

Understanding How People With Mental Health  
Difficulties Experience Substance Use

## Abstract

### **Background**

Quantitative studies dominate research exploring reasons for substance use and experiences of substance use by people with mental health difficulties. This limits the depth of understanding which can be gained about these experiences.

### **Objectives**

In the present article we synthesized current qualitative research in this area to provide enhanced theoretical knowledge of these experiences.

### **Methods**

Following a systematic literature search, we identified 12 studies which explored how people with mental health difficulties experienced using substances, and which met additional inclusion criterion. We used Noblit and Hare's metaethnographic approach to qualitatively synthesize these studies.

### **Results**

Synthesis led to the development of two themes; 'substance use mediates acceptance and social inclusion' and 'substance use provides perceived opportunities for control and power'.

### **Conclusions/Importance**

The findings suggest that in the studies reviewed people's motivation for substance use was embedded in social and psychological contexts. It indicated that substance use could provide perceived benefits such as mediating the impact of mental health stigma, enabling the development of alternative identities, increasing their sense of power and providing opportunities for social inclusion. Mental health and substance use workers should therefore

aim to develop alternative opportunities for people with co-occurring disorders to gain such benefits, and seek to challenge mental health stigma.

*Keywords:* substance use, mental health, metaethnography, metasynthesis, service user experiences

## **Introduction**

Researchers have consistently reported that problematic illicit drug and alcohol use is more commonly experienced by people with mental health difficulties than those without (Merikangas et al., 1998; Regier et al., 1990). Hartz et al (2014) reported that people with 'severe psychotic disorders' were at increased risk for heavy alcohol use, heavy marijuana use and recreational drug use when compared to the general population. Furthermore, studies have reported that people with diagnoses of anxiety disorders, affective disorders and psychotic disorders are more than twice as likely to also experience alcohol and drug dependence (Merikangas et al., 2007; Kessler et al, 2005).

Researchers and clinicians have yet to agree how to define people with mental health difficulties who use substances (Guest & Holland, 2011). In this article we use the term 'co-occurring disorders' to refer to people with co-occurring mental illness and substance use problems and the term 'substances' to describe illicit drugs and alcohol. Consistent with the definition provided by the Department of Health, United Kingdom ([D.O.H.] 2002), we will conceptualize the experiences of co-occurring disorders as presenting on a continuum, ranging from people experiencing mild or moderate mental health difficulties (e.g. depression, anxiety) accompanied by recreational use of alcohol or illicit drugs, to people with severe mental health difficulties (e.g. psychosis, bipolar disorder) and substance misuse.

### **Service Provision for People With Co-occurring Disorders**

People with co-occurring disorders represent a significant proportion of people who require support from mental health and substance use services (Schulte & Holland, 2008; Weaver et al., 2003), and are significantly more likely to use crisis mental health services and to

experience poorer outcomes compared to those who do not use substances (Abou-Saleh, 2004; RachBeisel, Scott, & Dixon, 1999).

To improve outcomes and quality of life for these service users, health departments in the U.K. and U.S.A have emphasised “quality, patient focused and integrated care” (D.O.H, 2002, p.4) through effective psychological, medical and social interventions (Department of Health and Human Services, United States [DHHS], 2005; D.O.H., United Kingdom, 2002; National Health Service confederation [NHSC], 2009). Authors of clinical guidance indicate that to do this it is important to conduct comprehensive assessments of service users’ needs, including psychological factors such as motivations for change (Abou-Saleh, 2004; DHHS, 2005; Turning Point, 2007). People with co-occurring disorders report that they value feeling understood by staff, and prefer staff to seek holistic understandings of their difficulties, including their substance use (Hawkings, Gorry, Dodd, & King, 2011). Developing detailed understandings of how people with mental health difficulties experience substance use could therefore facilitate the provision of more effective and appropriate care.

### **Factors Which Contribute to Co-occurring Disorders**

Factors proposed as possible contributors to the development of co-occurring disorders include psychosocial risk factors, genetic difficulties, 'supersensitivity' to the effects of substances, and the presence of mental health difficulties itself causing or maintaining substance use. For a comprehensive review of explanatory models see Mueser, Drake and Wallach (1998) and Gregg, Barrowclough and Haddock (2007).

Research has also highlighted an association between stressful or traumatic life events, psychological distress and substance use (Nordfjærn, Hole, & Rundmo, 2010; Tate et al., 2008). For example, people who use substances have often experienced trauma (Darke,

2013; Peirce, Burke, Stoller, Neufeld, & Brooner, 2009; Peirce, Kolodner, Brooner, & Kidorf, 2011), and symptoms of psychological distress could act as a mediator between these traumatic life events and continued or increased substance use (Flynn, Walton, Curran, Blow, & Knutzen, 2004; Ullman, Peter-Hagene, Relyea, & Vasquez, 2013).

### **Motivations for Substance Use**

Clinical psychologists and motivational theorists have argued that as with people who do not have mental health difficulties, people with co-occurring disorders make decisions about substance use based upon individual subjective motivations. These could include the perceived advantages and disadvantages of use and abstinence, which could be influenced by internal psychological processes, social attitudes and past experiences. Motivational factors can fluctuate according to context, and be affected by personality characteristics such as impulsivity. It is argued that clinicians should therefore seek to explore motivational factors with service users on individual bases to develop their understanding of the association with mental health difficulties (Kavanagh & Connolly, 2007).

Studies in this area have predominantly employed quantitative methods to explore self-reported motivations for substance use, and have suggested that people with co-occurring disorders use substances for inebriation, to moderate mood, manage psychotic symptoms, enhance energy levels, for social reasons, and to manage side effects of medication (Bizzarri et al., 2007; Gregg et al., 2007; Kolliakou et al., 2011).

Research has explored self-reported reasons for substance use by asking open questions within largely quantitative questionnaires. However the methodological quality of this literature has been criticized as having unclear methodologies, and small sample sizes (Green, Kavanagh, & Young, 2004; Kolliakou, Joseph, Ismail, Atakan, & Murray, 2011).

Most research has therefore provided limited opportunities to develop detailed understandings of service users' reasons for substance use. More recently however, some studies have employed qualitative methodologies as their primary tool to explore self-reported reasons for substance use.

Our article aims to highlight and synthesise the qualitative literature to date which has explored experiences of substance use by people with mental health difficulties. Our aim is to develop clinicians' understanding of the role of substance use in relation to the experience of being an individual with mental health difficulties. The research question was defined as 'how do people with mental health difficulties experience using substances?'

## **Method**

### **Sample**

We systematically searched all major relevant bibliographic databases including Allied and Complimentary Medicine (Amed), Cumulative Index to Nursing and Allied Health (CINAHL), Medline, PsychINFO, Pubmed, Social Care Institute for Excellence (SCIE) and Web of Science using combinations of the terms qualitative, dual diagnosis, substance and substance related terms (such as addiction, cannabis, cocaine) with terms concerned with mental health difficulties (such as mental health, anxiety, schizophrenia). We applied limits of 'peer reviewed academic journal' and 'English language' articles to searches. The first author identified articles which were appropriate based on their title, then reviewed the abstracts, followed by the full articles if relevant. We also searched the reference sections of articles which were retrieved in full text to identify further studies.

### **Inclusion criteria**

We identified articles as appropriate if they qualitatively explored how people with mental

health difficulties perceived using substances. Articles were required to state that all participants experienced a mental health difficulty and previous or current substance use. Where articles contained mixed quantitative and qualitative methods, relevant qualitative elements were extracted and included in the review. Articles were excluded if their data source was solely questionnaires, if they focused on experiences of abstinence from substance use (see figure 1), or if the data analysis strategy chosen was limited in depth (e.g. content analysis, where results consisted of categorised themes without interpretative analysis).

INSERT FIGURE1 ABOUT HERE

#### **Quality assessment procedure**

We used the Critical Appraisal Skills Program (CASP; Critical Appraisal Skills Program, 2010), a checklist consisting of two screening questions and eight detailed questions which enables researchers to systematically evaluate qualitative research. The questions were as follows; 'was there a clear statement of the aims of the research?', 'is a qualitative methodology appropriate', 'was the research design appropriate to address the aims of the research?', 'was the recruitment strategy appropriate to the aims of the research?', 'were the data collected in a way that addressed the research issue?', 'has the relationship between researcher and participants been adequately considered?', 'have ethical issues been taken into consideration?', 'was the data analysis sufficiently rigorous?', 'is there a clear statement of findings?' and 'how valuable is the research?'. Similar to a previous metasynthesis (Duggleby et al., 2010), studies were rated out of three for each of the eight questions. Studies were given a score of one if there was little evidence or limited detail in the article to suggest how this aspect had been addressed, a score of two if an article described some discussion of the



issue, but there were noticeable absences of one or more aspects, and a score of three if studies had thoroughly considered this aspect and provided detailed discussion.

### **Analysis**

Studies included in the review were synthesized using an interpretative metaethnographic approach (Noblit & Hare, 1988). This approach allows researchers to interpretatively analyze concepts identified in studies to reveal higher order theoretical concepts creating novel insights into the topic being studied. Data synthesis followed the procedure exemplified by Britten et al. (2002) which involves the following seven steps; getting started, deciding what is relevant to initial interest, reading the studies, determining how the studies are related, translating the studies into one another, synthesizing translations and expressing the synthesis. 'Getting started' involved identifying a research question relevant to previous explorations in this area. In the second step we defined the purpose of the synthesis, designed inclusion criteria and assessed the quality of data. In the third step the first author read and reread articles included in the review to identify interpretative metaphors and concepts. In the fourth step of 'determining how the studies were related' the first author examined the data set searching for recurring concepts or themes, and subsequently arranged these concepts into juxtaposing lists to enable comparisons to be made and to understand relationships between them. The fifth step required the first author to 'translate the accounts into one another'. This involved comparing metaphors and concepts in each article with one another to build lines of arguments or 'second order' constructs. In the sixth stage the first author compared and synthesized second order interpretations to develop third order interpretations of the data set. It was not possible for multiple researchers to independently develop interpretations; however the first author discussed these themes with the second author to improve reliability.

## Results

### Sample

Twelve qualitative studies were included in the review, all of which were published between 2008 and 2012. Several pre-2008 studies were also found but were excluded as they did not meet other criteria. Reviewers did not screen or exclude based upon the year of publication.

The included articles consisted of 195 participants' experiences (see tables 1 and 2).

Interviews were used as a source of data in all studies, and one also conducted a focus group (Cornford, Umeh and Manshani, 2012). Studies were located in the UK, Canada, Australia, Sweden and the USA. Themes appeared to be consistent across cultures, although it is likely that cultural differences would be difficult to ascertain due to the variety of locations and small sample size.

INSERT TABLE 1 ABOUT HERE

### Findings

Through analysis two distinct themes emerged; 'substance use influenced social acceptance and inclusion' and 'substance use provided perceived opportunities for control and power'.

The former of these themes contained three related sub themes; 'participants sought normality and inclusion', 'reconstructing spoiled identities' and 'feeling rejected from wider society'.

**Substance use influenced social acceptance and inclusion.** This theme described how studies reported that participants with mental health problems had often felt excluded from social groups. Substance use provided them with opportunities to be accepted and to feel socially included by other people who used substances, although it also could diminish their experience of social inclusion in non-substance using communities. Some participants found that substance use provided social opportunities prior to the development of mental

health difficulties, whereas others found substance use played this role after their mental health difficulties had begun.

***Participants sought normality and inclusion.*** Researchers from many studies reported that numerous participants described feeling ‘different’ because of their mental health difficulties, and excluded from normal daily activities such as employment and relationships. Asher and Gask (2010) described how “most participants said they felt somewhat outside of society” (p. 99). Similarly Cruce, Öjehagen and Nordström (2008) reported, “As consequences of a psychotic illness, some [participants] suffered from a deep existential feeling of loneliness, a feeling of rejection” (p. 235). Several studies reported that large proportions of participants found that having mental health difficulties made it challenging for them to socialize with others to overcome these feelings of rejection and exclusion. For example, Asher and Gask (2010) reported that “All [participants] had persistent difficulties with social interaction. Reasons included being distracted by hearing voices or experiences of their thoughts being interfered with, having lack of drive to socialize, anxiety, or low/irritable mood” (p.98). These participants' symptoms and limited social skills therefore caused them to feel isolated and stigmatised. Brown and Stewart (2008) described, “Descriptions of depression were characterized by a profound sense of hopelessness (. . .) isolation and self-contempt” (p. 37).

In response to this, participants in most studies sought a feeling of being ‘normal’, and of acceptance from others which was provided through substance use. Healey et al. (2009) reported that patients used substances, “because they had an overriding desire to feel normal without the sedative effects of medication or to recapture how they used to feel before the diagnosis of bipolar disorder” (p. 122). Researchers in many studies reported that participants

initially experienced using substances as increasing their desire and ability to socialize with others which they viewed as a 'normal' activity. Healey et al. (2009) reported, "Another way of feeling normal through substance use was being able to mix and socialize with other people" (p. 122).

Some participants also reported that they felt more 'normal' and less stigmatized when they socialized within groups of substance-users because they perceived people who used substances as more understanding of unusual experiences, as they had observed similar altered perceptual states through substance use. Asher and Gask (2010) explained, "[Substance using] peers were more tolerant of unusual experiences as [they] might be explained away as being due to substance use" (p. 99). Researchers across most of studies reported that participants often achieved a sense of feeling accepted within communities where substance use was common because of the combination of these factors and of having a common shared interest (substance use). Lobbana et al. (2010) described a theme within their study where there was "a perception of shared experience and membership that is reinforced as relationships and networks grow around drug communities" (p. 1144). In contrast to this, Cornford et al. (2012) (who explored heroin users' experiences) reported, "The majority of respondents thought there were few meaningful friends for drug addicts—only drug acquaintances who did not care" (p. 589). This suggests that some participants viewed their contacts with others as revolving around substance use, rather than being loyal friends.

***Reconstructing spoiled identities.*** Authors in some studies described how significant proportions of participants reported that substance use provided them with an alternative identity to their dominating 'spoiled identity' associated with their mental health status. A

'spoiled identity' is a concept referred to by Goffman (1990) which means that a person who is identified as having a particularly characteristic which is linked to negative stereotypes (such as having mental health problems) can experience stigma which prevents the stigmatised individual from being fully socially accepted amongst other people. In the present review, alternative identities to 'spoiled identities' were created through developing alternative social contexts and experiences through substance use. Cruce et al. (2008) commented, "Most participants considered the identity as an addict more preferable than the identity of being mentally ill" (p. 234). Similarly Thornton, Baker, Johnson, Kay-Lambkin and Lewin (2012) reported that using cannabis "gave [participants] to be a part of a subculture of society, and one that was not related to their mental illness" (p. 285).

Authors of several studies reported that some participants viewed having an identity based on substance use as appealing, and as associated with social status developed through gaining knowledge and experience of substance use. Childs (2011) reported, "For some people, the 'cannabis culture' seemed attractive and exciting and provided a desirable identity" (p.706). Charles and Weaver (2010) described this as a barrier to abstinence from substances; "Social factors sustaining drug use included the sense of identity and social status it conveyed" (p. 104). Some studies reported that the status and knowledge participants gained from developing this identity led to increased self-esteem. Asher and Gask (2010) explained, "the activity of substance use was often acquired in youth and developed with increasing knowledge and skill over time, providing a sense of identity, a social activity and enhanced self-esteem through mastery of a subject" (p. 96).

*Feeling rejected from wider society.* Although authors of many studies reported that participants felt more accepted within substance using communities, some of these

researchers also described participants simultaneously experienced feeling more rejected and ostracized from wider society and communities where substance use was uncommon. For example studies reported participants felt rejected by close friends and family, and more excluded from wider social structures they already felt separate from (such as employment). Brown and Stewart (2008) described how alcohol use by women “often [contributed] to the loss of children and other relationships” (p. 43). Cruce et al. (2008) stated, “[Substance misuse] together with difficulties due to their mental illness led to exclusion from the labor market” (p. 236).

Consequently, although participants in many studies experienced feeling socially accepted by substance use communities (and experienced the feelings of safety, increased self-esteem and confidence which accompanied this acceptance), for many participants this was conditional depending on continued substance use, and varied according to whether they perceived fellow substance users as good friends or acquaintances. Authors of some studies reported that participants were therefore fearful of abstinence, because they feared this would lead to rejection from their substance-using peer group. As Lobbana et al. (2010) described, participants in this study experienced an “increased sense of detachment from non-drug using networks and related fear of isolation should existing group membership be severed” (p. 1144). Similarly Cornford et al. (2012) reported that “a lack of meaningful relationships with people both contributed to depression and made it difficult to stop drug taking” (p. 589).

**Substance use provided perceived opportunities for control and power.** The second theme described many participants’ experiences that substance use provided perceived opportunities for them to gain control and power over their lives. Participants in most studies described experiencing situations where they had limited control, such as over their

experience of mental health difficulties, their access to support, or by being subject to abuse. Cruce et al. (2008) reported that “Psychotic symptoms gave [participants] a feeling of insufficient control over themselves, their identity, experiences and ability” (p. 232). Many studies reported that for participants, using substances enabled them to exert control over their distress, unusual experiences or mood, or to provide control by “numbing them from overwhelmingly painful emotions that they often felt powerless to change” (Brown and Stewart, 2008; p. 36).

Authors from most studies reported that substances enabled participants to exert control over symptoms associated with mental health difficulties to achieve a more normal or preferred state. Costain (2008) reported that “Cannabis then gave [participants] them strength to control the voices” (p. 230). Authors gave examples that participants used substances to reduce unusual experiences, stress, anxiety, or distress associated with these states, and moderate mood (by raising low mood or maintaining elevated mood).

Many studies reported that participants also reported that substances enabled them to alter physical sensations or induce desired physical states, for example they were used to increase energy levels, to help them to relax or sleep, and to reduce side effects of medications such as stiffness in their limbs. Asher and Gask (2010) described how “Almost all [participants] described using substances to treat mood, sleep, appetite or anxiety problems” (p. 103).

Studies reported that participants developed a sense of control over their experiences as their ability to use substances to effectively meet their needs developed. However some studies described that the amount of control participants’ perceived to have through substance use varied according to individuals and contexts. For example, participants in some studies

who reported mostly using substances confidently also said that it was not possible to control or predict the consequences of substances at all times, and that they could unintentionally experience undesirable consequences, including a loss of control when they became dependent on substances (Cruce et al., 2008). These included external consequences such as legal reprisals, and the impact of substance use on their relationships and their physical health. For some this could have a negative effect on psychological wellbeing. Brown and Stewart (2008) described,

[Alcohol use] was an imperfect method in the long term, often contributing to the loss of children and other relationships, isolation, poverty and unemployment, risk of sexual assault, and, ultimately, even more severe depression.(Brown & Stewart, 2008, p. 43)

This theme therefore suggests that participants from many studies experienced that using substances provided opportunities for control and empowerment, but the extent to which this was possible varied across contexts.

### **Discussion**

The reported findings suggest that having mental health difficulties can be an alienating experience. They indicate that using substances can provide opportunities to overcome these feelings of alienation by increasing perceptions of social acceptance and abilities to control experiences associated with mental health difficulties.

The first theme ('substance use influenced social acceptance and inclusion') suggested that some participants experienced feeling excluded, isolated and rejected from society because of their mental health difficulties. Over the past few decades, significant changes have been made to the ways in which people with mental difficulties are treated in many



countries, including the USA and the UK. For example, it is now widely recognised that people with mental health difficulties should be provided with support and treatment (medication and talking therapies) within their own communities wherever possible, rather than confined to institutions for long periods of time. There have also been campaigns to promote mental health difficulties (particularly anxiety and depression) as common illnesses experienced by many people (for example 'Time to Change' campaign against mental health stigma in the UK). However, people with mental health difficulties are often perceived by the public as being violent, dangerous, and peculiar (Angermeyer & Dietrich, 2006; Jorm, Reavley, & Ross, 2012) which can result in discrimination, stigmatisation and exclusion (Sharac, Mccrone, Clement, & Thornicroft, 2010) and can reduce individuals' self-esteem (Ilic et al., 2011). This can impact on individuals' ability to recover from co-occurring disorders as feeling socially included is central to this process (Slade, 2010; Tew et al., 2012).

Participants experienced substance use as providing opportunities for social acceptance and inclusion within subcultures of substance users, in a world where they often felt excluded and rejected because of their mental health difficulties and their subsequent 'spoiled identity'. However, substance use itself could also lead to feelings of rejection from family and non-drug using communities. This suggests that participants experienced both mental health and substance use identities as stigmatising, but participants appeared to understand a substance use identity as less stigmatising due to the immediate benefits it could provide within specific subcultures.

Researchers have identified that developing valued 'positive' personal and social identities and overcoming stigma are important elements of recovering from mental health difficulties (Slade, 2010; Tew et al., 2012). In his description of social identity theory, Tajfel

(1982) suggests that people's membership of particular groups (such as 'people with mental health difficulties') contributes to their self-concepts. He suggests that if membership to a particular group impacts positively on people's self-esteem, their identification with this group intensifies (Tajfel, 1982). However if their membership to a particular group does not impact positively on their self-esteem, they might seek to disaffiliate with this group. In the present article, this might suggest that participants sought to affiliate less with the group 'people with mental health difficulties' and more with the group 'substance users' because although both could have a negative impact on self esteem via public stigma, the 'substance user' identity had additional potential benefits of increased self-esteem and association with social status within their substance-using communities.

The second theme described how participants experienced diminished power and control in their lives and used substances to regain this control. People with mental health difficulties can often experience being in marginalized, powerless and controlled positions within society (Christens, 2012). Indeed, those in the most powerless positions in society are most likely to experience psychological distress because of exposure to trauma, such as poverty, racism, sexism and violence (Christens, 2012). This sense of powerlessness can be exacerbated by subsequent experiences of stigma toward mental health difficulties and by being enveloped by a psychiatric system which can be experienced as removing control and self-determination (Christens, 2012; Shattell, Andes, & Thomas, 2008; Walsh & Boyle, 2009).

According to learned helplessness theory, people who experience uncontrollable events can develop beliefs that they are powerless to influence these, which can lead to reduced investment in attempts to exert control over aspects of their life they have previously

experienced as uncontrollable, an increased sense of powerlessness and consequential low mood (Seligman, 1972). Furthermore, people can generalize their experience of perceived helplessness to other aspects of their lives (such as relationships and employment).

In the present metasynthesis, many participants reported experiencing a lack of control and helplessness because of their mental health difficulties, and using substances provided an opportunity to counteract these experiences by controlling their emotional and physical states. When this was effective it was experienced as leading to increased psychological wellbeing and self-esteem. However when participants experienced a loss of control over their substance use, this could cause them to feel powerless in other areas of their lives, as their continued substance use impacted upon these (such as family relationships and friendships, and involvement with criminal justice systems). Therefore although substances provided some opportunity for power and control with participants' lives, this was limited. Researchers have argued that to increase powerfulness and control for people with mental health difficulties, and thus promote recovery, interventions aimed at empowering service users should be used at many levels of systems, rather than simply on an individual level (Christens, 2012; Fitzsimons & Fuller, 2002). This highlights the importance of providing community and system level empowerment opportunities rather than solely relying on people to source their own individual methods of empowerment (such as substance using). Local communities and services would be best placed to identify what the most appropriate opportunities for doing this could be, but it could include strategies such as involving service users in decisions about their own care, in designing and running services, and in developing and running leisure and support services within their community.

### **Limitations**

One weakness of this study was that only the first author reviewed bibliographic search results to identify appropriate studies, which could increase the subjectivity of the review. However, where there were ambiguities about including specific studies this was discussed with the second author to reach consensus. Our use of CASP criteria could be criticised as no studies were excluded on the basis of their score. Our review aimed to capture the breadth of experience in this area therefore we considered that excluding studies in such a small sample size would reduce opportunities for developing an understanding of people's experiences.

### **Implications**

Findings from this review suggested that people's motivations to use substances incorporate experiences of their social contexts and complex psychological processes which occur as a response to these. It suggests that using substances can have a number of indirect influences on psychological wellbeing such as mediating the impact of stigma, enabling the development of alternative identities, increasing their sense of power and providing opportunities for social inclusion. However using substances was an imperfect strategy for achieving these goals. This suggests that mental health and substance use workers should aim to develop alternative opportunities for people with co-occurring disorders to achieve these benefits. For example, services could increase opportunities for users to develop and explore identities which are separate to both their mental health difficulties and their substance use, possibly through positive psychology approaches, solution focused brief therapy or narrative therapy. The aim of these approaches is to support people to build alternative (positive) identities or 'narratives' about their lives, by recognising positive qualities (e.g. skills, personality characteristics, and coping strategies) rather than solely focusing on repairing difficulties, such as those involving mental health and substance use which could exacerbate

the sense of having a 'spoiled identity' (Seligman & Csikszentmihalyi, 2000, p. 5). This review also highlights the ongoing need to reduce stigma toward people with mental health difficulties.

### **Future Research**

The findings of this review illustrate the complex role of stigma in experiences of people with co-occurring disorders. It would be helpful to gain a better understanding of this interaction, specifically the roles of self-stigma and public stigma for these service users. It would also be beneficial to conduct additional research into the use of resource based approaches to explore the potential usefulness of these approaches in enabling individuals' recoveries.

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