucially, DDA was helpful for coping with a crisis and reduced suicidal ideation, providing a safety-net. This could potentially decrease the risk of avoidable deaths, in a context where services are stretched and access to treatment is limited (Drummond, 2017). The integrated approach, the 5 additional steps and the inclusive nature of the group, were regarded as the main strengths of DDA in comparison to other groups. The longitudinal approach showed that throughout a year, DDA offered continuity of care. Different aspects of the programme became important throughout the process of change. The safe and welcoming atmosphere of the group, as well as the lived experience, competence, compassion, and availability of the facilitators were crucial for ~~the~~ initial engagement and retention. Acceptance of self and of others, the development of a positive identity and the formation of a DDA social identity dominated the first stage of DDA attendance. These all led to increased self-esteem, renewed hope, and a stronger motivation to change. The acquisition of coping strategies and the experience of a spiritual dimension became more central during the second round of interviews. During this stage, the workbook was valued as a useful tool for reflection. Acquisition of new skills enhanced a sense of self-efficacy, which contributed to ~~the~~ progression in various areas of self-development, which enabled members to take on more responsibilities in and outside the group. Finally, the focus shifted from being inwardly centered at T1, to be focused on the group at T2, and then out to the family, friends, or wider community at T3. This was shown by the increased search for opportunities to engage with the external community.

The qualities of the main facilitator emerged as a contributing factor to the positive experience of the participants, this is in line with other studies showing the characteristics of the facilitator can influence the outcome of peer support groups (Griffith, *et al.*, 1998; Delisle, 2016). According to Repper and Carter (2011) people attending peer support groups view their facilitators as role models in recovery and gain ideas for sustained wellbeing. Hope is instilled when a person begins to entertain the belief that if the facilitators could achieve this role, so could they at some point.

Training, and standards for facilitators may prove useful for DDAUK to retain the benefits of facilitation without incurring the costs of inappropriate facilitator influence (Griffith et al., 1998).

Finally, DDAUK fits in well with the current UK NICE Guidelines on co-existing severe mental illness and substance misuse, which recommends that services should be "integrated, inclusive, and there when needed" (NICE, 2016). Crucially, DDA responds well to the UK Government's agenda of reducing loneliness and integrating vulnerable individuals back into society (HM Government, 2018). The DDA groups in Oregon demonstrate that its success can be sustained in a variety of settings and can provide support for thousands of people with concurrent disorders (Monica *et al.*, 2010). Roush (2008) also provides some valuable insight of the role that clinicians can have in initiating DDA programmes while maintaining a distant role, in line with the 8th traditions of AA and DDA which each state that groups; "should remain forever nonprofessional" (Alcoholics Anonymous World Services, 2003, p. 562; Dual Diagnosis Anonymous, 2020, p. 9). Nevertheless, given the complex needs of people with concurrent disorders, collaborating with external clinicians is vital, particularly when supporting individuals who have been affected by trauma. Commissioners and service providers also play a critical role in enabling access to DDA. As recommended by PHE (2014), "commissioners should develop a vision of recovery where mutual aid is fully integrated with alcohol and drug services, this will ensure that all staff are aware of the value and benefits of mutual aid and how it fits in with the local treatment offer". In case of concurrent disorders, joint working between mental health and addiction services commissioners is essential, DDA UK was made possible thanks to the effective joint commissioning from mental health and drug and alcohol services, and further funding is essential for DDAUK to continued growth.

There are several limitations to this study. Firstly, the sample size was small, however, retention in longitudinal studies with individuals with mental health and addiction disorders is challenging, in addition, being the first DDAUK pilot, the overall number of regular attendees was 30, hence the sample represented 20% of the group at the time of the interviews. Further, the diverse range of disorders included in the sample reflected the overall characteristics of the group. The inclusion of a carer could be considered inappropriate as family members normally do not sit in traditional AA meetings, however, DDA has proved to have a distinct identity, for example, the "extended family" of DDA Oregon encourages the participation of family, friends, important others and clinicians in various capacity (Monica *et al.*, 2010; Monica, n.d.), thus the authors thought that giving voice to this participant would provide an additional perspective. His experience showed

that DDAUK has the potential to support carers in their own right, even if the family member with "dual diagnosis" does not attend the meetings. Further studies with this specific group are needed to corroborate the encouraging results presented here. Future research should also assess the impact of service utilization and cost effectiveness of DDAUK. Both Drummond (2017) and Livingstone (2019) argue that closure and poor provision of substance misuse and mental health services, due to austerity measures from the Government, have contributed towards poor outcomes. Certainly, peer lead groups may at the very least offer continuity of care for individuals with complex needs. Finally, future research should further investigate the facilitator's influence on outcomes, criteria to identify and train new facilitators and mechanisms to assure fidelity in the implementation of the DDA programme.

In conclusion, despite these limitations, the present study contributes vital knowledge towards research surrounding independent peer support (Gillard, 2019; Pistrang, Barker, & Humphreys, 2008), especially in the context of concurrent disorders. The longitudinal aspect is a strength as it adds to the understanding of the process through which DDAUK can enable positive change in individuals with complex needs. On-going evaluation with a larger sample and objective measures are needed to corroborate and expand the present findings.

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