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The effectiveness of a psycho education programme for individuals suffering from dual diagnosis

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DECLARATION

I, Sarah Jean Lamont declare that this researcher report is my own. It is being submitted for the degree of Masters of Science in Occupational Therapy in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University

Researcher's Signature

.....

..... day of, 2011

DEDICATION

With many thanks and love to my husband, parents, family and friends for all their love, support and encouragement throughout my studies. It has all been appreciated and fundamental in what I have achieved.

And to my late grandfather, Dr Alastair M. Lamont whose brilliance has been my inspiration.

PRESENTATION FROM THIS STUDY

This research was presented at the World Association of Social Psychiatry (WASP) Conference held in Johannesburg 22-26 March 2004.

Title of presentation:

THE EFFECTIVENESS OF A PSYCHO EDUCATION PROGRAMME FOR
INDIVIDUALS SUFFERING FROM DUAL DIAGNOSIS.

ABSTRACT

This research report discusses the findings of a qualitative study conducted with individuals suffering from dual diagnosis hospitalised at Sterkfontein Hospital. The study was motivated by the need to improve the level of insight in these individuals in the perception that this would improve their prognosis and reduce service utilisation. The aim was to explore the participants' perceptions of a group psycho education programme to establish factors that they perceived as effective in meeting their needs and improving insight. This study used an investigative methodology, incorporating purposive sampling, and priori coding to interpret and analyse the data. The themes that emerged were, "Motivation to Attend the Programme", and "How did the Groups Help Me to Change?", and concluded that the participants experienced the programme as beneficial. The factors that they perceived as significant were identified to assist in the establishment of an effective group psycho education programme for individuals suffering from dual diagnosis, and in bridging the reported gap between the psychiatric and substance abuse treatment approaches.

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NOMENCLATURE

DEFINITION OF KEY TERMS

The following terms have specific relevance to this research and are used as follows in the context of this work.

Dual Diagnosis/Co morbidity: describes when an individual has a substance use disorder that coexists with an axis I and/or axis II psychiatric illness. ^(1, 2)

The Medical Model of Addiction: describes loss of control over the use of a drug, which infers a sense of helplessness for which the abstinence-based method of treatment for the addiction is the dominant form of clinical intervention. ^(3, 4, 5) This is also referred to as the psychiatric or disease model for addiction.

The Psychiatric Treatment Approach: describes the treatment of the Axis 1 and/or 2 diagnoses through use of medication and traditional treatment regimes, which could include the use of addictive medication, especially in the treatment of depression, anxiety disorders and sleep disorders. ^(1, 2)

The Substance Abuse Treatment Approach: describes the individual's identification of his/her addiction and the acceptance of them being an addict, through the 12-step programme, differing in the belief that this is achieved through a self-reflective programme, and the use of medication is traditionally avoided. ^(3, 4, 5)

Intellectual Insight: describes improved self-knowledge without the corresponding change in behaviour. ⁽⁶⁾

Affective Insight: describes the change in behaviour following a growth in intellectual insight. ⁽⁶⁾

CHAPTER 1

INTRODUCTION TO STUDY

1.1 BACKGROUND TO STUDY

In the population seeking help from the South African public mental health service the number of Mental Health Care Users (MHCUs) diagnosed with a major psychiatric disorder with a co morbid substance use/ abuse disorder or dual diagnosis has increased substantially in the last decade.⁽⁷⁾ Although no figures are available for South Africa, according to the USA's Drug and Alcohol Information Service (DASIS) Report noted an increase from 12-16% of MHCUs with this diagnosis between 19995 and 2001.⁽⁸⁾ This group of MHCUs represent a considerable challenge to Mental Health Care Providers (MHCPs) to ensure appropriate care for the complex and sometimes conflicting needs of these users.

Literature describes dual diagnosis as the relationship that exists between psychiatric illness and substance abuse^(2, 3) and that a substance use disorder may coexist with an axis I and or II psychiatric illness.^(2, 3) Dual diagnosis is a relatively new term⁽⁷⁾ that conceptualises a new approach to the management of MHCUs with this complex problem. However, in spite of acknowledging this relationship, current treatment interventions by all members of the psychiatric multi-disciplinary team, including the occupational therapist^(2, 3) has failed to satisfactorily address the complicated problems that a dual diagnosis proposes.

It has been observed by the multi-disciplinary team at Sterkfontein Hospital responsible for the care of MHCUs with dual diagnosis that the current treatment offered does not take cognisance of both the treatment regimes of the psychiatric treatment approach and that of substance abuse sufficiently to be effective. Thus the treatment of MHCUs suffering from dual diagnosis continues to be 'split' despite substance use disorders being considered a psychiatric problem, MHCUs have been treated for their psychiatric symptoms within Sterkfontein Hospital, and then referred to a substance abuse treatment facility for the treatment of their substance use disorder.^(2, 3)

In spite of occupational therapy philosophy advocating for a holistic approach being used in the treatment of all patients the occupational therapy delivered to these MHCUs fall short in the holistic approach that occupational therapy proposes.⁽⁹⁾

This lack of integration in treatment fails to allow the MHCUs to develop insight into how both their disorders are linked and can exacerbate each other, in that their use of substances to alleviate their psychiatric symptoms exacerbates their psychiatric illness and in turn increases their need for the use of their substances. The psychiatric approach used at Sterkfontein Hospital focuses on the medical approach to alleviate the symptoms of the psychiatric illness and occupational performance, whereas the substance abuse approach used in the substance use facilities focuses on supportive treatment, and often requires the MHCU to stop their psychiatric treatment in adherence to the 12-step programme.^(2, 3) As a result treatment is not only 'split' but is also conflicting and fails to develop insight through psycho education into the co existence of both disorders, leaving the MHCUs to continue to perceive their co existing illnesses as separate. Thus they remain unaware of how their dual conditions negatively impacts on their occupational performance and of the specific steps required in managing their co-existing illnesses thus improving their overall occupational functioning.^(2, 3, 9) This lack of intellectual insight results in a more severe course of both their psychiatric and substance abuse disorders and a poorer occupational outcome in both the short and longer term. Reduced emotional insight prevents the necessary changes in the individuals' behaviour from being made resulting in multiple admissions to hospital thus removing them from their home and work environments for long periods of time, resulting in them experiencing a decrease in quality of life, and a poorer prognosis both medically and in occupational performance terms.^(2, 3, 9, 10)

This reduced treatment outcome impacts negatively on the MHCUs and their families as with a poor level of insight into their dual diagnosis, both parties are left not understanding the increased financial implications due to ongoing treatment, loss of productivity, as well as the social implications, resulting in the feelings of resentment and thus poorer compliance to treatment. This in turn results in an increase in service utilisation resulting in increased service costs, as admissions are more frequent and often longer as well as the investment of social support for the MHCUs and their families after discharge due to the poor prognosis of the MHCUs.^(2, 3, 9, 10)

1.2 STATEMENT OF THE PROBLEM

Occupational therapists in their treatment of MHCUs with substance use disorders and other major psychiatric conditions rate the development of insight, into their diagnoses and resultant occupational dysfunction, as an important treatment aim and frequently use psycho education groups as the treatment modality to achieve this. The current occupational therapy programme offered to MHCUs with dual diagnosis at Sterfontein Hospital was not considered to be effective as it was not holistic in that an integrated approach to the two conditions was not utilised and therefore the impact of both conditions was not fully considered when trying to improve the occupational performance capacity of these users.

Although there is considerable professional literature on group work and psycho education, occupational therapy literature that justifies the effectiveness of psycho education groups as a treatment modality that positively impacts on the occupational outcome of MHCUs suffering from dual diagnosis could not be found. There is also no literature that describes what the content of such groups should contain or which group work techniques should be used.

1.3 THE PURPOSE OF THIS STUDY

The purpose of this study was therefore twofold:

- Firstly in light of the lack of previous research that relates to the delivery of a group work occupational therapy focussed psycho education for MHCUs with dual diagnosis, a qualitative research design was used to designed psycho education groups that would be included in the occupational therapy programme for MHCUs with dual diagnosis and
- Secondly a qualitative study was used to evaluate whether the group programme that was designed would be useful to bridge the gap in addressing the insight, and stated needs of those users suffering from dual diagnosis being treated at Sterkfontein Hospital in Krugersdorp, South Africa.

1.4 THE AIM OF THIS STUDY

Thus the aim of this study was to develop a series of occupational therapy psycho education groups aimed to integrate both the treatment models of psychiatric disorder and substance abuse, then for these groups to be evaluated by MHCUs suffering from dual diagnosis in terms of whether they contributed to participants achieving insight into both their disorders, and increasing their awareness of the steps they needed to take to manage both their conditions and improve their occupational performance.

1.5 THE OBJECTIVES OF THIS STUDY

To achieve the above stated purpose and aim the study had the following objectives:

- o To design an occupational therapy group psycho education programme from the expressed needs of MHCUs diagnosed with dual diagnosis.
- o For MHCUs diagnosed with dual diagnosis to evaluate the newly developed occupational therapy group psycho education programme that would be offered as a component of the occupational therapy programme by:
 - o Determining the factors inherent in the group process that the participants identified as effective or non-effective for improving insight in a group occupational therapy psycho education programme specifically designed for MHCUs with dual diagnosis.
 - o Exploring if the participants perceived improvement of insight into their illnesses contributed to their awareness of the steps required to be taken to manage both conditions contributing to their dual diagnosis.

1.6 JUSTIFICATION OF THIS STUDY

The study, with the help of the participants, will enable the researcher to describe the development and evaluation of an occupational therapy group psycho education programme which has been specifically designed to improve the insight of MHCUs with dual diagnosis. As there was limited literature on occupational therapy group psycho education programmes for MHCUs with a dual diagnosis the perspectives of the participants were important for this study, thus qualitative research was selected. This group psycho education programme will attempt to integrate both the treatment approaches of psychiatric disorder and substance abuse into the group process so that the psycho education program outcome will be for participants to have raised their

level of knowledge and awareness of what they need to do to manage their psychiatric condition as well as their substance use problem thus contributing to improving their ability to live effectively in the community, to be activities healthy and thus improve their quality of life. ⁽⁹⁾

While this research aims to describe an occupational therapy group psycho education programme developed for the dual diagnosis users being treated at Sterkfontein Hospital, the protocols can be adapted to the treatment of users in other contexts in South Africa.

It is hoped that this research will also describe how occupational therapists can incorporate psycho education groups into their treatment programs for MHCUs with dual diagnosis, and what group work factors users perceive as valuable in assisting them in meeting their needs, and to gain insight.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This study aimed to investigate whether a series of occupational therapy psycho education groups, integrating both the treatment approaches of psychiatric disease and substance abuse, would be useful to bridge the gap in the current treatment when addressing the needs of MHCUs suffering from dual diagnosis.

National and international literature in books and journals published in the last twenty years was reviewed on the following topics: occupational therapy groups and group programmes for mental health care users, dual diagnosis and the treatment, psycho education, insight and group programme development to inform this study.

In the literature reviewed no studies were found on occupational therapy psycho education programmes for MHCUs with dual diagnosis, therefore related international and national topics were reviewed with the following purposes in mind:

- The first was to establish the complexities of MHCUs suffering from dual diagnosis and the contribution an occupational therapist can make to improve the insight of this cohort of users.
- The usefulness of a psycho education programme in improving insight for this cohort of MHCUs
- Group psycho education for MHCUs with dual diagnosis as a component of their occupational therapy.
- The development of a psycho and evaluation of an occupational therapy group treatment programme.

2.2 COMPLEXITIES OF MANAGING MHCUs WITH DUAL DIAGNOSIS

2.2.1 PREVALENCE

A high prevalence of co morbidity between drug use and other mental health problems among individuals of all ages has been noted.^(7, 10) The prevalence rate of alcoholics and drug addicts in medical and psychiatric practices range from 25% to 80%.^(2, 3) Studies conducted in the USA cited by Dackis and Gold in Doweiko included the

research by Galanter, and Kluber which demonstrated that approximately 30% to 50% of psychiatric patients have concurrent problems with alcohol or drug use^(3, 11), while Kessler, McGonagle, Zhao, Nelson, Hughes, Eshleman, Wittchen and Kendler showed that 26.6% of the normal population suffer from substance use disorders.^(3, 12) These figures are similar to the findings by Mirin and Weiss, included in Dackis and Gold in Doweiko, who concluded that 40% of a mixed group of substance abusers had concurrent psychiatric diagnoses while only 21.4% of the normal population^(3, 13) had substance use problems, which is slightly lower than the figures found by Kessler et al that reflected 26.6%.⁽¹²⁾ Dackis and Gold also referred to studies of Regier, Famer, and Rae in 1990 which concluded that mental disorders increase the lifetime prevalence odds for any substance use disorder to 2.7 times above the normal risk values, and up to 10 to 20 times when the psychiatric diagnosis is schizophrenia or bipolar mood disorder, manic episode.^(3, 14) These figures have been reviewed by Miller, included in Dackis and Gold in Doweiko, who demonstrated the following rates of dual diagnosis in various psychiatric disorders: 80% in individuals with antisocial personality disorders, 50% in individuals with bipolar disorder and schizophrenia, 30% in individuals with depressive and anxiety disorder.^(3, 15) These prevalence rates are consistent with more recent studies completed in the late 1990s.^(3, 16, 17)

2.2.2 REASONS FOR THE HIGHER PREVALENCE RATES

Psychiatric and dual diagnosis literature, ascribing reasons for the high prevalence of substance use disorders in psychiatric populations, as compared in the general population, are contradictory. Some research suggests that individuals suffering from psychiatric disorders use substances in an attempt to self-medicate and alleviate the distressing symptoms and consequences that psychiatric illnesses such as anxiety and mood disorders produce.^(15, 18) Other research suggests the opposite, proposing that substance use can lead to symptoms of psychiatric illness, namely anxiety and depression. Thus the reasons are complex and multidimensional and it seems that either of these scenarios may apply in specific individuals, and that substance use and psychiatric illnesses are mutually interactive in an individual MHCU, so that each exacerbates the other.⁽¹⁸⁾ Lack of intellectual insight would prevent the individual MHCU from appreciating this relationship and therefore results in a higher, than commonly appreciated, prevalence of dual diagnosis namely substance use disorders

in individuals suffering from psychiatric illness, and a negative impact on their occupational performance.^(9, 18)

2.2.3 GAP IN THE SYSTEM

In spite of dual diagnosis having a higher prevalence, it has been reported that health care providers, including occupational therapists, do not adequately identify or refer MHCUs needing intervention for alcohol and drug addiction.⁽¹⁵⁾ Considering the high prevalence of substance use, it is ironic that although screening for substance use is both simple and effective, implementation of such screening or intervention programmes within psychiatric and other health care institutions is relatively limited.⁽¹⁵⁾

It may be argued that MHCUs suffering from dual diagnosis represent a challenge to treating health professionals, as according to Nathan, it is necessary for a MHCU to be drug-free for a period of 4 to 6 weeks before an accurate diagnosis of the primary psychiatric dysfunction can be made which would be a costly and an unacceptably long time delay in treatment facilities.^(19, 20)

Such MHCUs have been described as the 'hidden victims of drug dependency'.⁽¹⁹⁾ One reason why they remain hidden is that health care providers are often not trained to detect substance abuse problems, especially in the mentally ill. Further, dual diagnosis MHCUs are heterogeneous in terms of psychiatric diagnosis, the substances they abuse, and the impact that these have had on their lives. Therefore the lack of a formalised or structured pattern to identify dual diagnosis results in mental health professionals failing to recognise the possibility that a mentally ill user may also be suffering from a co morbid substance abuse problem.^(19, 21) Furthermore, MHCUs are often unable to discuss their chemical use as a result of their psychiatric problems. The MHCU suffering from schizophrenia may be too disorganised to describe their chemical use, whilst those suffering from paranoia or a phobia may be unwilling to disclose essential information on their coping mechanisms for drug-related anxiety.⁽¹⁹⁾ A lack of intellectual insight into their condition, and thus their inability to make the connection between the two disorders, may further prevent MHCUs from disclosing the relevant information necessary to make an accurate diagnosis and assessment of the causes of occupational dysfunction in the MHCU.

Perkel describes this inability to clearly identify MHCUs with dual diagnosis as the gap in the system. ⁽²⁾ The existence of this gap is supported by Nathan who cited studies by Ananth, Wandewater and Kamal who examined a sample of psychiatric subjects, each of whom had been seen and diagnosed by mental health professionals on admission to a psychiatric treatment centre. None of the subjects selected for the study had been diagnosed as having an alcohol or drug abuse problems. However the results from the study concluded that 54 of the 75 subjects reassessed should have received a diagnosis of a substance use disorder in addition to their psychiatric diagnosis, resulting in 75% of MHCUs' substance use disorder being undiagnosed and thus resulting in them receiving incomplete treatment. ^(20, 22)

Rado, in Nathan et al. suggested that the number of MHCUs diagnosed with dual diagnosis was in fact increasing ^(20, 23), possibly due to the growing awareness of the existence of substance abuse in psychiatric illness amongst health care providers. However, despite this fact, *"fewer and fewer clinics are accepting patients with this profile"*.p252 ⁽²⁰⁾ Therefore literature states that at the very time when health care professionals are beginning to recognise the need for their treatment, and there is a growing acceptance that addiction is a bio-psychosocial disease from which recovery is possible, MHCUs are often being refused treatment at either psychiatric or chemical dependency treatment centres. ^(19, 20, 21)

The gap is widened by an ideological difference that persists between the field of psychiatry and the rehabilitation services for substance abuse. These differences between service providers harms both the addicted health care user and society as it only allows for marginal recovery, as the health care user is not treated in a comprehensive manner. ^(2, 24) Due to the "difference" in orientation (medical versus substance focused), there is a lack of treatment integration resulting in poor treatment of substance abuse disorders in mental health settings and mental disorders being poorly treated in drug rehabilitation settings. This can further result in potential organic damage or death of MHCUs. ^(2, 24) Of all addicted MHCUs, only a lucky few actually experience both solid sobriety and good mental health and appropriate occupational performance, as they and their families were exposed to both the twelve-step programme and psychiatry at the right time and in the right way. ^(2, 24)

Furthermore a lack of comprehensive treatment results in an increase in service utilisation as demonstrated in a study by Drake, Osher, Noordsy, Hulbut, Teague and Beaudett who found that even minimal use of alcohol by MHCUs suffering from schizophrenia – drinking in amounts clearly not abusive by traditional standards – was a factor that predicted those MHCUs who would require re-hospitalisation within a year. ^(19, 25)

A study on MHCUs suffering from schizophrenia who reported a tendency to self medicate found that, the chemicals helped them deal with anxiety, insomnia, boredom, depression, and the side effects of their prescribed antipsychotic medications. ⁽¹⁹⁾ However it was also found that substance use may contribute to familial conflicts. As a family withdraws from the user as a result of the increased levels of conflict, his/her available social support base becomes smaller. This in turn results in further difficulty in coping with the demands made on him/her by everyday life and with weaker social support, longer, more frequent periods of hospitalisation result. Therefore the negative impact of substance abuse on an individual's psychiatric condition and occupational performance becomes clearer. ^(19, 21)

When considering the level of pain experienced by the mentally ill, the cost of lost productivity in work, ability to use time effectively, the cost of hospitalisation and treatment, and then adding in the financial, social, and personal cost brought on by substance use in MHCUs suffering from dual diagnosis, the need and importance to address this problem becomes evident. ^(19, 21)

2.2.4 WHERE IS THE MANAGEMENT OF DUAL DIAGNOSIS GOING WRONG?

The complexity of a dual diagnosis and the unique manner in which the illnesses within a dual diagnosis exacerbate each other, demands a multidimensional, multi-disciplinary and integrated approach to treatment, which is generally lacking in most treatment settings in South Africa. ⁽²⁾

Diverse approaches for the treatment of substance use problems have been developed; some focusing on the drug problem, while others focus on the broader approach

addressing psychological, insight, occupational performance, behavioural and lifestyle issues. ⁽³⁾ Most treatment programmes stress the importance of self-control and personal choices in the use of a substance, and thus it is well recognised that a treatment programme's success is largely dependent on the addicted MHCU's motivation for change, which is reflected in their intellectual and affective insight, and attitude to the substance and the treatment regime. ⁽²⁶⁾ An important variable that has been identified within the treatment process is the concept of self-efficacy, i.e. the individual's belief in him/ herself that he/she will be able to overcome their substance abuse problem. ⁽²⁷⁾

The medical approach focuses on the medical symptoms of a disorder and thus always includes and focuses on the approved psychopharmacological treatment thereof. It stems from a paternalistic belief that the health care provider has the best interest of the health care user at heart and is in control of the treatment. ⁽²⁸⁾ In occupational therapy the medical approach focuses on the biological causes of the mental illness and the treatment scheme is directed towards establishing intellectual insight to increase the affective insight to restore the MHCU's ability to participate in "life". ^{(9,} ²⁹⁾ Treatment continues until the MHCU's condition is sufficiently stable to permit a realistic channelization of his residual abilities in all areas of occupational performance. ^(9, 29)

Work by Beynon, Soares-Weiser, Woolacott and Duffy, Gray and Upadhyaya and others has shown that the unilateral approach of the medical treatment of mental illness is insufficient and thus health care providers are challenged to be aware of the co morbidity that exists within mental illness and the need to address both the medical and the psychological needs of the user in treatment. ^(30, 31, 32) This is supported by du Toit in occupational therapy literature that emphasises that treatment should aim to restore functional independence, emotional and mental stability, and spiritual vitality in all patients, which would also apply to the MHCU, who can assume the degree of personal responsibility within their residual mental capacity. ⁽²⁹⁾ This requires the improvement of intellectual and affective insight to allow the MHCU to assume and enact his occupational roles.

In the medical approach, pharmacological treatment remains the primary intervention in the management of the illness, however it is said that medication cannot manage all the aspects and consequences of the conditions. Such aspects include depressed mood and fluctuations in mood that can affect the MHCUs cognitive functioning, psychosis and thought disturbances, as well as behavioural changes that can impact on the MHCUs ability to engage in treatment and daily life functioning. This then results in the emotional consequences of grief, loss, anger, frustration, shame and guilt, as well as the social consequences of stigma, relationship, financial, health and time stressors. (33, 34, 35)

Psychiatric and occupational therapy literature emphasises the importance of psychosocial interventions that target these issues that are untouched by the medical treatments. Such issues include compliance to medication, understanding and awareness of the symptoms of the illness and awareness of the importance of early intervention and coping skills. It has been shown that long-term pharmacological treatment combined with psychosocial interventions have resulted in a better prognosis of MHCUs suffering from mental illness as they obtain better management of their illness and show improvement in their level of functioning in all aspects of daily living, thus leading to a better quality of life. (29, 30, 31, 32, 33, 34)

From the above perspective of the treatment of mental illness, it is clear that a MHCUs suffering from dual diagnosis already has to negotiate complex and differing difficulties with regards to self-control and the ability to accept responsibility for their own behaviour brought about by both their substance use and their mental illness. The Axis 1 and/or II diagnosis from which they suffer may influence their ability to motivate themselves and sustain their efforts, to comprehend the cause-effect process that influences behaviour, and to be critical in their evaluation of their behaviour. Thus they experience difficulties in participating optimally with the treatment programmes established to address substance use difficulties. ⁽²⁾

It has been well recognised that the current problem within the treatment of substance use disorders is that the existing treatment approaches are intolerant of inappropriate and different behaviours. ⁽²⁾ These approaches are structured, confrontational and demand intense displays of affect of which the mentally ill health care user may be

incapable. MHCUs suffering from mental illness may experience difficulty with abstract concepts and thoughts, thus preventing them from being able to accurately interpret and evaluate themselves, situations and others, as well as present themselves appropriately. They may also experience difficulties with concentration, from increased levels of internal and external distractions, that prevents the required active and passive concentration span necessary for attendance in a group programme. These cognitive restrictions and disruptive behaviour compromises their ability to perform within the substance approach, and therefore the substance approach is seen to be ineffective in meeting their specified treatment needs. ^(2, 21, 33, 34) Similarly, the psychiatric approach, which is more permissive, does not focus on personal choice and personal controls sufficiently, and allows substance abusers to manipulate the system, behave impulsively and disruptively without appropriate consequences within their treatment process and the treatment environment. ⁽²⁾

Another complication that results from the conflicts in the two approaches is around the use of prescription medication. Substance abuse specialists', who work with MHCUs suffering from dual diagnosis, have confining attitudes towards psychopharmacology and tend not to prescribe psychiatric medicine or stop other prescription medication. Recovering addicts are often uncomfortable with the use of medications to control their psychiatric condition. Many substance use specialists believe that any use of drugs serves as only to substitute one addiction for another, despite the legitimacy of prescribed medications. ⁽¹⁹⁾

Non-compliance to medication regimes is a significant problem in MHCUs suffering from dual diagnosis. Kashner, Smith and Rost, included in Doweiko, showed that MHCUs suffering from dual diagnosis are 12.8 times more likely to be non-compliant and not follow health care provider's prescriptions as psychiatric MHCUs who do not use substances. ^(19, 36) Not only do they refuse to take the prescribed medications, but also continue to use their substance of choice, even after admission to an inpatient psychiatric treatment facility ⁽¹⁹⁾, further exacerbating their psychiatric illness, their occupational dysfunction, and complicating their treatment. Health care professionals are therefore of the opinion that MHCUs suffering from dual diagnosis frequently drop out of treatment, and that once the crisis that led to the current admission has been stabilised, the MHCU will return to previous behavioural patterns. These beliefs

compromise the treatment of these users, as treatment staff are often not motivated to invest the necessary time and energy into working with these users for an effective resolution of their problems.⁽¹⁹⁾

If a MHCU's difficulty with substances has been noted, and an appropriate referral to a chemical dependency treatment facility is made, the user's difficulty in receiving appropriate and comprehensive treatment does not end. MHCUs suffering from dual diagnosis are often viewed by chemical dependency professionals as primarily psychiatric users, whilst mental health professionals often view them as primarily substance abuse cases. This unacceptable state of affairs, pointed out by Layne⁽³⁷⁾, evolves from a political climate, where the treatment of health care users suffering from mental illness is separate from that of the treatment of user's suffering from substance use disorders. This division in treatment philosophy, referred to before, results in staff frequently viewing them as "not our problem" and they are referred elsewhere.^(19, 21)

This attitude together with the behavioural difficulties of MHCUs suffering from dual diagnosis make them unattractive to chemical dependency facilities, whilst the psychiatric hospitals often refuse to accept them until their chemical dependency problems have been addressed. Furthermore, mental health professionals are often inadequately trained and experienced in working with users suffering from addiction, and thus prescribe potentially addictive substances as part of their psychiatric care, and fail to recognise the affect of their substance of choice on their occupational performance. Therefore, all too often, the outcome of this refusal-to-treat policy and ignorance or denial of the co morbid disorder is that the user is bounced between the psychiatric and chemical dependency treatment programmes, with their problems and disorder never being effectively addressed.^(19, 21)

It can be concluded that treatment outcomes are reduced if the focus in treatment is limited to only the mental health or substance use of the MHCU, resulting in sequential or parallel intervention that is not integrated. This causes higher rates of relapse of substance use disorders, more severe courses of psychiatric illnesses, higher service utilisation, chronicity, lower treatment retention, and poorer outcomes.⁽²⁾ These poorer outcomes have been cited as including institutionalisation, homelessness

and housing instability, criminality, as well as homicidal and suicidal behaviour.⁽³⁸⁾ Therefore the affect on the MHCUs occupational performance is clear. The role of dual recovery therapy would therefore include the interfacing between the two approaches, encouraging collaboration and integration of the two approaches, dismantling artificial distinctions, cross training staff, and educating self-help groups⁽²⁾, thereby reducing the serious outcomes that result from a lack of integration

The United Nations Office for Drug Control and Crime Prevention emphasised the importance of accessible treatment for any person with a substance use problem. Treatment services and facilities may be sufficient; however that does not guarantee their use.⁽³⁹⁾ Various factors negatively influence the use of facilities, such as the cost of treatment and the social support systems available to the MHCUs to actually access the treatment resources. This is particularly important when addressing an individual with co morbid mental illness. MHCUs suffering from mental illness are often subjected to stigma, resulting in isolation from social support systems, and difficulty in maintaining employment. They thus lack both the psychosocial and financial resources to fund current substance abuse interventions, an important consideration when assigning a user to the specific and appropriate treatment facility.⁽³⁹⁾

Few effective programmes are available in either the private or the public health sectors in South Africa today, either at the hospital or community level, and this indicates a further failure of the current system.⁽²⁾

2.2.5 WHAT NEEDS TO BE DONE?

A person with a mental illness behaves in an abnormal way. In fact mental illness can encompass virtually any behavioural departure from what is considered normal or socially acceptable behaviour.⁽¹⁸⁾ Every person behaves abnormally, irrationally, and unrealistically at times, however it is when this behaviour persists that mental illness may be indicated.⁽¹⁸⁾ It is thus clear that individuals suffering from mental illness require specified treatment techniques, and those also suffering from a co morbid substance use disorder, may not be able to follow the established rehabilitation programmes implemented in the drug rehabilitation settings. The treatment needs for these individuals need to be established, considering the complexity of the interaction

of the diagnoses and the essential difficulties that present in a MHCU with dual diagnosis.⁽²⁾

Many people with drug and alcohol dependence require treatment by specialised treatment units in hospital settings.^(27, 40) The results of project Matching Alcoholism Treatment to Client Heterogeneity (MATCH) highlighted the importance of identifying and considering the most important characteristics of the patient so that they can be assigned to the most appropriate treatment option.⁽²⁷⁾ It should be noted that although the research on project MATCH was discontinued and never published, the principles of project MATCH have been supported and verified, and thus should be continued.^(21, 41, 42) The reason for project MATCH's failure can be seen to be as a result of the authentic treatment needs, of the subjects studied, not being accurately identified by the researchers. The researchers proposed the anticipated needs and thus the intervention failed, as the MHCUs' needs were never correctly established. Literature on counselling psychology and substance abuse treatment refers to the extensive process that is required to establish the needs of MHCUs. This literature agrees that the user's needs should be established through the gathering of an extensive history; and this should be taken prior to the selection or inclusion of the MHCU into treatment intervention, so that the needs of the individual can be considered in the selection of appropriate treatment.^(21, 41, 42) It is also a principle of Reed's model, a model that describes the overview of occupational therapy intervention, to establish the client's needs of treatment, so that the client may establish a sense of autonomy and actualisation in their treatment.⁽⁹⁾

The main contention regarding the plan or format of intervention for MHCUs with dual diagnosis involves the options between outpatient, inpatient or therapeutic communities. Various factors influencing this decision include the severity of the drug addiction and the psychiatric illness, the physical health of the MHCU, the financial resources, and the social support available to the MHCU.⁽³⁾ Availability of services for MHCUs with dual diagnosis within both the private and public health sectors needs to be increased so as to ensure that this specific group of health care users can be identified and their needs addressed within all socio-economic groups.^(2, 3)

It has been documented that the treatment of substance use disorders is dynamic and has developed over the past few decades, and shows evidence of continued change.^{(42,}

⁴³⁾ The combination of the changing availability and affordability of drugs, the changing populations accessing substance use treatment and the changes in treatment have resulted in scientific literature that has been published having to be frequently updated. ⁽⁴³⁾ Therefore the need for current research within this field is essential, especially for those MHCUs diagnosed with dual diagnosis. This will allow for the factors that influence the effectiveness of treatment to be identified, and thus assist in the development of a specific treatment programme, which will meet the needs of users suffering from dual diagnosis, irrespective of socio-economic and other demographic factors.

The bridge between the psychiatric and the substance abuse approaches also needs to be built, so that MHCUs suffering from dual diagnosis can be caught within the system, to promote treatment retention and reduce service utilisation. ⁽²⁾ In isolation these approaches, as described above, are reductionistic and give direction to the treatment of a primarily single diagnosis and its symptomology and thus the treatment techniques advocated concentrate on one aspect of the MHCU's pathology, while excluding others. ^(2, 38) That is the psychiatric approach focuses on the use of medication and traditional regimes in the treatment of the Axis 1 and/or 2 diagnoses, often dismissing the fact that medication prescribed could include addictive substances, versus the substance abuse treatment approach that focuses on establishing acceptance of the MHCU's addiction through self-reflection and the 12-step programme, resulting in abstinence from their drug of choice, but often dismissing the need for medication, and hence dismissing the psychiatric approach. ^(1, 2, 3, 4, 5, 38)

Although it is becoming increasingly apparent that MHCUs suffering from dual diagnosis require specialised treatment programmes to meet their needs, few such programmes exist. The traditional approach has been to address the MHCU's mental illness first, then once stable from a psychiatric point of view to begin to explore the user's substance-use pattern. The decision as which condition to treat first – the psychiatric condition or the substance use disorder – is often unimportant, as research does not support either approach conclusively. Doweiko and Layne suggest treating both disorders concurrently, an alternative to the either/or approach used by most treatment facilities currently. ^(19, 37)

For a treatment programme to meet the identified needs of MHCUs suffering from dual diagnosis, a team approach is essential. An approach must be employed where the philosophies of both camps – psychiatric and substance abuse treatment philosophies – are synthesised and geared to the individual user.⁽²⁾ Chemical detoxification by a professional with knowledge of both psychiatry and chemical dependence is the necessary first step in treating MHCUs with dual diagnosis. Once detoxification is achieved the team can determine the sequence of intervention by determining which problems are a manifestation of the psychiatric illness and which problems are the results of the user's use of substances.^(2, 19, 21) The bridge between the two approaches would thus be built in the consideration of the psychiatric approach and the use of medication to treat the Axis 1 and/or 2 diagnoses, whilst encouraging abstinence of addictive substances. Hence medication prescribed would include non-addictive alternatives in consideration of the substance abuse approach, and include psycho education to promote intellectual insight, and the 12-step programme and self-reflective techniques to increase affective insight into their disorder and promote acceptance of the changes that the MHCU is required to make to improve occupational performance within all areas of daily living.^(1, 2, 3, 4, 5, 9, 38)

Various studies have divided the intervention for MHCUs suffering from dual diagnosis into three phases:

The **first phase of treatment** involves the detoxification, psychiatric stabilisation and accurate diagnosis of the MHCU. Studies then show that once this is achieved, it is important to involve the user in a series of education sessions, where the user is exposed to psycho education, skills on money-management and other life skills, and social support. During this phase it is important to establish a therapeutic relationship with the MHCU so that his/her insight into his condition can be addressed so as to ensure that the MHCU begins to understand and internalise the information that he/she receives at this phase. It is important to include the MHCU's family and support structures into treatment. Research has shown that at this phase of treatment, the decision between the need for inpatient or outpatient treatment can be made. The MHCU's condition will determine this.^(19, 21)

The **second phase of treatment** involves further psycho education and the continuation of the MHCUs rehabilitation programme so as to ensure prevention of recurrence of both the substance abuse and the psychiatric disorder. Research has shown that group therapy is an important element at this stage as it allows for peer support and assists in the user's acceptance of the abstinence from substances. ^(19, 21)

The **third phase of treatment** involves educating the MHCUs on the long-term lifestyle changes and skills necessary to sustain abstinence. Many of the techniques used in general drug rehabilitation programmes remain useful in the treatment of MHCUs suffering from dual diagnosis. The groups should focus on teaching MHCUs specific life skills to assist them to learn how to function in society without the use of substances. ^(19, 21)

In summary, research reviewed in this section of the literature review has shown that in order to address the difficulties of dual diagnosis, both the mental illness and substance abuse need to be considered equally. A team of staff members, including an occupational therapist, who have knowledge and experience in both philosophies, should be involved. The use of group therapy and psycho education to improve both intellectual and affective insight are integral elements of the rehabilitation of MHCUs suffering from dual diagnosis, and that users need to be consulted to determine their specific needs.

2.3 THE USEFULNESS OF A PSYCHO EDUCATION PROGRAMME FOR DUAL DIAGNOSIS

There is no occupational therapy literature that has specifically researched the usefulness of psycho education within treatment programmes for MHCUs suffering from dual diagnosis, although textbooks advocate that this should be included. ^(33, 34)

Very limited occupational therapy literature was found that details the contents of psycho education programmes or specific delivery techniques that have been proven to be successful of the management of MHCUs in general, or users with dual diagnosis in particular.

A single research article was found on the importance of psycho education in the context of occupational therapy for people with dual diagnosis. This article concluded that occupational therapy should focus on psycho education to establish intellectual insight into the MHCU's use and/or dependency of substances, whilst considering the individual's cognitive functioning. This in turn will develop the affective insight to utilise the skills required to live independently in the community. ⁽⁴⁴⁾

Psycho education has been reported to be critical to treatment of MHCU's as it enhances compliance, and therefore improves their prognosis in the longer term. ⁽²⁸⁾

Psycho education is reputed to achieve this by developing the MHCU's understanding of their illness and the therapeutic interventions that they will experience, thus encouraging them to commit to longer-term involvement. ⁽²⁸⁾

Psycho education has become an important feature in the treatment programmes of occupational therapists. ⁽⁴⁵⁾ Insight has been described as a critical factor in the development of life skills and in teaching individuals new ways of solving problems.

⁽³⁸⁾ This handbook on the group psycho education for individuals with dual diagnosis also reports on the success of psycho education in creating changes in individual's behaviour and refers to Alcohol Anonymous (AA), Narcotics Anonymous (NA), All-Anonymous (Al-Anon) and therapeutic communities approaches that base the premise that individuals can control their problems if they understand them better. ⁽³⁸⁾

Therefore it is assumed that psycho education will enable people to learn new skills if they understand the underlying problem by, increasing their intellectual insight into their issues. ⁽³⁸⁾

The concept "Intellectual Insight" is described as improved self-knowledge without the corresponding change in behaviour. ⁽⁶⁾ This improved self knowledge then requires the consistent practice to cause changes in their life, thus increasing the 'affective insight'. ⁽³⁸⁾ Affective Insight has been described as the change in behaviour following a growth in intellectual insight. ⁽⁶⁾

According to the Mental Health Illness Policy Organisation, several studies have shown that poor intellectual insight results in an increased non adherence to medication and an increase in violent behaviour. ⁽⁴⁶⁾ This is in keeping with research related to poor insight in the treatment of substance abuse that has indicated that the level of intellectual insight determines the individual's willingness to change, the

long-term clinical outcomes and compliance to treatment. ⁽⁴⁷⁾ This substance abuse literature refers to research that has considered the use of substances as being one of the most important risk factors for symptoms of mental illness and reports the difficulties of establishing intellectual insight in these individuals due to the resulting psychotic symptoms, poor judgement, poor impulse control and cognitive impairments. This research reported that developing intellectual insight is a condition of substance abuse treatment and essential to establish the connection of the use of substances and the onset of their psychiatric symptoms and the need for treatment programmes. ⁽⁴⁷⁾ Therefore this literature emphasises the importance of intellectual insight in developing the MHCU's understanding of the relationship between their use of substances and their mental illness, hence understanding how both their conditions in their dual diagnosis can exacerbate each other.

Psycho education has been described as involving three aspects; therapeutic interaction, clarification of facts and enhancement of coping strategies. Therapeutic intervention according to Swaminath involves the development of a therapeutic relationship in which the medical information is imparted by the MHCP whilst respecting the subjective views and opinions of the MHCU. ⁽²⁸⁾ Clarification relates to the interactive approach of the therapeutic relationship that ensures the MHCU understands the information given by the MHCP which should be comprehensive, but at the same time simplifying the scientific and medical facts. Finally enhancement of coping strategies focuses on strengths and resources of the MHCU and not the deficits, thus allowing the user to *“gain awareness of the road forward and how to manage the symptoms and consequences of their illness to their life and functioning.”* p2 ⁽²⁸⁾

Research by Swaminath has shown that a health care professional's willingness to provide educational information to the MHCU's on their illness and treatment that is required, is an important factor for the MHCU in the selection of their treating professional. This research showed that communication about the health care system and how it works, and the prognosis of the MHCU's illness is more important than the inclusion of *“medical jargon, fancy gadgets and high tech testing.”* p2 ⁽²⁸⁾ and is in keeping with the new consumer protection act where it is legislated for.

Swaminath also found that psycho education promoted the MHCU's confidence in their health care professional, resulting in the user relying on their health professional as the reliable information source, rather than gaining it from the internet and lay professionals who Swaminath refers to as '*informed others*'.p2⁽²⁸⁾

Most of the research on psycho education has focused on how information is best delivered. Some studies have shown that individual psycho education, and not just group programmes, can also be effective in increasing adherence to treatment (compliance to medication and implementation of coping strategies).^(48, 49) The didactic approach of individual psycho education facilitated the reduction in stigma associated with the user's illness, thus enhancing the possibilities that the user would seek treatment.^(48, 49) As psycho education aims at improving the user's prognosis by increasing users' insight into the management of their symptoms and treatment retention, this research indicates that individual, didactic psycho education is effective.

Studies however have advocated that psycho education is better done in a group context, as the group members benefit from information, feedback and support gained from both the contributions of the professional and their peers.^(48, 49) Recent research on group psycho education also concluded that health care users are more likely to respond to unstructured group content than they are to structured group content thus suggesting the benefit of having the group members establish the group content.⁽⁴⁸⁾ This is in keeping with research findings of Cowls and Hale who investigated what MHCU's value in psycho educational groups. This qualitative pilot study which suggested that psycho education is best delivered within the group context where the MHCUs benefit from the supportive milieu, client-driven discussions, connection with peers and voluntary attendance.⁽⁵⁰⁾ This is in keeping with information in "A Handbook for Leading Inpatient and Residential Psycho Educational Groups for Mentally Ill Chemical Abusers" which refers to group psycho education programmes being effective in increasing the intellectual insight within individuals suffering from mental illness as well as substance abuse. It also notes that group psycho education programmes are being widely utilised in establishing a shift in intellectual insight.⁽³⁸⁾ A single article that researched group psycho education in the context of occupational therapy also concluded that participants continue to value the methods of traditional

occupational therapy groups that include the use of related activities to facilitate group discussions.⁽⁵⁰⁾

It has been recommended that group psycho education focuses on educational material related to the MHCUs' condition and allow the individuals to discuss the information as they perceive pertains to them, thus the group process should be non-confrontational. In substance abuse groups, this allows the individuals to discuss issues openly and learn from their peers; it is the group leaders and members that assist the individuals to gain insight into the dynamics and patterns of their use of substances. In mental health psycho education groups, it is important the information around their symptoms and the effects of their medication are explored to encourage compliance to treatment. In dual diagnosis psycho education information regarding their use of substances and the effects on their symptoms both need to be explored.⁽³⁸⁾

In the single research study carried out by Miklowitz on MHCUs suffering from dual diagnosis the author demonstrated a marked reduction in the participants' use of substances on completion of the group psycho education programme; however there was a higher incidence of users' reported psychiatric symptoms. The study concluded that this increase in the reporting of psychiatric symptoms was due to the MHCUs increased awareness, thus demonstrating the effectiveness of the psycho education in increasing the MHCUs' knowledge of their illnesses and management thereof.⁽⁴⁸⁾

In summary, the literature found suggests that psycho education is important in the context of the treatment of all psychiatric conditions, but has also been shown to reduce the use of substances in MHCUs diagnosed with dual diagnosis in a single study. Although limited research studies have been found on the efficacy of psycho education programmes presented in the context of occupational therapy programmes all occupational therapy texts advocate that this should be done. Literature on what should be done and how the educational material should be presented was also limited and reported some evidence that it is best presented in a group, and that it has a number of aspects including the use of activities to facilitate the therapeutic interaction, clarification of facts, and enhancement of coping strategies. Finally the literature suggests that a MHCP's willingness to give information that is

understandable, and describes the prognosis, influences the credibility of the MHCP in the MHCUs' eyes and influences their positive feelings to that provider.

2.4 GROUP PSYCHO EDUCATION FOR DUAL DIAGNOSIS AS A COMPONENT OF OCCUPATIONAL THERAPY

2.4.1 OCCUPATIONAL THERAPY RESEARCH INTO DUAL DIAGNOSIS

Research has shown that the occupational performance problems that result from substance misuse in the context of severe mental illness remain one of the greatest challenges for all occupational therapist in South Africa. ^(2, 33, 34) Yalom's curative factors propose that psycho education in a group context may be more effective through getting and receiving feedback from others, getting ideas from others and learning from their experience, learning that others have problems similar if not worse than yours, developing a sense of belonging and being able to draw on support from others as well as supporting others and being able to express strong feelings in a safe place. ⁽⁵¹⁾

A single article on occupational therapy for people with dual diagnosis has indicated that Kielhofner's Model of Human Occupation, is used widely by occupational therapists as a framework that has assisted in guiding intervention with MHCUs suffering from dual diagnosis. ⁽⁴⁴⁾ In this research this model was used to study MHCUs' needs in helping them to actively pursue leisure time activities and develop alternative strategies for coping with stressful situations. The study concluded that treatment intervention from an occupational therapist resulted in the MHCUs' level of occupational functioning improving by giving them insight into the factors influencing their occupational performance. ⁽⁴⁴⁾ The study that was completed was the first reported research into the occupational therapists contribution to the treatment of MHCUs suffering from dual diagnosis. The authors stated that

*“because working with people with dual diagnosis requires an integrated approach and wide range of therapeutic skills, the traditional emphasis of a holistic approach and bio-psychosocial involvement should place occupational therapists in a good position to be case manager of this group of individuals.”*p173 ⁽⁴⁴⁾

This statement is validated in the article in that it reports that the occupational therapy approach is flexible and adaptive in meeting the MHCU's needs and results in positive changes in specific behaviours and the MHCU's occupational functioning.⁽⁴⁴⁾ The authors attribute these positive changes to three factors:

1. Occupational therapists base their practice on the consideration of the MHCU's needs.
2. Occupational therapy addresses the MHCU's needs directly by developing new skills and offering practical alternatives to previous maladaptive behaviours.
3. Occupational therapists treat the MHCU holistically, thus considering all internal and external factors that affect the occupational performance of the MHCU and then adapt the presentation of the treatment intervention in accordance to the MHCU's individual capabilities.⁽⁴⁴⁾

Rehabilitation literature in the field of substance use; emphasises the importance of the MHCU developing a sense of self-efficacy and responsibility.^(24, 27) The occupational therapists in this field, work mostly within the humanistic frame of reference, thus encouraging the MHCU to gain a sense of accomplishment, autonomy and self-actualisation in the context of the users occupational performance.^(32, 34, 44) With an in-depth knowledge of physical, psychological, social and mental functioning, together with the skills and resources available in the individual's environment, the occupational therapist is uniquely equipped for a role that is relevant within the treatment of dual diagnosis because of their understanding of both conditions and psychiatric and substance abuse treatment approaches.^(9, 33, 34, 50, 53))

2.4.2 THE VALUE OF THE OCCUPATIONAL THERAPIST IN GROUP PSYCHO EDUCATION PROGRAMMES

Occupational therapists are considered key members of the multi-disciplinary team needed to effectively treat patients with both mental illness and substance use disorders.^(33, 34) Thus, as proven above, it can be said that an occupational therapist can also contribute to the multi-disciplinary treatment of those MHCUs suffering from dual diagnosis.

Occupational therapy's domain of concern is the occupational performance⁽⁵⁴⁾ of each MHCU in the context of the environment in which they live, socialise, work, and play

and enact the roles and habits expected of them.⁽⁵⁵⁾ The occupational therapist's main contribution would be in the prescription of meaningful individual and group occupations selected to meet the MHCUs with dual diagnosis specific needs, interactions and environmental demands to enable them to regain, develop or retain the occupational skills and roles required to maintain personal well being, and to achieve meaningful personal goals and relationships appropriate to the relevant social and cultural setting.^(9, 55) This is achieved through establishing intellectual insight and in turn to develop affective insight, for a MHCU with dual diagnosis to understand their condition as well as the way in which their condition impacts on their life and how they are able to live it. Occupational therapists because of the domain of concern and the nature of their training are well positioned to do this.⁽⁵⁶⁾ Thus psycho education which includes knowledge of the two co-existing conditions as well as how they impact on occupational performance, and the life skills to practically manage this, should always be included in occupational therapy programmes, in order to establish intellectual and emotional insight.

There is some evidence that the MHCUs benefit from psycho education that is presented in a group context using group process principles. It is assumed that this would also be true of MHCUs with dual diagnosis.⁽⁴⁷⁾ Occupational therapy literature confirms that group work is a substantial component of occupational therapy practice in the field of mental health.^(33, 34) It is included in the role and the scope of the occupational therapist⁽⁵⁶⁾ and is used to satisfy both the individual's needs and the occupational performance demands of their dysfunction, such in the case of MHCUs with dual diagnosis, to practically manage the complexities of both diagnoses in their daily activities.⁽⁵³⁾

As occupational therapists are trained in the humanistic frame of reference, as well as the client-centred approach, and are capable of working across the psychiatric and substances use philosophies, occupational therapists are uniquely placed to understand the complexities on occupational performance that both conditions of the dual diagnosis have.^(9, 53) As referred to earlier in this review, the effects of dual diagnosis impacts on all areas of occupational performance, and therefore the occupational therapist's holistic approach allows for all of these to be considered.^(9, 19, 21, 30, 31, 32, 33, 34, 35)

2.4.3 FACTORS THAT MAY INFLUENCE THE SUCCESS OF AN OCCUPATIONAL THERAPY GROUP PSYCHO EDUCATION PROGRAMME FOR DUAL DIAGNOSIS

A review of literature of group therapy and the factors that influence the effectiveness of group programmes was completed to assist in the development of the group psycho education programme and the evaluation framework of this study. The development of the programme would also need to consider the section above on psycho education, as psycho education by nature is about the effective acquisition of knowledge. This section will focus on how this is best achieved within a group context, as it was concluded in the above section, that psycho education is most effective when completed within a group programme.^(48, 49) This is in keeping with substance abuse literature which stated that group work is advocated as effective as individual therapy in improving insight and bringing about behavioural change in MHCUs, and is suitable for managed care settings as the treatment is brief and cost-effective.⁽²¹⁾

Research suggests that the advantage of using groups for therapeutic intervention with MHCUs is that groups provide a sense of community and a natural laboratory that demonstrates to the members that they are not alone, and that there is hope in creating a different life. Groups are reported to have immense power to move people in creative and more functional directions by allowing participants to explore life-long problems and create opportunities to do something different from what they have been doing in the past.⁽⁵²⁾ Group work has been proven to be effective in the treatment of individuals suffering from substance use disorders, and therapeutic groups have been recognised as valuable in developing a social support network as an important protective factor against relapse.⁽⁵⁷⁾

Occupational therapy literature also described the effectiveness of group work when working with individuals suffering from psychiatric illnesses as it has a dual benefit in the mental health sector; it is both economic in that it enables the treatment of several MHCUs simultaneously whilst effectively addressing the individual MHCUs' social interaction and social skills, enables changes in particular behaviours and the development of new skills.^(33, 34) Group work is thus used extensively within mental health in-patient treatment settings by occupational therapists, and also continues

outside of treatment settings with the increased trend of self-help groups being run within communities. (21, 33, 34)

The advantages of group work include the opportunity that group work provides the group members to experiment with their style of interacting with others and thus learn more effective social skills. Group work also allows for a re-creation of the everyday world – diverse membership can encourage exposure to a number and variety of personalities, behaviours and schools of thought that can in turn broaden the repertoire of each individual member, and allows for richer, more diverse interaction and feedback. This fosters personal growth through providing the opportunity to learn about themselves as a result of the experiences of others. Another advantage is that group work assists identification with others through the sense of universality that is experienced in the group process. Group work also allows the individual to learn and experience how they affect others as constructive and effective feedback received from fellow group members provides the group member with powerful input on how the individual is perceived by others. (52)

Thus the benefits of group work have been widely documented. (33, 34, 41, 57, 58, 59)

From the literature reviewed the following factors were identified as influencing the effectiveness of group therapy and hence were fundamental in developing the group psycho education programme, and the evaluation framework of this study.

a) Group Entry

Yalom (1995) emphasised the importance of preparing each individual for the group process. (52) This preparation includes exploring the advantages and misconceptions about groups with each potential group member so as to ensure maximum active participation from each participant, and in turn maximum individual benefit from the group process (52)

In preparing individuals for group work, it is also important to address the misconceptions of groups. Not everyone is suited to group work. It was said that some MHCUs may be too hostile or fragile to benefit from the group process, or may have had a previously damaging experience from group work that prevents the group process from having the intended therapeutic benefits. Further misconceptions to be explored with potential group members include that group work may be threatening

and that solutions worked out in groups are not necessarily directly translatable into each and every members' individual lives, that in a group one loses one's own individual identity, and that the group prescribes how people should behave.⁽⁵²⁾

Thus it is essential that before a MHCU is accepted into a group, the therapist spends time with the user to ensure that they understand the group process, identify with group procedures and understand the intended benefits. This is also important to ensure the individual's compliance to the group programme and also allows the therapist the opportunity to assess the user's appropriateness for group work, and for the group which he/she was intending joining. Literature therefore states that no MHCU should join a group before this discussion has taken place and the joint decision between the therapist and the MHCU is taken for them to join the group.⁽⁵²⁾ This was considered closely when developing this study by ensuring each participant was interviewed individually prior to the group programme beginning.

Results from a qualitative research study by Cowls and Hale also indicated that MHCU's value of voluntary entry into a group, and this too was considered in this research study.⁽⁵⁰⁾

b) Group membership

Literature reviewed highlighted the importance of group membership when developing a group programme. Cowls and Hale indicated that the supportive milieu, created by group membership, is a key element in the value of a group psycho education programme.⁽⁵⁰⁾ This research referred to assessing the language capability of group members as important for both the therapist and MHCUs to be able to communicate. Group and substance abuse literature supported this by reporting that group work requires a shared language and a shared need amongst the group members so as to ensure relevance of the group content for each participant. Communication was therefore reported to being essential in establishing group interactions and dynamics. The literature stated that without communication and a shared need, the individuals would fail to gain insight from the information being shared by the therapist and the fellow MHCUs and the usefulness of the group techniques of confrontation and group pressure would fail to develop. These specific techniques are referred to by the literature as being important in establishing awareness of individuals

into the behavioural changes that they need to make. ^(19, 58, 59) This factor was considered closely in the sample selection for this study.

c) Group norms

Research into group therapy, in both occupational therapy and psychological contexts, underlines the importance of establishing group norms or contracts that each group member is required to sign, as it facilitates group cohesiveness and awareness of the need and importance of adherence to confidentiality by the group members. ^(33, 34, 41)

This factor was considered when developing the group programme for this study, and the establishment of group norms was structured within the first group of the programme as confidentiality was essential in developing group cohesiveness, which group literature states as influencing the effectiveness of the group process. ⁽⁵²⁾

d) Group Goals

The establishing of group goals is described in psychology and substance abuse literature as important to the successful running of a therapeutic group as it allows the group members to be aware of the subject matter to be addressed in the groups and gives the participants a sense of autonomy over the group process to develop within the group. ^(41, 57) This too was considered when establishing the group programme of this study as it was also the objective of this study to establish the expressed needs of MHCUs suffering from dual diagnosis.

e) Group Contents

Substance abuse literature suggests that group content that addresses the MHCUs' expressed needs is a critical factor in the successfulness of group work as a therapeutic agent. ⁽²¹⁾ It states that content should consist of a combination of theoretical knowledge and facilitation of content through group interaction, thus enabling all group members to benefit from each others' experiences. This literature referred to group content of psycho educational groups needing to address critically important issues relating to their co-existing disorders and their impact on their occupational performance and potential treatment obstacles that they may encounter. ⁽²¹⁾ The literature on group psycho education programmes also stressed the importance of including coping skills training and information that addresses the individuals' awareness of signs of relapse in the group content so as to increase insight and improve the individuals' awareness of the steps required to be taken to manage their illness. ^(21, 28, 38) The literature reviewed was thus important in this study, as it was the purpose of this study to address the needs of the group participants, therefore in this

study the participants' needs were established and considered closely when developing the group protocols of the psycho education programme of this study. Information regarding both their mental illness and substance use disorders and coping strategies for the difficulties they may encounter was also included into the protocols of the group programme for this study.

f) Group Techniques

The group techniques used in managing the groups are determined by the group facilitator and; the only common role within all groups is that of the group leader.⁽⁵²⁾ The main function of the group leader is to establish the group and maintain control over the group membership, as well as provide the setting in which the group is to be convened.⁽⁵²⁾

Group leadership therapeutic techniques can vary; however psycho education and occupational therapy literature advocates the combined passive and active role of the group leader as he/she gently guides and assists the focus of the group members' attention on the group content, whilst taking an a more didactic approach when imparting specific and scientific information.^(28, 33, 34, 45) This assists in the development of the group dynamic and allows for the technique of group confrontation to be more effective. The effectiveness of the "laizaire faire" leadership style is also described as important in the development of the sense of autonomy within the group members and hence facilitating the shift towards an internal locus of control.^(33, 34, 45) Occupational therapy and group literature has described this technique as a more easy-going, passive and less directive approach to the didactic approach, which mirrors the role of a teacher with a more active stance and an authoritative style of imparting information.^(33, 34, 45, 52)

Another factor discussed in substance abuse and group literature as having an influence on group work, is that of the leader's personality.^(21, 52) It has been found that group members respond well to the willingness of the leader to share themselves with the group, a caring attitude, enthusiasm, openness, and directness; further describing the "laizaire faire" approach. Leaders should not rely on their title or professional accomplishments for respect, but should use the therapeutic techniques and understand the value of using oneself as an instrument in therapy to gain respect from group members. Group members respond well when they perceive the leader to

be genuine in their behaviour, this allows them to trust the behaviour and make them more likely to model the therapist. This does not demand idealism from the therapist, but prescribes that the therapist acts on his or her own advice, and understands that they come from a position of power that they are not using. This allows the group members to perceive the leader as genuine, sincere and trustworthy, which in turn results in the leader being respected, and optimal group facilitation.^(33, 34, 52) Substance abuse, psycho education and group literature all refer to the importance of the group leader when running psycho education groups, of having an extensive knowledge base so as to ensure reliability of the information imparted by the therapist.^(21, 28, 57) These concepts discussed by the literature are important to consider when embarking on a programme in which group work is to be incorporated.

The use of handouts and audiovisual material was also referred to in the literature as being an effective technique for providing “focused feedback” in the imparting of knowledge, as well as allowing the group members to relay and impart the knowledge that they have gained from the groups onto others outside of group.^(21, 41, 59) Qualitative research by Cowls and Hale also indicated that the use of ice breaker, warm ups and activities within the group was highly valued as when related to the topic, promoted and facilitated the emotional content of the discussions.⁽⁵⁰⁾ These techniques were all included in the leadership style and group techniques used in this study, thus the review of the literature assisted deeply in the development of the psycho education programme for this study.

g) Group Structure and Context

The factor of group membership needs to be considered as a factor in the group structure, and delineates the benefits of both open and closed groups.^(21, 41) Literature on substance abuse and psychology highlighted that a closed group is more advantageous for data accumulation and group cohesiveness.^(21, 41)

The importance of the timing of the length of the group sessions and the succession of the group sessions is described in the group literature as important for group success to allow for information to be imparted, group interaction to be achieved as well as maintaining the intensity of the information and group dynamic. Therefore it is agreed that for an effective group dynamic to develop and information to be shared, the

groups need to be structured more than once a week and the context should allow for interaction amongst the group members.^(41, 52)

The ideal group space was described as the context that allows for all group members to feel more comfortable and thus share more openly and honestly, thus facilitating group interaction.⁽⁴¹⁾ It should also be quiet and thus external distracting factors that could disturb the group process are limited and this promotes the group norm of privacy and confidentiality.⁽⁴¹⁾ Substance abuse and psychology literature also referred to structuring more time for individual sessions or using the post session technique so as to allow for integration and consolidation of the therapeutic work achieved within the group process.^(21, 41) These factors were thus considered closely when structuring the groups for the psycho educational groups of this study. Although initially the researcher did not structure post sessions within the programme, feedback from the participants in the second interview of the main study allowed post individual sessions to be incorporated into this study.

It can therefore be concluded from the literature reviewed that group psycho education programmes for MHCUs suffering from dual diagnosis are effective, and that the occupational therapist is a valued member of the multi-disciplinary team in both the development and execution of such programmes. The factors that need to be considered when developing and evaluating an occupational therapy group psycho education programme for MHCUs with dual diagnosis include the importance of considering group membership, group content, group techniques, and the group structure, and context of the group. The group literature also suggests that the leadership style is another important factor that impacts on the level of group interaction that exists between the group members and allows for the group techniques to be executed effectively. As the group interactions are fundamental in the sharing of new information, group interaction, and all factors influencing group interaction, should be considered when planning a group intervention aimed at increasing the level of insight in MHCUs with dual diagnosis in a group psycho education programme, and developing new coping strategies for the management of their illness.^(21, 33, 34, 41, 52, 57, 58, 59) These factors were thus included in the development of the group psycho education programme for this study.

2.5 DEVELOPMENT AND EVALUATION OF A GROUP PSYCHO EDUCATION PROGRAMME

Anderson, Boris and Kleckham described the process involved in the development of a psycho education programme for MHCUs with dual diagnosis. ⁽³⁸⁾ They suggested that the initial step in the development of such a programme should be to define and research issues and problems so that the most effective treatment technologies are included. The research into the problem should also involve asking the MHCUs their understanding of the problem and what their needs of such a programme would be so that the problem can be redefined and the programme designed accordingly. This handbook on group psycho education for the dually diagnosed also proposes the use of a reputable conceptual framework in establishing a comprehensive and more effective system of directing the programme. The conceptual framework should direct the purpose and every element of the programme so that it will meet the needs of the MHCUs in every phase of recovery and rehabilitation. It also suggested that a comprehensive programme should allow for ongoing stabilisation and rehabilitation as relapse occurs often in both mental illness and substance abuse, therefore continuity of care should be enabled. ⁽³⁸⁾ Costs of the programme with regards to all resources need to be considered in the development of the programme, as well as the timing implications. ⁽³⁸⁾

In regard to the evaluation of a programme support was found on the usefulness and effectiveness of qualitative evidence in the field of psychiatry. ⁽⁶⁰⁾ This article reports that the overall results of a qualitative evaluation enhances the programmes credibility and viability of a programme as it provides critical information of what is working successfully within the programme for the MHCUs and what needs to be adapted within the programme to further enhance the value of the programme. Qualitative research thus provides a detailed description of the programme that includes the social context within which the programme is being run, and this information allows for knowledge to be generated and for decisions to be made within the specific environment. ⁽⁶⁰⁾

When conducting a qualitative evaluation, as in this research study, literature on longitudinal qualitative research states that the establishment of an appropriate

research design is imperative. ⁽⁶¹⁾ Establishing the research design involves three important steps; establishing the objectives of the study, identifying the appropriate sample, the time frame it will take to achieve the evaluation, objectives, and the selection of the appropriate tools for the qualitative study as this will determine the data analysis. ⁽⁶¹⁾ This in turn will influence the analysis and reporting of the data, as this article reported that it is vital that the researcher is clear what the objectives of the evaluation are and that data is recorded accurately. The cost and time implications also need to be considered to ensure the evaluation is effective in the value it proposes to bring within a cost effective and adequate timeframe. ⁽⁶¹⁾

It was important to consider these in the development and evaluation of this research design to ensure that the study remained realistic in terms of time and costs.

2.6 CONCLUSION

It can thus be concluded that to bridge the current gap that exists within the treatment of dual diagnosis, both the mental illness and substance abuse need to be considered equally. Therefore the team of staff members involved, including the occupational therapist, need the knowledge and experience in both philosophies to ensure that these MHCUs are accurately identified, and all their needs addressed. The literature showed that the use of group therapy and psycho education are integral elements of the rehabilitation of MHCUs suffering from dual diagnosis, and that users need to be consulted to determine their specific needs.

Psycho education was shown to be effective in the treatment of all psychiatric conditions and also created effective behavioural changes in MHCUs suffering from dual diagnosis. Psycho education is effective in the MHCU developing intellectual and affective insight into their conditions, the management of their symptoms, and their illness, and hence allowing for improved treatment retention and improved long-term prognosis for the MHCU.

The literature reviewed also advocated the occupational therapist as a valued and competent team member to engage in group psycho education programmes and suggested the group factors of; group membership, group content, group techniques

and leadership, group structure, and context of the group be considered closely when establishing a group psycho education programme that addresses dual diagnosis effectively.

Therefore the review of literature was critical in the development of this study, the group programme and the establishment of the evaluation framework. It proposed that establishing the participants' needs of treatment, their experiences and their level of insight is important for the success of any group psycho education programme, and this was thus incorporated into the purpose of this study.

CHAPTER 3

DEVELOPMENT AND EVALUATION OF THE PSYCHO EDUCATION PROGRAMME

3.1 INTRODUCTION

This research aimed to investigate whether a series of psycho education groups, offered within the context of an occupational therapy programme at Sterkfontein Hospital, would be useful to bridge the gap in addressing the treatment needs of MHCUs suffering from dual diagnosis. This series of groups proposed to use a holistic and integrated approach ⁽⁴⁴⁾ by considering both the psychiatric and substance abuse treatment approaches described in the literature review ^(1, 2, 3, 4, 5), to assist the participating MHCUs, suffering from dual diagnosis. The main treatment aim of this programme is to achieve insight into both the MHCUs disorders and their occupational performance, thereby increasing their awareness of the steps they needed to take to stay well, and function more productively in the community.

The purpose of this aspect of the study was to design an occupational therapy group psycho education programme from the expressed needs of MHCUs diagnosed with dual diagnosis.

This aspect of study was divided into two phases with each phase having different stages.

- **Phase 1:** Development and establishing of the factors for the qualitative evaluation of the group psycho education programme. This phase addressed the first objective of the study (See 1.5). This phase of the study consisted of two stages namely:
 - o **Stage 1:** Development of the group psycho education programme considering the expressed needs of MHCU with dual diagnosis.
 - o **Stage 2:** The running of the programme (piloting) and the evaluation of the programme to identify the effective factors to be evaluated in the main study (Phase 2)
- **Phase 2:** Mental Health care user's perception of the usefulness of the programme based on the factors indentified in phase1. This phase met

objective 2 of the study. (See 1.5). This phase of the study also consisted of two stages namely:

- o **Stage 1:** The evaluation of the effective factors to meet the needs of the participants
- o **Stage 2:** The evaluation of the improved level of insight as an outcome measure.

The first phase of this study will be reported in this chapter while phase 2 will be reported in chapter 4.

3.2 DEVELOPMENT OF THE PYCHO EDUCATION PROGRAMME

3.2.1 RESEARCH DESIGN

A qualitative investigative method of research ^(60, 62) was used in this component of the study. This is because, although there is literature on groups and group-work processes there is no specific literature that was found to inform the specific development of the occupational therapy group psycho education programme for MHCUs diagnosed with dual diagnosis, and because the researcher wanted to identify the perspectives, experiences and expressed needs of these specific MHCUs, and these to be included in the design of the group psycho education programme. It was therefore decided that an investigative approach be utilized. ⁽⁶³⁾

The outcome of investigative research is to build on existing clinical knowledge to establish more clinical application, and not create new information. ⁽⁶³⁾ The investigative methodology was designed to address qualitative research within the clinical setting where the Health Care User's experiences are the focus of the research. ⁽⁶³⁾ This research design is strongly related to grounded theory, naturalistic inquiry, and ethnography, as well as borrowing values from the phenomenological approaches in the methods of data collection. Sample selection within investigative design is purposive, and is theoretically generated thus only a small sample is required. The data collection and analysis serves to locate the findings within the framework of existing literature, or bodies of knowledge and thus intends to make these understandings more practically applicable within the clinical setting. ⁽⁶³⁾

Most qualitative methods require the researcher to eliminate preconceptions; however in the investigative methodology it is presumed that there will be some theoretical knowledge, clinical pattern observation, and scientific basis on which the research study is based. Therefore a critical review of the current knowledge then forms the basis of the analytical framework on which the sampling, research design and early analytical decisions are made by the researcher. ⁽⁶³⁾ As a result it is common within the investigative research design for priori coding to be used, codes are drawn from the literature to create a conceptual framework on which the analytical process is based. ^(63, 64, 65, 66)

This method of qualitative research was selected as it felt that it best met the requirements of this study and the aims set out below.

This component of study aimed to:

- Investigate the perceived needs, personal experiences and level of intellectual insight of a small group of MHCUs, confirmed as having a dual diagnosis, so as to develop a relevant series of psycho education groups to be presented within their occupational therapy programme.
- Determine from the literature on psycho education groups any factors that would contribute to the development of the programme.
- Evaluate the group contents and group experiences by running the proposed group programme for the same small group of participants in order to develop a framework for evaluating the factors referred to in the literature review, and which were perceived by the participants to be most helpful in improving intellectual insight into their conditions and occupational performance. In the light of the fact that this study was a short report in a partial fulfillment of the requirements of a masters degree a decision was taken with the supervisor to limit the number of subjects to three, acknowledging that the data may not be saturated in this phase, but to make the research logistically manageable.

The investigative approach was used to develop both the group protocols and the framework for evaluation.

3.2.2 STUDY SAMPLE USED

In order to select a sample that could provide appropriate and adequate information a purposive method of sampling was used.^(64, 65) This is in keeping with the investigative research design described above.⁽⁶³⁾ The researcher invited a number of MHCUs from the population of users with dual diagnosis admitted to Sterkfontein Hospital in Krugersdorp, South Africa, who had been referred for occupational therapy to participate in the study. Participation in the study was confirmed by the multi-disciplinary team.

Three participants met the following inclusion criteria and were invited to participate. They all volunteered to do so.

- The dual diagnosis had been confirmed by a registered psychiatrist.
- All participants had been hospitalized for a minimum of 3 weeks prior to the group programme beginning, thus detoxification of each participant was ensured, and they were no longer displaying symptoms of acute psychosis which would negatively influence their ability to participate effectively in the programme.
- All participants had been referred for occupational therapy by the multi-disciplinary team and psycho education was an aim in the occupational therapy treatment plan of each of the MHCUs.
- All participants were either on an Explorative Patient Directed level of Creative Ability or above, as this ensured their cognitive ability to participate in the programme.⁽²⁹⁾

As this phase of the study was to develop the psycho education programme, the number of participants was determined by the availability of participants that met the selection criteria at the time of the investigation. The researcher decided that three participants were sufficient for this preliminary phase of the study. Kielhofner supports that a small sample size is relevant as the importance of qualitative research is “appropriateness” and “adequacy” and thus the focus of the sample selection is on who can give the most appropriate and adequate information. Therefore according to Kielhofner, random sample selection is not appropriate and the number of participants is not important, but more their exposure and knowledge of the phenomena to be studied.^(64, 65)

The sample was made up of the following three participants:

Information on the participants is vague to preserve the anonymity of the participants.

PARTICIPANT A: 24-year-old Caucasian male who had a long history of substance abuse but had had no previous history of treatment. His substance of choice was reported to have been stimulants namely cocaine and ecstasy. He had been admitted to Sterkfontein Hospital as a result of a psychotic episode and had been diagnosed with substance induced psychosis on admission to three weeks prior to this study. As a result of his illness he had lost functioning within all areas of occupational performance resulting in him having lost his job and being isolated from both his primary and secondary support networks.

PARTICIPANT B: 29-year-old African male who had a history of cannabis abuse. He had been admitted to Sterkfontein Hospital as a result of a psychotic episode. He had previously been admitted three times for psychosis, and had been involved in rehabilitation programmes previously, however he had failed to develop intellectual insight into how his substance use contributes to his psychiatric diagnosis. He reported that his cannabis use had always been a part of his culture and had been smoking from his early teenage years. He reported that he had never worked and thus his substance use had occupied a lot of his time in his premorbid activity profile, and hence would find it difficult to stop using, thus indicating how poor intellectual insight results in a lack of affective insight.

PARTICIPANT C: 52-year-old Caucasian female who had a history of abuse of prescription medication. She had been admitted to Sterkfontein Hospital as a result of a depressive episode resulting in a suicide attempt. She reported the underlying cause of her depression had been the loss of her job, and thus the financial pressures, as well as the loss of her children whom had been removed by Social Services. She thus reported feeling desperate and it was identified that she had lost both her worker and parental roles, thus resulting in role under load, imbalance in her activity profile, and a loss of comfort and satisfactions in her occupational performance. This was her first admission to a psychiatric facility, hence her level of intellectual insight was poor, and had been

diagnosed with a major depressive episode on admission 3 weeks prior to the programme commencing.

Although the sample was demographically mixed and represented different cultures, age groups, psychiatric disorders and substances of choice, all the participants were homogeneous in term of their dual diagnosis.

3.2.3 PHASE 1: STAGE 1: DEVELOPMENT OF THE PROTOCOLS FOR THE GROUP PSYCHO EDUCATION PROGRAMME

Access to the programme was negotiated by informing the participants about the purpose and expected outcomes of the research, and the series of psycho educational groups that they would participate in. They read the information sheet (See Appendix A) and all signed the consent form agreeing to participate (See Appendix B).

The researcher had had three years experience as an occupational therapist at Sterkfontein Hospital and was responsible for psycho educational groups in the occupational therapy department. The researcher collected the data by interviewing each participant three times however a different set of questions was asked in interview 1 and 2 but the questions in interview 2 and 3 were the same (see Appendix C). The only steps that were taken to ensure validity and rigor of the data were reflexivity.^(64, 65) The researcher continually reflected on her observations and experiences in both the interviews and in running the psycho education groups. Field notes were maintained on these experiences and reflections,^(64, 65) as the participant's experiences and perceptions were being explored at that moment in time, and were to be considered in the development of the programme. The small number of participants may have influenced the trustworthiness of the data but since the data would be pooled when it was included in the protocols for the group sessions, and that the participants would be given another opportunity to evaluate the contents and group procedures, this was thought to be acceptable.

The fact that the researcher gathered the information and analyzed the data in this stage was a concern and potentially may have biased and influenced the trustworthiness of the information. This data collecting procedure was therefore changed in the main study, described in chapter 4, to avoid this bias.

The first interview was carried out in order to develop the psycho education programme while the second and third interviews aimed to establish the most useful content and group work processes to develop intellectual insight into the dual diagnosis, and to develop the framework to evaluate the psycho education programme.

The interviews were not tape recorded but the information was recorded as field notes with the researcher making notes whilst the participant answered the questions described below.

Initial interview to identify needs

The purpose of this first interview was to introduce the research to the MHCU, to initiate a therapeutic relationship and then based on their past history, the informal assessment of their understanding of their problems and their perceived needs developed the protocols for the group psycho education programme. The first interview was conducted individually with each participant by the researcher. The interview was completed in the researcher's office. At the beginning of the interview the researcher confirmed that each participant was aware that their involvement in the study was completely voluntary. It was also confirmed that the participant was aware that they could withdraw from the programme at any point without compromising their treatment in any way. Each participant was told that the use of their names would not be recorded in the study and thus confidentiality of their identity would be maintained.

The initial interview consisted of loosely framed questions (see Appendix C), which explored three key areas based on the researcher's experience and the factors identified in the literature review as important in a psycho education programme in the context of dual diagnosis.

- The participant's perspective on the reason for participation in psycho education groups. This included specific questions around their understanding of their psychiatric condition, their diagnosis, and what influence this has had on their life and occupational performance. From this information, the participant's level of intellectual insight into their mental illness was concluded.

- The participant's view of their drug history and their experiences of how their use of substances had influenced their life, both positively and negatively. This established the impact drugs had made on each participant's life, and whether the participant had identified the link between their use of substances and their psychiatric illness as well as admissions to psychiatric institutions.
- The needs that the participant wished to address in the psycho educational group programme.

From the responses to the questions the participants' baseline level of intellectual insight was ascertained as well as their stated level of motivation to attend the groups and their expressed need for change. This was important for two reasons:

- To determine the exact level and nature of the knowledge that the MHCU had with respect to the substance(s) that they used, the quantity and the impact of their substance use on their illness, behavior and occupational performance so that the correct information was consistent with the level of the MHCUs understanding, as well as their level of creative ability could be included in the programme to ensure it met the therapeutic needs of the participants to improve intellectual insight
- But also to be the norm against which the outcome of improved intellectual insight was to be measured for each participant individually and then collectively for the group.

The data from this first interview was analyzed using priori coding that identified the themes from the literature on psycho education and group therapy, ^(52, 64, 65, 66) so as to allow the researcher to ensure that the group psycho education programme was designed to address the participants' expressed needs, and was appropriate to their experiences, but aimed at achieving improved intellectual insight.

The analytical process within investigative research does not involve a word-for-word or line-for-line coding, as in inductive coding, but is more in the contextual nature of the data, where the data is respected and remains intact against the theoretical analytical framework. The researcher is thus guided to focus and engage in a more intellectual process thus creating patterns and themes within the data from a professional

perspective in making sense of the most important ideas to be conveyed in a new manner. The researcher is thus required to engage in a dialogue between the theory and the data.⁽⁶³⁾

From the data collected in the first interview common themes were identified, and then further categories and subcategories were recognised.

The theme “ motivation to attend the programme “ was identified from the literature as a key component to change in recognition of the well described phenomenon that desire to change is the first step in abstinence for any substance abuser. The categories or priori codes in this theme were derived from the literature as insight is describe as the cognitive and emotional process that that facilitates abstinence and for any groups process to be meaningful it has to be consistent with the needs of the group participants.
(19, 20)

TABLE 1 Analysis of the Initial Interviews that Informed the Development of the Group Psycho Educational Programme.

<u>Theme</u>	<u>Categories</u>	<u>Subcategories</u>
Motivation to attend the programme	Insight into dual diagnosis	<p>I only understand my psychiatric illness.</p> <p>I have a poor understanding of my substance abuse.</p> <p>I don't understand the relationship between my psychiatric illness and my substance abuse.</p> <p>How did my condition affect me?</p>
	My needs to be addressed in the programme	<p>How will I cope?</p> <p>What resources are available to help me?</p> <p>What happens if I get sick again?</p>
	Must I really stop?	<p>Do I need to stop?</p> <p>What will I gain if I stop?</p> <p>What will I lose if I stop?</p>

The interviews confirmed that the theme to be addressed in the development of the programme was the level of motivation within each participant to attend the proposed group psycho education programme. The link between the three categories, insight into dual diagnosis, my needs to be addressed in the programme and my personal experiences informed the basis of the group contents, and had to be appropriately aligned to ensure the participants remained motivated. Thus the range of insight difficulties had to be addressed as well as the individuals MHCUs concerns around giving up their substance in the light of their personal histories relating to their substance abuse.

The proposed content of the psycho educational programme was further informed by the subcategories in which the participants expressed the following:

1. INSIGHT INTO DUAL DIAGNOSIS

i. I only understand my psychiatric illness

Participant B: *"I suffer from psychotic episodes"*

All the participants had a basic level of intellectual insight into their psychiatric illness and agreed that this had been addressed in previous groups that they had attended. While this minimal level of intellectual insight does not assume that the MHCU understands their complex illness this is an important first step where MHCUs have little idea of what is wrong with them.

ii. I have a poor understanding of my substance abuse problem

Participant B: *"Smoking is part of my culture and everyone, all my friends smoke (dagga)!"*

All participants were unaware of the facts about their drug of choice and the process of addiction. The participants' stated needs lay more in increasing their understanding of the substance use and why it is a problem for them and not for others in their social group but not specifically about their psychiatric illness.

iii. I don't understand the relationship between my psychiatric illness and my substance abuse

Participant A: *"...what is the difference between my medication and drugs?"*

Their lack of intellectual insight into the relationship between their use of substances and their psychiatric illness was clear. However there was an expressed need to understand the relationship that lies between their two conditions.

iv. How did my condition affect me?

Participant C: *"I have lost my job and my family"*

The lack of intellectual insight of the participants into how their condition contributed to their occupationally dysfunctional behavior and how this behavior ultimately contributed to their social, financial and interpersonal problems was evident from the analysis.

2. MY NEEDS TO BE ADDRESSED IN THE PROGRAMME

i. How will I cope?

Participant B: *"My drugs help me to relax, so how can I relax now"*

The analysis revealed that the participants' substance use was entrenched in their cultural context where it was an accepted practice or they used it to relax, cope or feel part of their social setting. They all expressed the need to explore how they would cope without their substance, and how or what they would do as a substitute.

ii. What resources are available to help me?

Participant B: *"Where do I go when I want to smoke and I am at home?"*

All participants expressed the concern that giving up their substance, even to improve their health, may be difficult and expressed the desire to know what resources were available for them to seek help and support .

iii. What happens if I get sick again?

Participant B: *"What do I do when I get sick?"*

In addition all participants expressed the need to understand the likelihood of further episodes. What they needed to do to stay well and out of hospital, and what factors were likely to cause a relapse, and how this would be recognized.

3. MUST I REALLY STOP?

Participant A: *"It's going to be difficult to cope without them; do I really have to stop?"*

Participant C: *"If I stop my pills I can maybe get my children back"*

Participant B: *"When my friends are smoking, what am I going to do?"*

This category further confirmed that the group psycho education programme needed to address the participants' level of anxiety concerning the consequence of stopping their use of substances and their ambivalence between the incentives for stopping, in other words what they may gain, but at the same time what would they be likely to lose through this action. It therefore highlighted the participants' need to decide on their intention with respect to their substance abuse and that making that decision was difficult and has consequences that would affect their health, occupational performance and the people close to them. Furthermore this subcategory also heightened the need to

explore their feelings of guilt concerning the affect their condition had had on their family and friends.

The analysis of the data from the first interview (the expressed needs of the participants) and the use of the literature on group psycho education for dual diagnosis was used to develop the programme. ⁽³⁸⁾ Since the main purpose of this section of the research was to generate information on which to develop the psycho education programme for MHCU with dual diagnosis the credibility of the information was not rigorous as it was planned that the credibility of the programme would be tested through the later interviews and in the next phase of the research.

The guidelines on the development of a group psycho education programme for dual diagnosis) established that the group psycho education programme should contain the following information:

- The definition of a drug and the differences between recreational and prescribed drugs,
- The difference between experimentation with substances, substance use, substance abuse, and substance dependence/addiction,
- The process of addiction,
- How have their substances affected their behavior, occupational performance,
- The relationship between their psychiatric illness and their use of substances (dual diagnosis) and how they need to stay compliant to their medication and abstinent from their substances (the management of both conditions).
- How to cope with stress and relax without drugs, highlighting that stress could trigger relapse of both of their conditions. Stress management thus being an important component for both their psychiatric illness and their substance use disorder.
- Triggers for relapse,
- How to cope with these situations that have been identified as triggers,
- How to cope with relapse of both their psychiatric and substance use disorders,
- What resources are out there for them to access?

Aspects that would be included in the programme as they were identified as a need from this interview are:

- Dealing with the guilt resulting from the consequences of their use of substances and symptoms of their illness, and the impact this had had on their support network,
- Grieving the loss of drugs, and how to replace them, as well as acceptance of their psychiatric illness to motivate compliance to treatment (promotion on affective insight).

How the literature was used in conjunction with the participants' perceptions to develop the group psycho education programme: (See Appendix D)

Literature on dual diagnosis emphasized the importance of including content regarding both the approaches of psychiatric and substance abuse treatment and that treatment be geared to each individual MHCU. ^(21, 28, 38) This was achieved in the group protocols described in the literature, where psycho education was addressed in both mental illness and substance abuse. Although the participants felt that they understood their psychiatric illness, groups still focused on increasing their intellectual insight beyond understanding their symptoms, ensuring they understand the importance of treatment compliance, abstinent from substances and the need to manage their triggers, people, places or things that have been identified as increasing an individual's chances for relapse of both conditions e.g. stress management. ⁽³⁸⁾ The group content focused more on the psycho education around their substance use as this was the expressed needs of the participants. The treatment approach for substance use disorders strongly encourages abstinence from substances and this was emphasized in the groups. This treatment approach also encourages the use of the twelve-step programme and encourages the use of a therapeutic community facilitated by Alcohol and Narcotics Anonymous (AA and NA). ^(1, 57) As access to such meetings was not available, the group participants were introduced to these meetings and given handouts of the groups available in their community. The twelve-steps, according to the substance use treatment approach should be facilitated by a recovering substance user ⁽¹⁾, and as the researcher was not of this criterion, the group participants were encouraged to seek such support once they returned to their community and had access to such resources. Intellectual insight into their psychiatric illness was also addressed, but focused more on the causes, symptoms and their steps in the management of their condition, and thus drawing the connection between their substance use disorder and their mental illness. In

the groups that followed, each participant was given the opportunity to explore how both conditions have impacted on their lives individually and what changes they need to make in their individual lives. The experience of a therapeutic community however was facilitated by the researcher in the utilization of the group dynamic and by using the group techniques and leadership style ⁽⁵²⁾ to facilitate interaction amongst the group participants to establish the sense of autonomy and universality within the group members.

The literature on group therapy techniques discusses the influence the group leader's approach has on the MHCUs' response to the information and content of the group programme. It suggests that the leader should not rely on their title to accomplish respect from the group members but rather approach the group in an enthusiastic, open, willingness to share yet directed manner. The group leader should gain respect from the group members by being perceived as genuine, trustworthy and a role model to the participants. The researcher planned to achieve this by maintaining a flexible approach and in the psycho education sessions shifting to a more didactic approach where her knowledge and experience in the subject matter was imparted. ^(28, 33, 34, 52) This was in keeping with Swaminath who suggested the didactic approach was important in ensuring the MHCUs receive realistic information about their condition. ⁽²⁸⁾

The importance of the therapeutic relationship was also referred to in the literature on groups. This was addressed when the researcher started establishing the therapeutic relationship within the initial interview with each participant. The literature stated that the therapeutic relationship when established allows for the MHCUs' insight to be addressed and allows the MHCUs to understand and internalize the information received in the programme. ^(45, 52) This was achieved by the researcher in her leadership style of the group, where the participants were encouraged to contribute to the discussions and activities, and techniques used ensured each participants' application of intellectual insight into their individual situations, both prior to admission and after discharge. The researcher's leadership style encouraged group interaction allowing group cohesiveness and a sense of universality to develop. It allowed for support and confrontation of the group participants not only from the researcher herself, but from the fellow group members as well, a need that was indirectly expressed. This again was the researcher's

attempt to simulate the therapeutic community of the AA and NA fellowships of the substance use disorder treatment model. ^(1, 45, 52)

Although literature on psycho education stated the importance of the inclusion of MHCUs' family and support systems as important, this was not included in this phase of the study's group programme. ^(28, 30, 31, 32) This was largely due to the fact that Sterkfontein Hospital is only an inpatient treatment facility and therefore the participants' families were not available to attend the programme. The group psycho education programme thus focused on the development of intellectual insight within the participants.

The literature on dual diagnosis emphasized that both treatment approaches of psychiatric care and substance use focus on establishing intellectual insight into maintenance of rehabilitation, thus preventing relapse in both their substance abuse and psychiatric conditions. ^(2, 21) Both treatment approaches also included the importance on focusing treatment on gaining intellectual insight into the long-term lifestyle changes that need to be made to sustain abstinence from their substance of choice as well as the development of life skills to assist in coping with their mental illness without their use of their substances (affective insight). From the description of the group programme, and the group protocols presented in Appendix D, it can be seen that the researcher considered this in the inclusion of the content in the dual diagnosis information session, the development of insight into the participants' triggers and management thereof, in the stress management session and in the balanced lifestyle session where each individual applied this insight in their individual plan for discharge.

Literature pertaining to the substance use disorders treatment approach stated that the programme should allow for peer support as this facilitates the MHCUs' acceptance of abstinence from substances. ^(1, 57) The MHCUs should also develop a sense of self-efficacy and responsibility. ^(27, 52) The researcher considered this in the structuring of the groups and in her leadership style where feedback and active participation from the participants was encouraged at all times. In the first group attention was given to establishing cohesion between the participants and in establishing a sense of autonomy and responsibility over the group programme, and group process, where the discussion was focused on the group aims and the topics the participants wished to have addressed

in the groups. The groups that focused on the establishment of new coping mechanisms also facilitated the participants' development of self-efficacy, and they were left with the knowledge, skills, and a plan on how they can cope with their illness, their use of substances, and life stressors. This was also important in the treatment of their mental illness, as the management of their self-subsystem was addressed in improving their sense of self. ^(33, 34, 52) Peer support was also facilitated, as discussed above, by ensuring each participant was aware of the resources available within their community, with the inclusion of all support groups for their mental illness, Alcohol Anonymous and Narcotic Anonymous meetings (AA and NA meetings) and other support resources available after discharge.

Literature on groups also states the importance of preparing the participant for group therapy and spending time with each individual MHCU as it ensures that each user understands the group process and enhances investment and compliance to the programme. ⁽⁵²⁾ It also allows the occupational therapist to establish whether the MHCU is appropriate for the group programme. This was achieved by the researcher in the initial interview of this phase of the study, as each participant was interviewed individually, and their appropriateness for the programme was established and their motivation for attendance to the programme was assessed.

3.2.4 THE PROPOSED PSYCHO EDUCATION PROGRAMME

Considering these principles and the core content, established from the literature of psycho education for dual diagnosis, and the data from the first interviews, identified above, the group psycho education programme was then divided into 8 sections to ensure that the participants' needs were to be met, their experiences, and level of insight considered, and these were:

- **Group 1: Ice Breaking** – establishing group cohesion, the baseline level of each participants' insight into dual diagnosis, through each participants' sharing of their life story. The definition of a drug, and the difference between use of a substance, abuse and dependency on a substance was introduced, and the process of addiction.
- **Group 2: Dual Diagnosis Information Session** – where the relationship between the participants' mental illness and use of substances is explained and

how the management of their mental illness involves abstinence from drugs and any form of intoxication

- **Group 3: The Impact of Dual Diagnosis on their Lives** – using Kielhofner's Model of Human Occupation ^(9, 44, 45) as a framework a comprehensive group discussion was facilitated to enable each participant's identification of the areas of their life that have been impacted on by both their mental illness and/or their use of substances.
- **Group 4: Triggers** – identify each participant's main trigger (people, places or things that make them vulnerable to relapse) and through a group discussion assist them in establishing coping mechanisms or methods to avoid these dangerous places, people, things and times.
- **Group 5: Support Systems** – the importance of support in remaining mentally well and abstinent from substances, and awareness of where in their communities the participants can gain this support
- **Group 6: Stress Management** – what is stress, and the difference between healthy stress and unhealthy stress/distress, and how to cope with stress and relax without substances.
- **Group 7: Balanced Life style** – the importance of a balanced lifestyle in maintaining a healthy level of stress both as to avoid triggers for relapse in both their mental illness and their substance use, and drawing of a balanced activity profile so as to establish a healthy discharge plan.
- **Group 8: Termination** and highlighting the shift in insight and the changes needed to be made in each participant's life.

The details of how this information was presented in the group programme will be found in the detailed group protocols in Appendix D. Information on all the content, techniques, structuring, leadership style used and handouts given is available in these protocols.

The groups were run twice a week (in keeping with the literature that suggests groups should be held more than once a week ^(41, 52) for the duration of 90 minutes per session. As the group membership was limited to 3 participants this time frame allowed for adequate time for discussion of all content and the participants active participation. A break of 10 minutes was structured in the middle of each session, when necessary, so as

to ensure the maintenance of maximum concentration of the participants, but this break was never utilized. The groups were held in the group room of the Occupational Therapy Department. It was a quiet, secluded room that allowed for privacy and limited external distractions, and was a room that each participant was familiar with to encourage a sense of comfort within the participants, suggested by the substance abuse and group literature. ^(21, 41)

The researcher at this point failed to include post individual sessions for the participants, despite the literature suggesting this. ^(21, 41) As the group membership was limited to three participants, it can be argued that the participants had gained sufficient individual attention within the group process. Post sessions were included in the main study, once this feedback was gained from the second interview of the participants in the main study.

3.3 PHASE 1: STAGE 2: EVALUATION OF THE GROUP PSYCHO EDUCATION PROGRAMME FOR MHCUs WITH DUAL DIAGNOSIS

3.3.1 INTRODUCTION

The purpose of this step in the development of a relevant psycho education group for MHCUs with dual diagnosis was to identify the factors that would be used to evaluate the success of the programme. The group literature suggested that the three critical areas needing exploration were the group contents, techniques and group experiences ⁽⁵²⁾

The research procedure used to identify the critical factors to be used in the evaluation of the psycho education programme was to run the proposed group psycho education programme on the same small group of participants. This was done to develop the framework for evaluating the factors, which were perceived by the participants to be most helpful in improving insight into their dual conditions and occupational performance.

3.3.1.1 Data Verification

The concepts of validity and reliability are incongruent within the qualitative nature of this study. Credibility within investigative research is achieved by the manner that the

specific analytical decisions are presented and contextualized within the larger picture
(⁶¹) In practice this means the subjectivity of the knowledge and the position of the researcher needs to be transparent. (⁶³)

Similarly, validity must be distinguished from the researcher's sincerity and position, in that findings are plausible and confirmatory with regards to the clinical knowledge, and are presented with new understandings. (⁶³) In practice this means findings are relevant in that concur with established theory and offer a new clinical application thereof.

This research used the criteria recommended by Guba and Lincoln, (⁶⁷) to ensure the trustworthiness of this data.

- i) Through member checking in interviews two and three, where the same participants' experiences were explored, and thus there was more than one interview focusing on the same information. (Interview 2 and 3 included the same questions (see Appendix C)). The researcher made use of her field notes to ensure that the interpretation of the data was consistent with the observations that she made of the participants' performance within the groups. If the participants' feedback indicated that they had made changes in their behaviour and had engaged actively in the group programme, the researcher could reflect on her group reports where she had recorded the participants' level of performance in each group, and confirm consistency in the information gathered. This also includes the data verification step of reflexivity. (^{64, 65})
- ii) The background qualifications and experience of the investigator as the researcher is the major instrument of data collection and data analysis. (^{67, 68}) The credibility of the researcher as a competent clinician has been described above.
- iii) Through triangulation that included observations of participants' behaviours in and out of the group (reflexivity), (^{64, 65}) and the observed /reported changes. The participants' behavior within the groups was recorded by the researcher in her field notes. Therefore, as described above, when the participants' feedback referred to a behavioural change, the researcher could reflect back to her group reports and cross-check whether she had observed behavioural changes within the participants. When the participants' referred to behaviour changes that had occurred outside of group, and in the structured environment of the ward, the

researcher made use of the nurses' reports and feedback gained in ward round from other health care practitioners. These reports contained confirmation of changes in the participants' behaviour, changes in social support groups within the ward, and results from urine-cannabis tests, thus cross-checking the reports of the participants. Hence both the field notes of the researcher and the nurses' reports assisted the researcher, when the researcher felt that data received had been tainted by her bias.

As the sample size was very small, and selected only to achieve the development of the psycho education programme the information gained could only be said to be transferable within the same organization; Sterkfontein Hospital Occupational Therapy Department. ^(67, 68)

The concepts of dependability and confirmability may not have been achieved, as the detail of the information given regarding the research design and the personal nature of the data, may not allow for this phase of the research to be repeated. However it was never intended that this phase of the research should be repeated.

3.3.1.2 Ethical Considerations

This research was approved by the Ethics Committee on Human Research (Health) as the researcher received ethical clearance from the University of the Witwatersrand prior to starting the research. (Appendix G)

Permission was given by the CEO of Sterkfontein Hospital, received in a letter, to conduct this research, and thus the researcher had the support of Sterkfontein Hospital. (Appendix H)

The researcher considered these ethical issues by implementing the three principles of:

Autonomy – The researcher ensured that all participants volunteered to participate and confirmed this through signing of the consent form. (Appendix A)

Non-maleficence – The researcher ensured that the study did no harm to any of the participants by considering all the MHCU's expressed needs.

Confidentiality - In this study the ethical considerations are in maintaining confidentiality of the data, preserving the confidentiality of the names of the participants and the use of the research for intended purposes.⁽⁶⁹⁾

3.3.2 IDENTIFYING THE FACTORS TO BE INCLUDED IN THE FRAMEWORK FOR EVALUATION

The second interview was held in the middle of the series of groups. It was also conducted by the researcher in her office to allow for continuity and consistency. At the beginning of the interview each participant was informed of the importance of their feedback on the groups they had participated in thus far, and that they would not be compromised in any way if their feedback was negative. This was important to encourage honest feedback, as the participants may have felt compelled to only give positive feedback as the researcher herself was conducting the interview. It is noted that for research purposes the researcher should not have run the groups and conducted the interviews, as this may have influenced the results achieved. It is for this reason that this was changed in the phase 2 of this study. At this phase of the study the researcher conducted the interviews as this phase focused more on the development of the programme. However in phase 2 where the emphasis of the data collected would be on the evaluation of the programme, it would be imperative that a neutral party be involved in the data collection.

As described before the interview data was gathered from the notes taken by the researcher in each of the interviews. From the data the common themes were identified using priori codes, the factors being established previously by the literature that had been reviewed.^(64, 65)

The second interview consisted of discussion round three loosely framed questions (See Appendix C)

- How each of the participants had experienced the groups thus far.

This was to examine whether they believed that the contents of the psycho education programme addressed their expressed treatment needs identified in the first interview.

- The factors, which need to be included in an evaluation procedure to critically review the group techniques, and group processes each participant had found useful in the groups, to promote their insight into their dual diagnosis.
- Changes they felt should be made to the programme: what they felt should be maintained and what could be excluded.

This gave each participant the permission to give both positive and negative feedback, and allowed the researcher to gain constructive criticism to ensure that the groups were of use to the participants, and succeeded in meeting their needs.

This also allowed the researcher to ascertain whether the group psycho education programme had achieved a shift in the participants' level of intellectual insight into both their substance abuse and their psychiatric condition, and the link between the two illnesses. It further established whether the participants had experienced the programme as successful and their level of motivation to continue in the group programme and implement the proposed life style changes (affective insight).

The third interview was conducted once the participants had completed the 8 series group psycho education programme that had been developed. It followed the exact format of the second interview described above. As no new information was found it was assumed that the data was saturated and has been analyzed with the second interview in the Table 2 below.

This assisted the researcher to finalize the group psycho education programme that was to be presented in phase 2 of this study.

TABLE 2 Themes Emerging from the Second and Third Interviews of the Series of Psycho Educational Groups of Phase 1 of this Study

<u>Theme</u>	<u>Categories</u>	<u>Subcategories</u>
These groups, did they help me?	What do I need to do to stop?	Changes in insight into dual diagnosis. How can I cope?
	Did I gain anything?	What groups stood out for me (content)? What about the groups helped (techniques)? What was good about the group leader (leadership style, structure)?
	Not everything was useful?	What groups were not helpful (content)? What about the groups would I change (techniques, structuring, context, leadership style)?

3.3.2.1 These groups, did they help me?

This theme allowed the researcher to establish the effectiveness of the groups in the middle of the programme. Analysis of this theme then allowed the researcher to be aware of what the participants perceived as useful and what they needed changed so that these insights could be used prior to the group programme ending. This theme then continued in the third interview to allow for confirmation of whether there had been a sustained shift in the participants' level of intellectual insight into dual diagnosis and the management of their conditions, and of what factors had been effective, and thus needed to be continued in the group programme of the main study. This theme was divided into

three categories that explored this theme in terms of whether the groups had been effective in meeting the participants' needs, what they perceived had worked for them and what needed to change. The seven subcategories then highlighted the specific details of these categories to assist the researcher in adapting the groups at this stage of the programme, and then confirming the group programme for the main study.

3.3.2.1.1 WHAT DO I NEED TO DO TO STOP?

This category was divided into two subcategories to establish whether the participants' expressed needs, established in phase1, had been met. Their needs were grouped into needing to understand their use of substances more and the facts around substance abuse, and the researcher had identified the need to address intellectual insight into their psychiatric illness and the relationship between the two conditions (dual diagnosis). The other need expressed by the participants was learning to cope without their drug of choice, and the second subcategory explored this.

i) Changes in insight into dual diagnosis

Participant B: *"I know the four steps to keeping well, I must drink my medication, must see the doctor at the clinic, I must stop all my drugs and I must cope with my stress"*

All the participants expressed a shift in their level of intellectual insight, in having a deeper understanding of their mental illness and the relationship that exists between their conditions. The participants were surprised at what they had learnt in the group and all reported that they are now aware that if they want to get better and go home, they have to take their medication and stop using their drug of choice. They also expressed understanding of their triggers (people, places and things that render them vulnerable to relapse) ^(21, 57), both for their mental illness and their substance use and were aware of resources in the community to assist them with the management of their condition, such as professionals, clinics and support groups.

This demonstrated a shift in the participants' level of insight into their mental illness, their use of substances and dual diagnosis. The programme had thus been effective in improving the participants' level of intellectual insight.

ii) How can I cope?

Participant B; *"My friends are a problem because they all smoke, so I have to make new friends from the groups and my soccer"*

Participant A: *“I am going to cope with stress by having a life that is more balanced....”*

This subcategory highlights the expressed need of the participants to gain more coping mechanisms. In the second interview the participants all reported that they did not feel that this had been adequately addressed, however from the list of group goals they were aware that it would be addressed in the groups to follow.

From analysis of the third interview the participants perceived that they had recognised their triggers for both their mental illness and use of substances. They identified their main trigger as stress for using their substances. They had also been made aware that stress can trigger their mental illness. They were all aware that they had used their substances as a coping strategy for their stress and were now aware of how this contributed to their mental illness. Stress management was therefore an important focus of the group programme and the participants perceived that they were more capable of managing their stress levels. They had identified other triggers as dangerous people, places and times. They perceived that they had identified effective methods of avoiding these triggers and thus felt more empowered over the management of their triggers

3.3.2.1.2 DID I GAIN ANYTHING?

This category highlighted what the participants had perceived as useful in the groups thus far. The subcategories divided the data into what they found useful in the group content, techniques and the researcher’s leadership style.

i) What groups have stood out for me (content)?

Participant C: *The group with all the pictures of the chemicals and how they are unbalanced when we sick and balanced when we well was good”*

All the participants reported finding the content on psycho education into their psychiatric illness useful. They had also found the content around what is a drug, the process of addiction, and the difference between medication and drugs helpful. They now understood why their use of substances was influencing their psychiatric illness, and was counteracting their medication, as well as how their substance use had become a problem.

This category assisted the researcher in establishing the specific details about the content, techniques and leadership style that the participants had perceived as effective. This data assisted the researcher in ensuring what should be repeated in the main study.

ii) What about the groups helped (techniques)?

Participant A: *“The pictures helped the most because you could really see what was going on and what was wrong.”*

Participant C: *“I could really see what I need to change to keep my chemicals straight and my stress levels safe.”*

The participants all reported that the use of pictures and diagrams had helped them to understand the information. Diagrams were used in both the dual diagnosis information session on mental illness and substance abuse, as well as in the description of the process of addiction.

iii) What was good about the group leader (leadership and structure)?

Participant A: *“I liked that we were in control so that we discussed everything that we needed to discuss.”*

Participant A *“There was no chance for us to slack off because the groups were so small you couldn’t hide, and Sarah always asked us questions.”*

All the participants felt that the less didactic approach of the researcher allowed them to be actively involved, made them feel autonomous over the group process and helped to build group cohesion. The participants all reported that the flexible approach of the researcher allowed them to remain in control of the group content and thus ensure that all their needs from the groups were addressed. They also felt by keeping the groups small it enhanced their active participation in the groups, as the group structure and the researcher demanded their active participation.

3.3.2.1.3 NOT EVERYTHING WAS USEFUL

The data from this category assisted the researcher in knowing what it is that she needed to change in the current presentation of the group programme, as well as what not to repeat in the main study. The participants felt that in the first group a lot of time had been wasted in developing the aims of the groups, and also felt that when it came to the dual diagnosis information sessions, more of a didactic approach would have been more useful, as the discussions in these sessions again resulted in time being wasted. They

recognized when discussions were helpful, and when the factual information should be given in a didactic approach by the researcher. This is in keeping with the psycho education literature that promoted the use of the didactic approach in imparting of theoretical information.⁽²⁸⁾

i) What groups were not helpful (content)?

Participant A: *"The groups where we got all the pictures and notes were the best. Sometimes the discussions just went on and the information then was not as good."*

The participants again reported on the use of time. They found the dual diagnosis information sessions very helpful. However when the discussion went round and round the value of the information was lost.

ii) What about the groups would I change (techniques, structuring, context, and leadership)?

Participant B: *"We need more notes so that I can show my family, and my friends on the ward."*

Participant C: *"Maybe if the groups were bigger we could also have more to discuss, we would have more support, there would be more information and the discussions would be better."*

Participant A: *"The first session was a bit of a waste because we focused on what we were going to do and I just wanted to get going."*

As discussed above, because the researcher conducted the interviews, the participants' ability to give negative feedback may have been limited, and thus the findings in this subcategory are questionable. It was thus imperative to change the data collection process for the main study (discussed in detail in Chapter 4). It can also be said that the participants were being treated in a large institution, and were more familiar to an autocratic and didactic approach, and thus were not accustomed, or skilled in giving negative feedback. They thus experienced the flexible and autonomous approach used by the researcher as empowering, and the positive effects of this clouded their objectivity, and their ability to give constructive criticism. The participants did however identify that they would want more handouts so that they could impart this information onto their friends and families. One of the participants also suggested that this programme be run for families and caregivers so that they too can understand their conditions, improve family support and reduce stigmatisation. They also felt that the groups could have more group members as

this may enhance the group discussions, allow for more support and imparting of information

The analysis of the data received from the second interview thus assisted the researcher in altering the programme. As from the protocols in Appendix D it can be seen that the dual diagnosis information sessions were now completed, feedback given regarding the more didactic approach in these sessions was used when conducting the main study

The data received from the final interview highlighted that all the participants had found the group programme beneficial. They enjoyed the flexibility of the group leader and group process, the support that they had received from each other, because the group was small, their active participation was required at all times. They were invested in the programme and requested it to be repeated for their friends and family. The flexible approach to the programme also ensured that the content of the group remained relevant at all times, and gave the participants a sense of autonomy around their treatment. The group programme was thus effective in creating a positive shift in the participants' level of intellectual insight into their conditions, their insight into the management thereof, and the participants perceived the group programme as effective in meeting their needs.

3.4 ADAPATIONS MADE TO THE GROUP PSYCHO EDUCATION PROGRAMME FROM THE RESULTS ACHIEVED IN PHASE 1 OF THIS STUDY

From the feedback the group programme was effective in improving the participants' level of intellectual insight into dual diagnosis, it was thus concluded that it would be a worthwhile study to repeat the programme in a main study, further exploring the factors that contribute to the efficacy of the group psycho education programme. The group programme for the main study was adapted and established from the close consideration of the results achieved in phase 1 of this study. These adaptations can be seen in the protocols of the main study in Appendix E.

It was important to include the needs identified by the participants and ensure that all needs were addressed in the planned group programme for the main study. The needs identified by the participants in phase 1 would be confirmed as to correspond with those

of the subjects in the main study, obtained in the first interview, prior to the groups of the main study commencing. If there were any different or additional needs identified for the main study, they would be included in the group programme of the main study.

The participants in phase 1 reported that time for the dual diagnosis information groups should be extended, as they found these sessions most helpful. The content of the group was thus broken up into sections to ensure that all needs were considered and that adequate time was allocated to the dual diagnosis information sessions, as well as the discussions. The main change in the protocols of both studies was in the initial group of each programme. In phase 1 the first group focused on establishing the aims of the group and then time for each member to share their life story to enhance group cohesion. In the main study this was changed, as feedback from the participants in the phase 1 noted that the time given for the aims of the groups was not useful. One participant did refer to finding the aims list helpful, as it assisted the participants in being aware of where they were in the programme, and whether their needs were being met, but this feedback was taken and in the initial group of the main study, less time was dedicated to establishing the group aims, and more dedicated to the life stories.

The results from phase 1 indicated the dual diagnosis information sessions, and the groups focusing on stress management as having the most impact, they were therefore included in the group programme of the main study. Although the results also showed the usefulness of the didactic approach, and suggested more time be dedicated to this in these sessions, the programme for the main study still ensured time within the group process to allow for the group discussions, as all members within phase 1 identified this as being important for group cohesion and active participation.

The use of the diagrams and group activities and discussion were also maintained in the programme for the main study, as they were identified as useful, as it ensured active participation of all the group members, bringing them to a common focus of the material to be covered, and that all group members saw the content of each group as relevant. Results from phase 1 also identified the diagrams of these sessions as most helpful in their understanding of the information discussed in these sessions. The participants also suggested that more handouts be given in these sessions, and so more handouts were developed for the main study. Where group work had been done on large

paper in phase 1, handouts were developed for the main study, so that each participant could individualise the group discussions, and have their work to take away with them.

From the feedback received in phase 1 of this study the factors that influenced the efficacy of the programme were evident. These were identified in the literature review and results confirmed them as important. They included, group content and techniques used, group structure, group members, leadership style, and group context. All were included in the evaluation framework to be used in the main study.

Group content and techniques have been discussed above. The participants of phase 1 referred to the importance of the number of group members being small as it encouraged active participation and interaction, as well as allowing for group cohesion to develop. One participant did report however that he felt if there were more group members the group discussions could be more enriching, hence in the main study the number of group members was increased to five, so as to enhance group discussions but not compromise group cohesiveness or active participation.

As all the participants in phase 1 had a good command of the English language, and all participants referred to the importance of understanding the content of the groups, this became a selection criterion for all subjects to participate in the main study. The criterion was that all subjects were to be able to speak and understand the English language, as all groups were to be conducted in English, and according to the literature, common language facilitates group cohesion and the technique of confrontation of group members. ^(19, 58, 59)

Feedback from phase 1 made frequent reference to the leadership style of the researcher in that they found the flexible approach facilitatory, but when it came to the dual diagnosis information sessions of the group programme, the participants recognised the didactic approach as being more helpful. Thus in the groups of the main study, the researcher maintained the flexible (*laizaire faire*) approach for the group discussions, so as to enhance the group members active participation within the discussions, allow for the sense of autonomy to develop within the group members, and encourage group cohesion, but shifted to the more didactic approach in the information session on dual

diagnosis where specific and scientific information was being imparted. This was in keeping with the psycho education literature.⁽²⁸⁾

No specific feedback was gained from phase 1 with regards to the context of the group. Questions around the context of the group were thus included in the second and third interview of the main study as these, according to the literature, may affect the efficacy of the group programme.⁽⁴¹⁾ The main study was thus conducted in the same group room as in phase 1 of this study. The group duration in the phase 1 of this study was effective as it was short enough to ensure all the participants could complete the programme before being discharged from hospital, but was long enough to ensure all subject matter to be addressed in the group programme was addressed. Therefore, as in the phase 1, the group programme consisted of a series of eight groups, running twice a week in the afternoons.^(41, 52)

The researcher also included more specific questions around these factors (group content and techniques, group structure, group members, leadership style, and group context) in the second and third interviews of the main study, so as to effectively explore the efficacy of these factors on the efficacy of the group programme. (Appendix F)

The researcher also identified the potential bias in the feedback gained from the participants in phase 1 of this study. The researcher recognised that as she was both the group facilitator and the interviewer this could largely have affected the participants' ability and comfort in giving negative feedback and constructive criticism, and hence the reliability and the validity of the feedback. This was therefore necessary to change in the main study. In the main study the researcher remained the group facilitator so as to ensure consistency in the group programmes, and so not to lose the feedback gained from phase 1 of this study. However the researcher only conducted the initial interview and an external interviewer was obtained to conduct the second and third interviews. The researcher still conducted the first interview as it allowed for a therapeutic relationship to develop between her and each group member prior to the group programme commencing, however the external interviewer conducted the second and third interview as it was in these interviews that feedback was received. (Details of format of interviews are available in Appendix F) The researcher also specified in the

interview format given to the external interviewer, that negative feedback, and constructive feedback was encouraged enthusiastically, so as to increase the reliability and validity of the data received in the main study.

3.5 THE EVALUATION FRAMEWORK

The following evaluation framework, which has been diagrammatically represented below, was developed to direct the data collection and data analysis in the main study. Its purpose was to assist in focussing on the key the factors that have been identified as important, from both the literature and confirmed by the findings of phase 1 of this study. Both sources of information were used to inform the evaluation framework because although the MHCUs in the sample were assumed to be able to identify their needs, it was believed that they would not have sufficient background to be able to comment on the psychodynamics of the group process. This was planned to improve the rigor of the evaluation of the effectiveness of the psycho education programme for individuals suffering from dual diagnosis.

Both the literature and the findings from phase 1 of this study identified the following factors as important in the effectiveness of group work within a psycho education programme and represented the priori codes that were used to guide the questions in the interviewing of the participants. Each code had been described in the literature review.

- Context
- Structure
- Leadership style
- Group members
- Content of the group
- Techniques

These factors will thus be considered in the data collection and the data analysis with regards to the effectiveness of the group programme in the main study. As the data collection and data analysis is dependent on the use of a series of interviews and hence feedback from the group members, the participants' ability to honestly express their experiences and perceived needs is important to consider. This in turn will be used to determine the effectiveness of the programme, and the factors that influence this.

The influence of these factors on the efficacy of the group psycho education programme will be measured against the perceived shifts in the participants' of the main study, level of insight into their Axis I and/or II diagnoses and their use of substances (dual diagnosis).

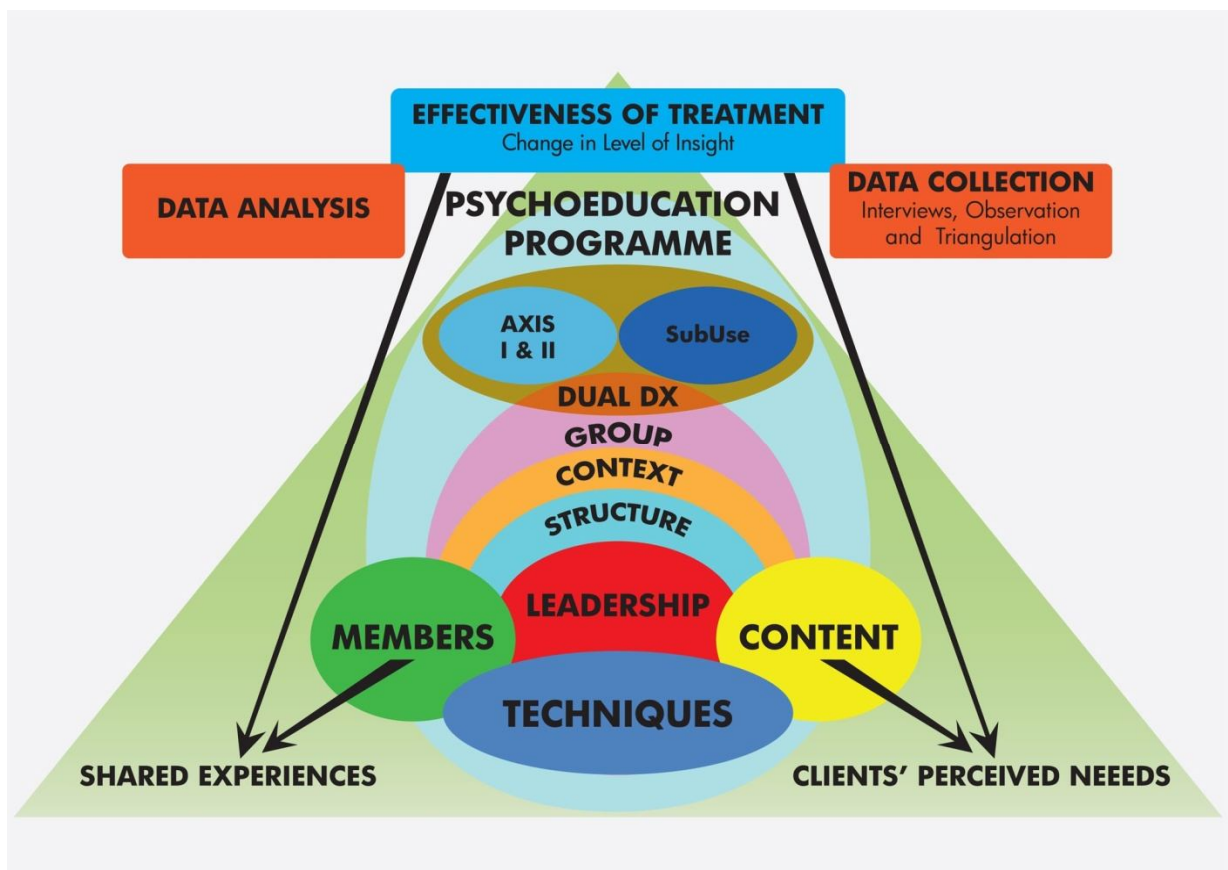


FIGURE 1: THE EVALUATION FRAMEWORK DEVELOPED FROM PHASE 1 OF THIS STUDY

This evaluation framework will be used to evaluate the effectiveness of the psycho education programme for individuals suffering from dual diagnosis during the main study. The programme is focused on increasing the insight of participants suffering from dual diagnosis through a series of psycho education groups. The evaluation framework has been developed from the literature, as well as from the feedback that was elicited from the participants that took part in phase 1 of this study. It therefore was used to establish the data collection and data analysis to be discussed in Chapters 4.

CHAPTER 4

PHASE 2: EVALUATION OF THE GROUP PSYCHO EDUCATION PROGRAMME

4.1 INTRODUCTION

This study aimed to identify the factors as perceived by the MHCUs with dual diagnosis, as contributing to their improved insight in a specifically designed group psycho education programme. The programme was designed as a series of groups integrating both the psychiatric treatment approach with the substance abuse treatment approach, and the development of the programme was described in the previous chapter.

This phase of the study therefore intended to evaluate this specifically designed psycho education programme using the factors that had been identified from the literature, and then confirmed in phase 1 of this study. (See Figure, p70)

4.2 RESEARCH DESIGN

The research design used in this phase of the study was also qualitative because the researcher wished to interrogate the participants' subjective experiences of the effectiveness of the series of psycho educational groups in the context of their occupational therapy, and used the same investigative methodology described in Chapter 3 as the objective was not to create new information, but to apply the new insights clinically. ⁽⁶³⁾ The series of groups, in which the participants suffering from dual diagnosis took part, aimed to improve their insight and understanding of the meaning of their experiences and social worlds involved in the recovery process, rather than to predict outcome. These understandings had been uncovered in phase 1 of this study, described in Chapter 3, and had been used to develop a group process designed to address these individuals' needs more effectively.

This was considered to be an appropriate methodology as qualitative research within the psychiatric ^(60, 68) and the drug use domain has been recognized as a useful method to focus on the meanings, perceptions, processes, and contexts of the world of drugs and offers ways of understanding drug use. ^(59, 70) Qualitative investigative research was also felt to be an appropriate research method to explore the contribution of an occupational

therapy group work programme has, to empowering the individual participant to change their occupational behavior so as to promote wellness and abstinence from the use of substances.⁽⁴⁴⁾ Investigative research is an approach that builds on existing knowledge to allow for practical application of the information.⁽⁶³⁾ As this study aimed at developing a programme to be included in the occupational therapy group programme of Sterkfontein Hospital, the investigative approach was selected. Qualitative research also allowed the individuals' perspective to be considered, thus emphasizing the MHCUs' autonomy and sense of value, by considering and utilizing their subjective experiences in the treatment.

4.3 POPULATION

The population from which the sample for this study was selected was all MHCUs at Sterkfontein Hospital, a specialist tertiary care psychiatric hospital within Gauteng, South Africa.

4.4 SAMPLE SELECTION

Qualitative investigative research requires a small sample that is purposive rather than randomly selected.^(63, 64, 65, 71, 72)

A sample of ten participants was selected using a purposive sampling technique,⁽⁶⁹⁾ and involved the selection of participants according to specific selection criteria.

The requirements for the inclusion of MHCUs in the research were that he /she:

- Suffered from an Axis 1 and/or 2 psychiatric illness and co morbid substance use disorder (dual diagnosis) confirmed by the referring psychiatrist.
- No longer demonstrated acute symptoms of their psychiatric diagnosis thus ensuring an adequate level of cognitive functioning to participate, understand and internalize the content of the groups. (Explorative patient directed to Experimental therapist directed).^(29, 33, 34)
- Needed to be hospitalized for a minimum of a further four weeks so as to allow the group process to be completed.

Mental health care users were excluded from the study if they were not sufficiently conversant in English to participate in the group process.

No criteria related to gender, age, substance of use, drug career history, and psychiatric illness was specified.

The first ten participants, referred for psycho education, and that met the above selection criteria, were invited to join the groups. The research was explained to them (Appendix A), and they signed the consent form (Appendix B), confirming their willingness to participate in the study.

4.5 METHODS USED TO COLLECT DATA

The purpose of this phase of the research was to evaluate which factors, from the participants' experience, within the groups he/she perceived contributed to improving their insight, and the effectiveness of the psycho education programme in the context of their treatment.

Access was negotiated by informing potential participants, who had been referred for occupational therapy and met the inclusion criteria, about the research and inviting them to participate. ⁽⁶⁹⁾ Those MHCUs that were willing completed the ethical procedures described below, and were included in the group psycho education programme.

The data for this phase of the study was also collected in a series of three semi-structured interviews with each participant. These interviews were audio taped unlike in the phase 1 of this study. This was included to eliminate bias in the information gathered, and ensured trustworthiness of the information gained, as the interview would be transcribed and the contents checked whereby reducing researcher bias. This was further ensured, with an external interviewer completing interview 2 and 3, and not the researcher as in phase 1.

A modified version of the Seidman's model of interviewing was used to provide a relevant framework and method of interviewing to explore the phenomena of this study in the training of the external interviewer. ⁽⁷³⁾ This model of interviewing was selected as it provided a useful structure within which the interviews were developed, and gave important guidelines of how questions should be formatted and the interviewer should conduct him/herself during the interview. The interviews were semi-structured as per

Seidman's recommendations, and were recorded and are described in detail in Appendix F. This method of interviewing was used only in phase 2 of the study as interview protocols had to be developed for the external interviewer. As the researcher conducted the interviews in phase 1 of this study, formal training of the interviewer, and interview protocols were not necessary.

- **The initial interview** was completed by the researcher. Its purpose was three fold; to allow for a therapeutic relationship to develop prior to the commencement of the psycho education programme, to establish each individual's needs and their level of insight.

This initial interview also provided an opportunity for the purpose of the study to be accurately explained to each participant, as the literature reported it was also important to explain the advantages and misconceptions of the groups.⁽⁵²⁾ This was achieved by ensuring that an introduction to the group programme was given to each participant individually, to allow participants to ask questions, and have complete understanding of what was expected from them within the programme. This was clarified by each participant being given the information sheet to read (Appendix A) and once the participant felt assured and comfortable, they signed the consent form (Appendix B).

The participants' level of insight was established by asking them about their life story and thus an extensive life history was taken. Their level of insight was reflected in their perception of why they should participate in the programme, the benefits from participating, and the participants' needs from the programme were also established. This assisted in assessing their motivation to attend the programme. Very poor insight may result in a poor level of motivation to attend the programme, and hence the participant's willingness to participate in the study. (Appendix F) Change in the participants' level of intellectual insight was used as an outcome which was used as a measure of the success of the group psycho education programme. The assumption being that improved insight was facilitated by using the dual approaches to substance use would be more effective than just a single approach.

The participants' diagnosis of a dual diagnosis was further confirmed in the initial interview to ensure that each participant met the inclusion criteria of this study.

The time between the initial interview and the commencement of the group psycho education programme was limited to a maximum of a week. This was to ensure that the participant's motivation to take part in the programme was not influenced by the time lapse between the initial interview and the programme starting.

Each participant took part in a series of eight psycho educational groups designed on the basis of the findings of phase 1 of this study. The groups ran over a four-week period, thus two sessions per week were held. This was in keeping with the group literature that referred to the importance of the frequency of groups being held more than once a week.^(41, 52) Each group session was held within the group room within the occupational therapy department. This was a familiar venue to each participant which allowed for the comfort of the participants to be structured. The group room was in the corner of the department which ensured it was quiet and secluded, thus facilitating privacy and limited external distractions. The groups were also run in the afternoon when the department was less busy, further reducing external distractions. Each group session lasted 90 minutes. The group membership was limited to five group members, and thus this time frame ensured that all planned content would be covered. An optional break of 10 minutes was also given after a period of 45 minutes, to ensure maximum levels of concentration of the participants were maintained. This was in keeping with the group literature^(21, 41, 52) and the protocols for these groups can be found in Appendix E.

- **Interview 2**

Two weeks after the start of the programme, an external interviewer completed the second interview. The purpose of this interview was to establish the participants' subjective view of the factors, techniques and interventions that they perceived as effective in the groups that had been run up to this point. A semi-structured interview was used as this interview focused on the details of the participant's present experiences within the group programme, and their reflection on the meaning of their experiences.⁽⁷³⁾ Therefore the narrative approach was necessary. The guidelines that the external interviewer used are

recorded in Appendix F. These guidelines were informed by the evaluation framework that was developed during the psycho education programme development in phase 1 of this study and were summarized in: The Evaluation Framework Developed from Phase 1 of this Study p70.

An external interviewer was used, due to a limitation identified in phase 1 of this study, so as to improve the rigor and trustworthiness of the data gathering in this phase to reduce any bias that may limit the participant's comfort in giving accurate, honest and critical feedback. The external interviewer was the head of the Occupational Therapy Department of Sterkfontein Hospital at the time. She was selected as she was a skilled and experienced occupational therapist and had many years of experience in running groups. All the participants she was to interview were comfortable and familiar with her. This was important to the researcher, as she wanted the external interviewer to be approachable, and the participants comfortable when the giving of honest and accurate feedback. The external interviewer verbally consented to take part in the study, after the study was explained to her, and she was also trained in the interviewing of the participants.

Training of the external interviewer

The external interviewer was given the proposal of the study to peruse so she was aware of the aims, objectives and research process.

The interview guidelines (See Appendix F) were given to the external interviewer prior to the interviews. This allowed the external interview to familiarize herself with the interview procedure that she was to complete, and the nature of the information she was required to collect. There was an opportunity for her to ask the researcher any questions and clarify any difficulties that she had with the interview process and content. She was given guidance on the nature of the feedback that she was required to gather to ensure that the group content remained relevant to the MHCU group. The external interviewer was encouraged by the researcher to at no time lead the interviewee or compromise the relevant feedback, by interruption or moving to the next question too quickly.

The same external interviewer completed interviews two and three of all ten participants to ensure consistency and trustworthiness of the information collected in the interviews.

The second interview gave the researcher the opportunity to receive important feedback from the external interviewer about the group process. The purpose of this feedback was to allow relevant changes to be made to the programme, before the programme was terminated. This was to allow for each participant to benefit from the programme, and not wait until the end of the programme for necessary changes to be made, thus promoting effectiveness of the programme. It was planned that if changes were made to the programme, the structure of the third interview would be changed accordingly to allow for accurate interpretation of the groups. If the feedback introduced new factors or concepts within the interpretation, these would be addressed in the analysis of the data, and incorporated in the adapted evaluation framework of the main study.

Feedback remained anonymous, as the external interviewer was instructed that no feedback was to contain identifying information, and therefore confidentiality of the participants was maintained. If the researcher needed any feedback to be clarified the external interviewer would have returned to the participant for clarification of information and feedback given, so as to ensure the participants' feedback was accurately portrayed.

In this study however no feedback was given to the researcher between the second and the third interviews that required the group protocols to be changed. The external interviewer reported a need for stress management to address the participants' triggers to their use of substances, but as this content already existed in the planned group protocols, there were no significant changes needed to be made to the programme. The external interviewer did report that the participants requested an individual session to assist in clarification, consolidation and personal application of the information that they had gained from the groups thus far. The group literature had referred to the importance of post sessions ^(21, 41), and as this did not alter the group protocols, the researcher did incorporate this feedback by offering all participants an individual session after the group programme, to meet this expressed need.

- **Interview 3**

Similarly the same external interviewer completed the third and final interview after the termination of the psycho education programme. The purpose of this final interview was to explore the participants' subjective experiences of the group programme and the

factors that influenced changes in their insight, and understanding of the meaning of their experiences and social worlds, involved in the recovery process. Now that the group series was complete their previous comments could also be checked by them and modified, to allow for member checking and whether the data had been accurately interpreted, thus ensuring consistency in the participants' feedback, contributing to the trustworthiness of the data.

As in phase 1 of this study it can be argued that two interviews may not have been sufficient in achieving data saturation. The questions in interview 2 and 3 (see Appendix F) were very similar, and very little new data was identified from interview 3, and thus it can also be argued that the saturation of the data was reached. At this point the recordings of the second and third interviews were made available to the researcher.

The raw data was stored securely by the external interviewer between the second and the third interviews, to ensure the safety and confidentiality of the data. Once the raw data was made available to the researcher, after completion of the programme and the third interview, the raw data was stored by the researcher and the interviews were transcribed. The raw data was stored in a locked safe within the occupational therapy department and in accordance with the procedures described by the HPCSA. Once the raw data had been transcribed, the audio recordings were destroyed, by taping over the raw data and then discarding of the tapes.

4.6 DATA COLLECTION

All initial interviews were completed in the office of the researcher, and the second and the third interviews were conducted in the office of the external interviewer. This was to allow for privacy and comfort of all participants as each participant was familiar with the environment of the interview.

All interviews were completed in the morning. This was to ensure that each participant was alert and able to concentrate for the duration of the interview. Each interview was limited to approximately 45 minutes, again to ensure maximum concentration of the participants.

The researcher and the external interviewer adhered to the guidelines of each interview as presented in Appendix F.

All interviews were tape recorded as all ten participants gave consent for the interviews to be recorded (See Appendix B). To improve trustworthiness and rigor all interviews were then transcribed, word for word, from the recordings, by the researcher, to allow for data reduction and text analysis. Data was also collected through the researcher's field notes where the participants' behavior within the groups had been recorded. The nurses' reports and feedback gained in ward round from other health care practitioners were also used. These reports contained confirmation of changes in the participants' behaviour, changes in social support groups within the ward, and results from urine-cannabis tests, and were useful in cross-checking the reports of the participants.

4.7 DATA ANALYSIS

All thirty interview recordings were transcribed word for word.

The transcribed information was coded using priori coding, accepted in the investigative approach as the analysis of data is the dialogue between the data and theory. Therefore it is common for priori coding to be utilized, where the priori codes are developed from the literature, ⁽⁶³⁾ and the coding was also a planned comparison from the evaluation framework from the study completed in phase 1. ^(64, 65) These priori codes are enumerated in the evaluative framework that was developed during the first phase of this research as the codes to be used to evaluate the psycho education programme. As the codes had previously been established in the literature and then confirmed by the study in phase 1, there was no random checking of the codes to ensure trustworthiness in the interpretation of the data. This could introduce a limitation to this study and will be discussed in Chapter 5.

The data that was analyzed was divided into two sets:

- The data from the initial interview determined the perceived needs of treatment and established the baseline level of intellectual insight into dual diagnosis of the participants'.

The common themes and categories identified from the first interview were the participants' perceived need for attendance of the programme to develop insight; hence their baseline level of insight and their motivation for change.

- The data from the second and third interviews focused on the participants' experiences of the groups, and the shift in the participants' level of intellectual insight into dual diagnosis, and their awareness of the management of both their psychiatric condition and their substance use, and the factors of the psycho education programme they experienced as effective in establishing this improved level of insight.

The data from the second and third interviews were thus analyzed together and the common theme and categories were the participants perceptions on how the groups had helped them to change, how they perceived their level of insight had changed, their perceptions as to whether the psycho education programme had met their needs, and their feelings and experiences of the group programme. The evaluation framework was used to focus on the data that reflected feedback on the participants' experiences of the group members, the content of the groups, the techniques used, and how these were implemented, the leadership style used by the researcher, and the structuring and context of the group. The subcategories that were then established allowed the researcher to gain insight into why these factors were perceived as significant in the effectiveness of the programme, and ensured that the identified effective factors could be repeated.

4.8 DATA VERIFICATION

The concepts of validity and reliability are incongruent within the qualitative nature of this study. This research used the following procedures to ensure the trustworthiness of this data:

- The data verification used in this study aimed to achieve the criteria recommended by Guba and Lincoln.⁽⁶⁷⁾ Firstly the research aimed to achieve credibility (internal validity) by establishing a
“...match between the constructed realities of respondents and those realities as represented by the evaluator”. p237⁽⁶⁷⁾

The researcher achieved this, by ensuring the experiences and meanings, attributed by the participants, were accurately represented. This was achieved by the recording of all interviews and transcribing each interview word for word. The interview information was also verified:

- i) Through member checking in interviews two and three, where the participants' experiences were explored, and thus there was more than one interview focusing on the same information. Member checking was also extended to the use of the handouts in the group programme to clarify that the participants understood and could apply the information discussed. Member checking is a recognized method of achieving credibility/trustworthiness. ⁽⁶⁸⁾
- ii) As the recordings of the interviews were only made available to the researcher after the group programme had ended to control bias, the researcher made use of her field notes to ensure that the interpretation of the data was consistent with the observations that she made of the participants' performance within the groups. If the participants' feedback indicated that they had made changes in their behaviour and had enjoyed the active participation in the group programme, the researcher could reflect on her group reports where she had recorded the participants' level of performance in each group, and confirmed consistency in the information gathered. This also included the data verification step of reflexivity. ^(64, 65, 66)

Secondly, the proposed research did not aspire towards transferability (external validity) or the ability

"...to facilitate transferable judgments on the part of others who may wish to apply the study to their own situation".p242 ⁽⁶⁷⁾

It is however suggested that transferability was achieved in this study as the reader has been informed that only Sterkfontein Hospital was involved in this study. The number of participants was small and limited to ten, but detailed information was also given on the data collection procedure and the time implications these sessions entailed. ⁽⁶⁸⁾ Hence transferability to other situations is possible.

Thirdly, the study aimed for dependability (reliability), which comprised the process of honest reporting of data in order to allow for future replication.

This was achieved by the detailed audit trail, and that the information given with regards to the group programmes and interview questions, which allows for this study to be repeated.

Finally, the study aimed for confirmability (objectivity) in that the integrity of the findings were rooted in the data themselves and are available to be inspected and confirmed by outside reviewers. This was achieved through triangulation, to be discussed below and the detailed methodological description.⁽⁶⁸⁾

In order to enhance the meaningfulness of the study the following criteria were taken into consideration.⁽⁶⁷⁾

The concepts that were generated related to the group programme and included the group context, group structure, the leadership style and techniques used within the group, the content of the group and the group membership. These concepts were then related to the participants' perceived needs of the group programme and their shared experiences of the group programme to establish the effectiveness of the psycho education programme. Effectiveness of the programme was related to the participants' perceived change in their level of insight into both conditions of the dual diagnosis, namely their Axis I and/or II diagnoses as well as their substance use disorder. The consideration of the participants' expressed needs and the participants' perceived experiences, allowed for variation within the theory, as both these concepts could not be preconceived by the researcher, and the broader conditions that could affect the effectiveness of the psycho education programme were considered in the sample selection of this study. As described above, it was ensured that all the participants' selected in this study, had a level of cognitive functioning that allowed for participation in the group programme. Their efficiency of the English language allowed for them to comprehend the group content and that the participants' length of stay within the hospital ensured completion of the programme. It was also ensured that they had been hospitalized for a minimum of three weeks prior to the programme beginning to ensure detoxification had been completed. The process was considered in the series of interviews that were conducted in this study as it allowed for a baseline level of insight to be established in the first interview, and then the progress of the level of insight

within each participant to be tracked within the second and third interview. The series of interviews also allowed for the group programme to be adapted to the participants' needs if necessary, as their perceived needs and experiences were recorded in the second interview prior to the group programme terminating.

The openness and flexibility of this study allows for triangulation to be incorporated for the cross-examination of data in terms of "*data source (person, place or time), method (observation, interview document), researcher (investigator A, B), and or theory (qualitative text, recordings)*". p267⁽⁶⁷⁾

Specific methods of triangulation that were included were observations of participants' behaviours in and out of the group, and the changes thereof. The participants' behavior within the groups had been recorded by the researcher in her field notes. Therefore, as described above, when the participants' feedback referred to a behavioural change, the researcher could reflect back to her group reports and cross-check whether she had observed behavioural changes within the participants. When the participants' referred to behaviour changes that had occurred outside of group, and in the structured environment of the ward, the researcher made use of the nurses' reports and feedback gained in ward round from other health care practitioners. Hence both the field notes of the researcher and the nurses' reports assisted the researcher, when the researcher felt that data received had been tainted by researcher bias.

4.9 ETHICAL CONSIDERATIONS

This research was approved by the Committee on Human Research (Health) as the researcher received ethical clearance from the University of the Witwatersrand prior to starting the research. (Appendix G)

Written permission was given by the CEO of Sterkfontein Hospital, to conduct this research, and thus the researcher had the support of Sterkfontein Hospital. (Appendix H)

The researcher considered these ethical issues by implementing the three principles of:

Autonomy – The researcher ensured that all participants involved in this study were given the choice to volunteer to participate or not. They were informed about the purpose and procedures of the research by providing each participant with an information sheet (Appendix A) within the first interview. This interview was conducted by the researcher, allowing her to explain the research to each participant individually and for any questions to be answered prior to the research commencing. The researcher allowed the participants to volunteer their involvement, as in the first interview she clearly emphasized that their participation was voluntary and that they could withdraw from the research at any point. The participants were also informed at this stage that their feedback would be tape recorded, and consent for this was given in that each participant signed a consent form. (Appendix B)

Non-maleficence – The researcher ensured that the study did no harm to any of the participants by considering all the MHCUs' expressed needs. Each participant was also exposed to other forms of emotional support from other health care professionals (doctors, psychologists, nurses, social workers and other occupational therapists). The researcher encouraged the participants throughout the group programme to consult with their individual therapists, and as mentioned in the information sheet (Appendix A). The participants could withdraw from the study at any point without having to leave the group psycho education programme. The researcher designed the study so that it would benefit the participants as it aimed to develop insight into what factors facilitate the improvement of insight, which, as literature shows, is fundamental in the treatment of such individuals.⁽²¹⁾ Throughout the study the expressed needs of the participants were considered and opportunities made to adjust the programme to the participants' feedback received in the middle of this study.

Confidentiality - In this study the ethical considerations are in maintaining confidentiality of the data, preserving the confidentiality of the names of the participants and the use of the research for its intended purposes.⁽⁶⁹⁾ General information was published in this study, but this information contained no specific information e.g. the participants' residential addresses, family names, place of work, date of admission or specific length of hospitalisation, criminal offence charged for, or family background information. This ensured that the participants' identity was preserved and no participant could be accurately identified by those who read this study.

4.10 RESEARCH FINDINGS

4.10.1 DEMOGRAPHICS OF THE STUDY SAMPLE

The sample for the main study was made up of the following ten participants:

Participant A: 23-year-old African man who had been hospitalised at Sterkfontein Hospital for bipolar mood disorder, manic episode. He had been hospitalised for a month prior to the programme commencing, his mood had settled and he was excited about his potential discharge from hospital. He had a long history of abuse of alcohol and had poor insight into how his use of alcohol had contributed to his mental illness, and how his illness had impacted on his life. He had a loss of function within all areas of occupational performance resulting in him having no job and conflict within his primary support group.

Participant B: 25-year-old African male who had been admitted to Sterkfontein Hospital as a result of a psychotic episode. He had committed a crime and was in the forensic unit after a long history of mental illness and substance abuse. He had had previous admissions to psychiatric facilities for his mental illness but had poor insight into how his use of cannabis had contributed to his mental illness, and impacted on his occupational performance areas. He had conflict within his primary support group and was in his final year of studies, which had now been compromised.

Participant C: 47-year-old Caucasian male who had been admitted to Sterkfontein Hospital for bipolar mood disorder, depressed episode. He had a long history of mental illness and abuse of alcohol and had previous admissions to psychiatric facilities and rehabilitation centres. He thus had insight into the fact that both his mental illness and substance abuse had impacted on his life but had difficulty internalising his insight. He reported that despite his level of insight he had been non-compliant with his medication and had relapsed on alcohol. He was also distressed about his occupational performance areas as he reported that he was lonely as his primary and secondary support groups had been affected, he was divorced and had lost his job.

Participant D: 32-year-old African male who was hospitalised at Sterkfontein Hospital for a psychotic episode. He had a long history of the abuse of alcohol and had had frequent admissions to Sterkfontein Hospital. He had insight into the need to stop using alcohol but was unaware of the connection between his use of substances and his mental illness. As a result of his frequent admissions to hospital he had a poor level of functioning within all areas of occupational performance.

Participant E: 29-year-old African male who had been hospitalised within the Forensic Unit of Sterkfontein Hospital. He had a history of psychosis and a long history of substance abuse. He had poor insight into his problems with substances, reporting that he was using cannabis whilst in hospital, but had been using cannabis, petrol, benzene, glue and alcohol at home. His illness had impacted on all his occupational performance areas as he had lost contact with his primary support network and had not completed school, thus had had a poor work history.

Participant F: 32-year-old Caucasian male who had been hospitalised at Sterkfontein Hospital within the Forensic Unit. He had a long history of bipolar mood disorder and history of substance abuse of cocaine, alcohol and heroine. He had previous admissions to Sterkfontein Hospital and rehabilitation facilities and was aware that his use of substances had had a direct affect on his current admission, as the crime he had committed was drug related. He had a poor level of functioning within all his occupational performance areas, as he had a poor work history, and conflict within his primary and secondary support networks.

Participant G: 39-year-old African male who had a long history of mental illness and substance abuse. His drug of choice was cannabis, and he had been diagnosed with schizophrenia. His illness had impacted on all his areas of occupational performance resulting in a poor work history and conflict within his primary support network, as he had been removed from his family, and separated from his child.

Participant H: 35-year-old African male who had been admitted to Sterkfontein Hospital and diagnosed with schizophrenia. He had a long history of substance abuse, using cannabis, mandrax, alcohol and glue. He was still using cannabis whilst in hospital, which was impacting on his illness, but he lacked insight into this. He expressed a desire to stop using, but his incentives for this were based solely on his need to go home. He had a poor level of functioning within all areas of occupational performance as he had no job and limited social support.

Participant I: 29-year-old African male who had been admitted to Sterkfontein Hospital for bipolar mood disorder with a manic episode. He had a history of the abuse of cannabis but had poor insight into dual diagnosis, and to how his illness had impacted on all his occupational performance areas, as he had performed poorly within his work and social spheres.

Participant J: 29-year-old Caucasian male who had a long history of substance abuse and mental illness. He had been admitted to Sterkfontein Hospital with bipolar mood disorder, manic episode and had had frequent previous admissions to psychiatric hospitals, and a previous admission to a rehabilitation centre. His level of insight into his substance abuse was therefore good, and he could recognise how his use of crack and cocaine had impacted on all his areas of occupational performance. He had lost contact with his primary support network and had been living on the streets and had had an erratic work history. He did not have insight into how his substance abuse had impacted on his mental illness.

Thus the sample consisted of ten male participants of whom seven were African and three were Caucasian. The sample consisted of only men, as these were the first ten participants available that met the selection criteria of the purposive sample selection. The mean age of the participants was 32 years in an age range from 23 years to 47 years. The most common psychiatric diagnosis was Bipolar Mood Disorder (40%) (4 of the participants) followed by Schizophrenia (30%) (3 of the participants) or Psychosis (20%) (2 of the participants) and the most common substance of choice was Cannabis. All the participants had been hospitalised for a minimum of 3 weeks to ensure the detoxification process was complete, and would be hospitalised for a minimum of a

further four weeks, to ensure that the group programme would be completed prior to their discharge.

4.10.2 RESULTS OF THE INTERVIEWS

The priori codes that had been identified during the development stage of the group psycho education programme were used to organise the data into a number of categories and sub categories. Refer to Table 3 below for a graphical representation of these emerging categories.

TABLE 3 Themes Emerging from the First Interviews in the Main Study

<u>Themes</u>	<u>Categories</u>	<u>Subcategories</u>
The groups, did they help?	Insight into dual diagnosis	<p>I only understand my psychiatric illness</p> <p>I have a poor understanding of my substance abuse</p> <p>I don't understand the relationship between my psychiatric illness and my substance abuse</p> <p>How did my condition affect me?</p>
	Do I really need to stop?	<p>Do I need the programme?</p> <p>Should I participate in this programme?</p>
	What do I need to do to stop?	<p>My incentives to change</p> <p>My needs of Treatment</p> <p>What I hope to achieve from the programme</p>

4.10.3 THEMES FROM THE FIRST INTERVIEW

4.10.3.1 THEME 1: THE GROUPS, DID THEY HELP?

This theme dealt with the first objective of this study to establish the participants' perceived need for treatment and insight into their illnesses and their awareness of the steps required to manage both conditions. This was explored prior to the commencement of the psycho education group programme to confirm the participants' understanding of the need for the programme, and to determine how motivated they were to attend the group psycho educational programme, where the incentives were to return home to their families and make significant changes in their lives.

The participants' understanding of the need or motivation for the psycho educational programme varied from very positive to positive with varying degrees of insight. All participants demonstrated the understanding that they needed the programme, and thus were motivated to attend the programme.

Three categories and nine subcategories were identified within this theme.

4.10.3.1.1 INSIGHT INTO DUAL DIAGNOSIS

This category demonstrates the level of insight the participants had prior to the programme commencing. Results showed that participants had no or very limited understanding of the relationship between their psychiatric illness and their substance abuse and how the participants believed their substance use had affected their lives. This was important to establish the participants' understanding with respect to these two variables, as they would be used to measure the effectiveness of the programme in the second and third interviews

i) I only understand my psychiatric illness

Participant H: *"They say I have schizophrenia."*

Participant B: *"I am taking pills for that."*

Results demonstrated that most participants had limited intellectual medical insight into their mental illness, only being able to give the name of their diagnosis, but being unable to identify the symptoms of their illness. Some participants were able to identify that the treatment they were receiving in hospital was assisting them; however other participants only remained compliant to their treatment under the direction of the health care professionals.

ii) I have a poor understanding of my substance abuse

Participant E: *“Well it’s giving me problems the doctor says, but I think it helps me – it helps me cope.”*

Although all the participants admitted to using substances, most were unable to recognize the impact their substance use had on their mental illness and on their lives. They were unable to appreciate the consequences of their use of substances, and therefore the extent of their substances use, and that it was a problem.

iii) I don’t understand the relationship between my psychiatric illness and my substance abuse.

Participant A: *“I never think that my drinking affects my mental illness, because I don’t drink a lot.”*

Some participants were able to identify the impact their substance use was having on their mental state, but their insight into dual diagnosis and the connection between their two disorders was limited. A level of denial was also evident thus demonstrating the difficulty in changing their behaviour. Three participants had been to some form of rehabilitation center prior to this programme; hence their intellectual insight into the need to stop the use of substances was evident.

iv) How did my condition affect me?

Participant F: *“I am sick of being in this ward and I want to change my life. I have f***ed up my life by using drugs and coming back to hospital, and I just want a future.”*

The participants’ insight into how their condition affected them varied between those participants with some insight being more aware of the consequences of their substance use and mental illness, to those with poor insight being unable to identify their consequences to both their conditions. In the latter group it was evident that participants had an external locus of control demonstrated by their feelings of resentment at being in hospital and away from their home and families. All participants wanted to return home and those with some intellectual insight wanted to make lifestyle changes to improve their occupational performance, making specific reference to improving relationships with their families and being able to work.

4.10.3.1.2 DO I REALLY NEED TO STOP?

The literature highlighted the importance of establishing each participant's understanding of the procedure within and the reason behind the psycho educational programme. Thus it was important to establish each participant's view, as it influenced participation in the groups, and compliance to the programme.

i) Do I need this programme?

Participant E: *"I relapsed on my medication Sarah. That is my main problem...and I also had a problem with drugs, and bad friends. Bad friends that influenced me smoking dagga and I also have to stop that outside."*

From the data it was evident that all the participants felt that they needed the programme as they had identified that they had difficulties with their mental illness and/or their use of substances. Some participants were able to identify that their non-compliance to medication for their mental illness and/or their use of substances had contributed to their difficulties, and hence they identified that they needed the programme to assist them deal with these difficulties.

ii) Should I participate in this programme?

Participant H: *"Yes, because I want to stop, and I have seen that the people who are coming to your groups, they are no longer smoking, and they are going home."*

The findings suggested that most participants could identify a reason for being referred to the programme although the reason varied. For some participants their doctor had advised them to participate, thus their incentive initially to be in the groups was to comply with the doctor so that they could be discharged and return home. Other participants had been exposed to previous participants sharing their experiences of the groups in the ward, and the benefits that were perceived by them. Thus all the participants' decision to attend the programme was influenced by their perceived benefits from attending the programme. Most were motivated by the perceived incentive of being discharged and being able to go home, whilst a smaller number were motivated by overcoming the difficulties that they had identified.

4.10.3.1.3 WHAT DO I NEED TO DO TO STOP?

Participants' identified the need to change and what they hoped they would achieve from the programme. They expressed what their expectations for themselves would be at the end of the programme.

i) My incentives to change

Participant I: *"I won't go home until I have stopped smoking. That is what the doctor said, so I want to go home."*

The participants' incentive for change was determined by the desire to return home and they were aware that if they stopped using substances they would be discharged or given leave of absence. Participants with more insight were motivated by being able to control their illness and their lifestyles more, and by having a better quality of life.

ii) My needs of treatment

Participant G: *"If I can get information to know how to stop so that I can go home and work and see my son, I will be very happy."*

Participant I: *"I need to know how to stop taking drugs, and how to get a job and work."*

The participants that had poor insight identified their needs as being primarily to stop using their substance of choice in order to return home to their families. The participants who had partial insight identified that their use of substances had some impact on their mental illness and were able to explain their need as being how to stop using substances, and make changes to develop an improved lifestyle. They expressed some specific needs around how to cope with craving and to be assertive with friends, who use substances, as well as to prevent crime and to change their behaviour.

iii) What I hope to achieve from the programme

Participant E: *"I need to know stuff on what I can do when I am craving...I need to know how to stop when I go home, because it is going to be hard with my friends"*

Participant G: *"I need to know how to stop so that I can get a job and see my son."*

The level of insight also influenced what the participants' hoped to achieve from the programme. The participants who had a poor level of insight were again only hoping to achieve the decision to stop smoking, and thus gain a discharge from hospital and return home to their family. The participants with partial insight were hoping to achieve the ability to cope better with life and return to work. They wanted to achieve the ability to manage their life and behaviour, and were hoping to share their experiences and learn from the group.

- **SUMMARY OF THE RESULTS OF THE THEMES FROM THE FIRST INTERVIEW**

The results showed that the participants' baseline level of intellectual insight varied, with two participants having no insight into their condition, five participants having limited insight, and three participants who had previous experience in rehabilitation having fair intellectual insight into both their mental illness and substance use disorder. All the participants disclosed that their motivation to attend, and their incentives to change, was directed by their doctors. Their need to stop using substances was related to meeting discharge or long-leave of absence criteria, which included them being able to return to their families and work. They therefore experienced an external locus of control and their motivation for change came from authority and was not self-directed, and all the participants thus had perceived benefits of attending the programme.

The five participants with limited insight were able to name their diagnosis, but had limited understanding of their mental illness and the specific symptoms. In addition, although they admitted to using substances they were unaware of the impact their use of substance had on their mental illness, and their functioning in their daily lives. They thus failed to understand the stage of their use of substances and their psychiatric condition of dual diagnosis. These participants were thus in denial and could not appreciate the consequences their use of substances had had on their mental illness and their quality of life. The level of denial and, the external locus of control of these seven participants, with no and limited insight, implicated their contributions to the group discussions.

Three participants had had previous exposure to substance related rehabilitation facilities thus their level of insight into their substance use was higher than the other seven participants. They were found not to be in denial of the problems that result from using substances. They also had a higher level of insight into their mental illness and, were able to draw some connections between their non-compliance to their psychiatric treatment and their hospital admissions. Their locus of control was thus internal and their incentives to attend the groups and stop using substances were self-directed. They

were motivated to attend the groups, as they believed the groups would assist them in developing the knowledge and the skills to live an improved lifestyle.

All the participants were motivated to attend the programme and the objective of this study was to improve the baseline level of intellectual insight into dual diagnosis, the participants' motivation to change was facilitated. This increased the possibilities of a change in behaviour of the participants.

4.10.4 THEMES EMERGING FROM THE SECOND AND THIRD INTERVIEWS

The data received from the second and third interviews were analysed together for two reasons; so that the effectiveness of the programme could be measured in meeting the participants' expressed needs of the programme, and because, like in phase 1 of this study, to develop the group psycho education programme. The planned group protocols were not required to change, as no feedback was received by the external interviewer, after the second interview in the middle of the group programme that indicated a need for changes to the group protocols. The only feedback that was received from the external interviewer was that an individual session had been requested by some of the participants, to allow for the personal application of information discussed and gathered from the groups. The participants had requested this as they wished to verify the decisions that they had made, and check if their application of the knowledge was accurate. Hence the researcher, as the group literature suggested ^(21, 41), structured a session for each participant in the second half of the group programme; however only three of the participants utilised this session.

This phase of the study focused on the evaluation of the factors perceived as contributing to the success of the group psycho education programme in meeting the perceived needs of the participants, increasing their insight into dual diagnosis, the steps required in the management of both disorders, and thus bridging the gap between the psychiatric and substance abuse treatment approaches.

The priori codes that had been identified during the development stage of the group psycho education programme, and represented in Figure 1: The Evaluation Framework Developed from Phase 1 of this Study, were used to organise the data into a number of

categories and sub categories. Refer to Table 4 below for a graphical representation of these emerging categories.

TABLE 4 Themes Emerging from the Second and Third Interviews in the Main Study

<u>Themes</u>	<u>Categories</u>	<u>Subcategories</u>
Did the groups help me to change?	Is this what I wanted?	<p>Were my needs met?</p> <p>Changes in level of insight into mental illness</p> <p>Changes in level of insight into substance use disorders</p> <p>Do I understand the relationship between my mental illness and substance abuse?</p> <p>Can I use substances again?</p> <p>How can I prevent relapse?</p> <p>What resources are available to me?</p> <p>How can I cope?</p>

Did the groups help me to change?	What did I gain?	<p>Changes that occurred because of the experience of the group process in general</p> <p>What about the content of the group helped?</p> <p>What about the group members helped?</p> <p>What group techniques helped?</p> <p>What about the leadership style helped?</p> <p>What about the group structure helped?</p> <p>What about the group context helped?</p>
	Did it help me to stop?	<p>Should this group programme be repeated?</p> <p>What was the highlight of the programme?</p> <p>What should change in the programme?</p> <p>How does this programme differ to other programmes I have attended?</p>

4.10.4 THEME 1:DID THE GROUPS HELP ME TO CHANGE?

This theme was established from the objective, which investigated the participants' perceived improvement of intellectual insight into their illnesses and their awareness of the steps required to be taken to manage both conditions. This theme assisted in establishing whether the participants perceived that their needs were met within the programme, as well as what factors they perceived as effective in assisting them in improving their insight, and what they felt should change in the programme to allow it to be more effective. This theme also allowed the researcher to assess whether the

participants felt the programme should be repeated, and how they perceived this programme differed from other psycho education programmes they had previously attended.

These results revealed that all the participants had experienced the groups as helpful. There were three categories and nineteen subcategories within this theme.

4.10.4.1 IS THIS WHAT I WANTED?

This first category explored whether the participants felt that their needs were met within the group programme and the changes in the participants' level of insight into their dual diagnosis.

i) Were my needs met?

Participant J: *"Well I think we covered everything that we needed to cover and I know what I have to do when I get home and that was my main goal."*

From the findings the participants felt that at the time of the second interview not all their needs were met, but by the third interview all previously stated needs were met, and no new needs were verbalized. Many of the participants made reference to the list of goals that was established in the first group as verification that their needs were met.

The importance of having a list of goals for the groups was reinforced, as it was useful to the participants in maintaining motivation to attend the programme.

ii) Changes in level of insight into mental illness.

Participant E *"Well there is a lot about mental illness we have learnt – that we must take our medication and go to the clinic when we are at home,"*

Participant A: *"That my sickness makes my life difficult and I need to manage my stress..."*

The shift in the participants' level of intellectual insight into their mental illness was evident. They were aware of the importance of compliance to medication, and how frequent follow up with their doctor is important to them in maintaining their mental health. They could identify and understand their symptoms of their mental illness, and that these symptoms resulted from an imbalance in their neurochemistry. They understood that their medication created and maintained a balance within their neurochemistry, necessary for mental health. They also gained insight into the fact that their failure to remain compliant to medication

had caused relapses in their mental illness, and some of the participants could appreciate the effect this had on their families, and their ability to function within daily living activities. These participants were thus motivated to maintain their mental health so that they could return to work and their families, and compensate for the difficulties their illness may have caused.

It can thus be concluded that there was a marked improvement in all the participants' level of intellectual insight into their mental illness, and the management thereof, and all expressed the commitment to follow these steps. Only six of the participants however had developed comprehensive plans on how they intended on doing this, and only three of the participants, with previous experience to rehabilitation, had made use of the individual session to consolidate this knowledge into an effective action plan. It is thus evident from the results that an increase in intellectual insight was achieved within all the participants. However, only 60% demonstrated a shift in their affective insight, with only 30% demonstrating further intention to make the necessary behavioural changes established from their improved intellectual insight.

iii) Changes in level of insight into substance use disorders

Participant E: *"...I now know what is an addict and that I have to stop"*

Participant I: *"...The pictures that showed me the steps in addiction makes me see that I have a problem"*

The results demonstrated that there was a shift in intellectual insight into substance use disorders. The participants reported that they now understood the process of addiction and could recognise how they had moved through these stages, and had thus developed a problem with their use of substances. They also reported that they had learnt more about substances and the effects their drug use had had on their health and their occupational performance. They reported that they had previously seen their substances as a coping mechanism, but could now recognise that their use of substances compromised their general coping skills. All the participants were thus motivated to stop using their drug of choice. These results were triangulated through the ward reports, nurses' reports, field notes and urine-cannabis tests. These confirmed that all the participants had gained the intellectual insight to establish the initial behavioural change to stop using substances; however it cannot be determined whether the inherent drive for the change in behaviour was developed by the internalisation of the intellectual

insight as opposed to the participants' desire to meet the discharge or long-leave of absence criteria. Only six participants had made extended behavioural changes in their social network within the ward, and this, not being a criterion for leave of absence or discharge, can be assumed to be as a result of the participants internalising the information. This is in keeping with the results above, where only 60% of the participants had made an initial shift in their affective insight.

iv) Do I understand the relationship between my mental illness and substance abuse?

Participant A: *"I think understanding that if I drink alcohol, then I am asking to get sick, just like if I stop taking my pills..."*

Participant B: *"I can feel my head is better..."*

As a result of the increase in the participants' level of intellectual insight into mental illness and substance use disorders, the participants were able to recognise the relationship between their mental illness and use of substances.

They were able to recognise that their use of substances had contributed to their mental illness in that the substance had disrupted their neurochemistry, and resulted in a relapse in their mental illness. Thus abstinence from their drug of choice was as important as remaining compliant to their medication to maintaining their mental health.

Some of the participants also made reference to the fact that they could already recognise the benefits of stopping their substance of choice and the positive changes that this had in their lives; namely they could recognise the symptoms of their mental illness had improved. For example their concentration and other cognitive skills had improved, their behaviour was less disruptive, the money that they used on substances was now available to them, and as a result of their improved mental health, they had been granted ground parole, or that the doctor had given them a discharge, and they were returning home.

Participants were also able to recognise the benefits in changing their peer support group. They were now socialising with different people on the ward, and their fellow group members. They recognised the benefits of their new coping strategies as they had successfully avoided "dangerous places, people, things and times" and had experienced the importance of peer support in being able to achieve this successfully. The participants also received favourable reports from

the nursing staff and their doctors, and hence their possibility for discharge or leave of absence was now increased. The participants were aware of this. The improvement of insight was also demonstrated in the four participants who were able to recognise the difficulties they may experience after discharge in their adaptation, and transition from the containment of the hospital environment to their home environment.

It is thus evident from the above that the participants were able to recognise the relationship between their mental illness and substance use disorder. Their intellectual insight into dual diagnosis had thus improved and this was demonstrated by their awareness into the fact that the use of their substance of choice is closely linked to a relapse in their mental illness. The participants were thus aware that if they choose to stay well, and out of hospital, they were unable to use substances again. In addition they needed to be aware of the triggers and manage their stress levels more effectively, in order to prevent relapse. This improved level of insight was more evident in the 60% of the participants who had made noticeable changes in their behaviour, and thus making a shift from an improvement in intellectual insight into the development of affective insight. The group psycho education programme was thus effective in bridging the gap in developing and improving the level of intellectual insight into dual diagnosis.

v) Can I use substances again?

Participant G: *“No I can’t. If I smoke again I will get sick. I used to think that I can smoke a little bit, but the pictures showed me that I can’t. It will mix up my chemicals, and mixed up chemicals will make me sick.”*

As a result of the increase of insight into dual diagnosis, the participants were aware that if they choose to stay well, and out of hospital, they are unable to use substances again in the future.

vi) How can I prevent relapse?

Participant E: *“Maybe if I stop to smoke, take my pills and see the doctor, I won’t get sick again. If I do get sick it must be because of the stress, so I must watch the stress again and not be bored...”*

The findings showed that all participants had established a shift in their level of intellectual insight into dual diagnosis, and had developed a basic understanding of the relationship between the two conditions, the basic steps that they need to

follow to get well and prevent relapse including, taking their medication, regular follow up with the doctor to monitor their medication, and not to use substances. Some participants identified that stress also impacts on their conditions. They were able to recognize stress as a trigger for their use of substances and their mental illness and thus had insight into the importance of stress management, and necessary changes that needed to be made to manage their lifestyles, to further prevent the possibility of relapse.

Some of the participants' level of insight extended into understanding the difficulties of the transition between hospital and home will create, and the higher risk of relapse at this time. Participants that were not returning home therefore perceived themselves as being more fortunate in that the hospital environment they would be in would be safer for them.

vii) What resources are available to me?

Participant E: *"...I must go to the clinic. There are maybe also groups that I can go to in the community. I must check the numbers Sarah gave us, and when I go home I must ask the community. I also want to play music and soccer. This will help me with the new friends."*

From the findings it was established that all participants had some awareness of resources in the community that they could access help from. They were aware of the AA and NA meetings and the support groups for mental illness e.g. The Bipolar and Schizophrenia Support Groups. They were also aware of the importance of gaining support from peers, working through the twelve steps of recovery from substance use, and the value in finding themselves a sponsor within their community who has experience in managing their substance use. Some participants felt that there may be some difficulties in attending these groups and alternative options such as receiving support from their church or religious groups, community centres and their local clinics, sport clubs, and the importance of having hobbies and constructive use of leisure time would be important.

viii) How can I cope?

Participant C: *"Well I get my meds from Tara when I am an outpatient....I can get a psychologist there...."*

Participant F: *"... we discussed how to manage stress and our time, we discussed different options and not to get bored...."*

With the awareness of resources and the increase of insight into dual diagnosis the participants felt empowered by being aware of how to cope with both the conditions that contributed to their dual diagnosis. They referred to the group psycho education sessions that focused on making participants aware of their triggers and how to cope with these specifically. They were able to recognize stress and boredom as a trigger for their use of substances and their mental illness. Thus the practical procedures needed to balance their lifestyle, to manage their stress levels and contain boredom had been developed. The results suggest that the participants had a better idea of how work stress, financial stress, social anxiety, and relationship problems, influence and, were influenced by their conditions and what situations, people, things and specific times they needed to avoid. They also had developed an understanding of more effective coping strategies and had the opportunity to develop their own plan on how to live a more balanced lifestyle to combat and reduce their stress levels. Throughout the group interactions the participants were introduced to new ideas on how to socialize and use their leisure time more constructively.

Six of the participants had also had practical experience on the effectiveness of these new coping mechanisms on the ward when they had been exposed to “dangerous places, people, things and times” and had made use of their new coping strategies and support networks. They had experienced the strategies as being successful, and something they had practiced before being discharged.

As part of the subcategory “how will I cope” the participants were orientated to resources that were available to them after discharge. Results demonstrated that initially four participants were ambivalent about the necessity to make changes to their lives and to stop using their substance of choice. They referred to the difficulty they had with needing to socialise with their friends, participate in their “old” behaviour as it was their culture, and that their substance use had developed into a coping strategy. With an increase in intellectual insight, these participants were able to recognise that they needed to make changes. However results from this study do not reflect whether their improved level of intellectual insight developed a sustained change in behaviour, and thus affective insight. These results demonstrated the effectiveness of developing intellectual insight into what the participants would possibly lose and gain from the changes in their

behaviour to combat ambivalence to change. Six participants identified having to change their social support network as an important requirement for health. Throughout the programme the participants had experienced the groups, and the support from their fellow group members, as beneficial. 40% of the participants were concerned that once discharged from hospital they would lose this support. This is why the group programme helped them to identify support groups in their communities, and other resources within their community, to assist them in more constructive leisure time activities such as sport facilities, creative and hobby classes, and group activities like walk-for-life and debating groups. The participants perceived that this exposed them to all these resources, and gave them alternatives to overcome transport and/or finances constraints.

It can thus be concluded that the participants' intellectual insight into dual diagnosis, and the specific steps that they required to take to manage both their conditions had been addressed during the group psycho education programme and that the participants' perceived that their needs had been met and that their knowledge of dual diagnosis had improved.

4.10.4.2 WHAT DID I GAIN?

From the inductive reasoning used to interpret the data the main theme uncovered related to the participants' perception of how the groups had helped them. The two categories that emerged within this theme were, what has been helpful, and was the programme beneficial? The eleven subcategories within these categories then highlighted the group factors that the participants perceived had addressed their needs and what in the groups was helpful viz. the factors from the evaluation framework of phase 1 of this study; the content of the group, group techniques, and leadership style, group structure, and group context, and how they experienced these factors to have influenced the effectiveness of the group programme. The four subcategories of the second theme also highlighted the factors the participants perceived as non-effective and included their perceptions on what should change in the groups to increase the effectiveness of the programme. These issues will be discussed in the next section below.

i) What about the group process in general helped?

Participant J: *“Yes. I want to finish, and we have a list of information that we wrote in the First group, and I want to finish the list.”*

Participant C: *“...and we are working through it logically.”*

Some of the participants appreciated the fact that the first interview gave them the knowledge of what to expect from the groups. They also stated that the list of group goals that was established in the first group was helpful. They commented that this list of goals allowed them to know that they were working through their needs systematically, and allowed the group process to flow logically. This list also ensured that the motivation to continue the groups was sustained.

ii) What about the Content of the Group helped?

Participant E: *“All the things that we spoke about...All the things that we have decided, like not to smoke anymore, and the pizzas that we did, which are gonna help me when I am home.”*

All the participants found the content of the groups relevant and useful. The list of group objectives, discussed above, assisted this. The researcher used the list of goals to direct the logical flow of the discussions, and for the group members to be aware of where they are in the group process.

While some participants found it difficult to identify specific group content that they found helpful, others were able to identify specific group sessions, or content that they found helpful, or from which they could recognize the benefit. The latter group of participants identified content on dual diagnosis, the triggers, and stress management as most useful in helping them prepare for their discharge.

The three participants that had attended rehabilitation groups before still found the content relevant. They acknowledged that despite being familiar with this information they had failed to make the necessary behaviour changes. They attributed their failure to change largely due to their negative attitude towards treatment and their poor level of motivation to change. They expressed that the content on dual diagnosis was beneficial as it was different to their previous experiences. The content was directed on creating the links between their mental illness and their use of substances. This facilitated their understanding of the concept of dual diagnosis.

All the participants referred to the “pictures” as being the most beneficial aspect of the group content. This was the didactic information that was given on dual diagnosis where the links between the two conditions was addressed (Appendix E, group 2). This information addressed the causes of mental illness, the symptoms thereof, and how to manage mental illness, which included abstinence of substances. The similarity between the symptoms of mental illness and the effects of substance use were emphasised. This information also included the importance of managing both conditions, improving their mental health, and quality of life. The participants all expressed that this information made the relationship between mental illness and substance use disorders clearer.

It can therefore be seen that when imparting scientific information a didactic approach remains effective and that using diagrams assists with understanding. It also concludes that with an increase in the MHCUs’ level of intellectual insight, an increase in the motivation to change can result.

The participants also rated the group content that addressed the “triggers for using substances” as important. They felt that this allowed them to understand how to manage their use of substances more effectively. As one of the triggers, identified in the groups was stress, in the third interview all of the participants referred to the importance of the content that addressed stress management. With their increased understanding of dual diagnosis, they were able to appreciate that stress management was an important component to their management of both conditions, and that unmanageable stress levels could result in a relapse of both their mental illness, and their substance use disorder as taking substances was one of their reported previous coping mechanisms for stress.

The participants also referred to the content that addressed their “pizzas” (activity profile) (see Appendix E group 7) as important. It allowed them to plan their life, and come up with new coping strategies, prior to being exposed to their triggers as well as to develop a plan on how to live a balanced life to assist in their management of their stress. This gave them a further sense of autonomy to their lives, and left them feeling prepared to return home.

It is thus concluded that the content within the programme which was perceived as most important was that which established the relationship between both the conditions that

addressed the participants' triggers, stress management, and their activities health. This helped empower the participants with the knowledge, and skills to cope with everyday life, and their individual stressful situations. This in turn facilitated the motivation for change, and is an important outcome of a group psycho education programme.

iii) What about the Group Membership helped?

Participant E: *"They are very much helpful, and I like listening to them. Some of the stories have been very interesting, and helped me learn. They are very much supportive."*

All participants felt that their fellow group members added value to the programme. They reported that in the second part of the programme the group members had played a more active role, and that they all benefited from each other's ideas and suggestions. Results demonstrated that the interaction between the group members contributed to the effectiveness of the programme. This was the reasoning for language and participants to be on the Creative Ability levels of Explorative patient directed to Experimental therapist directed being selection criteria. ^(29, 33, 34) This ensured that all participants no longer demonstrated acute symptoms of their psychiatric diagnosis, ensuring adequate level of cognitive functioning to participate actively, further ensuring effective communication amongst the group members. This was also ensured by the criterion that all participants had been hospitalised for a minimum of three weeks prior to the group programme commencing.

Participants identified the technique of allowing each member to share their life story as valuable, as it allowed them to share more openly and honestly. The sense of universality that the life stories developed ensured that the participants felt understood, and they were more receptive to the feedback, and suggestions made by other group members. This will be discussed further in the section exploring the effective techniques. Four participants also referred to the use of the establishment of group norms as further assisting group cohesiveness. The norms assisted in establishing the group dynamic. This was another factor not considered in the evaluation framework of phase 1 of this study, and hence, was another unexpected factor perceived by the participants as being effective.

Three participants were also able to recognize that they were able to contribute positively to other group members. This allowed the feelings of self-efficacy to

be established, and allowed for an improved sense of self to begin developing. As a poor sense of self was established as a main cause of their use of substances, the group membership was effective in indirectly addressing this. It established a 'sense of belonging' in individuals who experience difficulty in feeling that they belong in society, and allowed them to feel that they can bring value to others.

This sense of belonging established in the groups extended outside of the groups and allowed for six of the participants to feel supported in the wards too. They expressed that they appreciated this and it allowed them to experience the importance of "safe friendship". They referred to the effective support they had received from the group members in the ward when they were craving or exposed to "dangerous places, people, things and times". In the ward they were exposed to the triggers of their drug of choice, and their "old friends" who were still actively using. They made reference to the support that they received from group members in the ward as being helpful and effective in stopping them from relapsing, and thus giving them the experience of successfully utilising new coping mechanisms and support systems.

This technique of group confrontation was also highlighted by five participants as being effective. There needed to be a strong sense of universality for the participants to consider each other's opinions, and for group pressure to be possible and effective

It can be assumed that the five participants, who referred to this technique as useful, were referring to the outcome of the effectiveness of the confrontation in the consolidation of their intellectual insight, and will be explored further in the section discussing techniques and group leadership.

The three participants who, had been in rehabilitation centres prior to the group programme, had mixed perceptions about the group members. They were frustrated by their level of denial, the time it took for the other group members to grasp the information being discussed, and to accept the changes that they needed to make. However they were still able to recognise some benefits in this group dynamic – teaching them patience, not to be impulsive, and gaining some ideas from these group discussions.

It can therefore be concluded that establishing group membership and cohesiveness through the techniques of life stories, developing group norms, and confrontation of group members facilitated a sense of belonging effective both in and out of the groups, and assists in developing intellectual insight in the participants, and a change in behaviour in 60% of the participants.

iv) What about the Group Techniques helped?

Participant A: *“The pictures that were drawn to show us the brain really helped me to understand. The information has made me think a lot.”*

Participant F: *The pictures and the stuff about triggers.”*

All participants referred back to the “pictures” as being the most beneficial. This was the technique of using visual aids and was used in the didactic information that was given on dual diagnosis. All the participants reported that the visual aids of the “pictures” helped them understand the relationship between mental illness and substance abuse more clearly. This was also the participants’ perceived highlights of the group programme to be discussed in the third category.

The participant reported that all the diagrams and handouts were useful as they assisted them in applying the information to themselves and because they could take them away, this enabled them to impart their knowledge to others and their families. The use of this technique of the personal application of the information discussed in the groups was perceived by all the participants as effective. It allowed each participant the understanding of how the information applies to them, and how they can implement it after the group programme had ended. This result was reflected in the positive feedback from all the participants pertaining to the sessions where they explored their triggers to substance use and stress management. They expressed how this helped them to understand what they needed to avoid, both in hospital, and when they go home, and they perceived this technique as effective in providing them with knowledge, and a method on how to stay sober. It also included the handouts on stress management and the technique of developing their own activity profile, the “pizzas”, that four participants referred to as assisting them in developing their personalised discharge plan to help them cope, and with an increase in intellectual insight they were aware that, if they applied this information they could manage their mental illness, manage their stress levels, and understood

stress as a trigger to both their conditions, and thus perceived the personal application of the information as useful in the management of their dual diagnosis. They also referred to this technique of personal application as being used to explore the triggers to substance use as helpful, as it allowed them to understand what they needed to avoid, both in hospital and when they go home. The technique of personal application of information was further utilised in the individual sessions offered to all the participants. This was as a result of feedback the researcher received from the external interviewer after the second interview. The participants had requested individual sessions to assist in the personal application of the information which had been covered in the groups; however only three of the participants utilised these sessions. This is reflective of previous results, discussed above, that concluded only 30% of the participants demonstrated further intention to make the necessary behavioural changes (affective insight) established from their improved intellectual insight. These three participants all had previous experience to substance abuse related rehabilitation, and appeared to perceive the technique of personal application of information, used throughout the group programme, as being insufficient in meeting their personal needs, and needed their understandings and decisions affirmed privately.

The technique of setting group norms in the first group, referred to above, was found to be helpful in developing cohesiveness amongst the group members and it was also established a sense of autonomy within each participant. Norm setting also assisted with the technique of confrontation of fellow group members, as the group members valued each others' input, and ensured consideration of the contributions of the entire group, referred to under the discussion on group membership.

It can thus be concluded that the techniques of visual aids and pictures, and handouts and personal application of information used in the group programme were effective in assisting the participants in the development of intellectual insight. The technique of personal application of information allowed the increased intellectual insight to be actualised into a plan on how to make the necessary behavioural changes. This facilitated the development of affective insight. This however, was not measured by this

study, but results reflect that the facilitated understanding of the information allowed for this information to be consolidated by the participants. The application of the information ensured that each participant understood the information and knew how to take this away with them. This left them feeling autonomous and prepared for the behavioural changes they needed to make.

iv) What about the Group Leadership helped?

Participant F: *“The groups were always fun, and she made us laugh. She made us also do work on our own and made us think...”*

Participant E: *“She made us talk and we all got time to talk. She also didn’t tell me what to do. The other guys did, but I decided.”*

Participants referred to the group leadership approach, adopted by the researcher, as being very different to the more autocratic approach they felt they were exposed to at home, in the wards and by other health professionals. All the participants referred to this approach as useful. Four participants expressed that it facilitated a sense of autonomy to make their own decisions, but only one participant recognised how this approach allowed him to shift from an external to an internal locus of control. These five participants perceived the leader’s “laizaire faire” approach made them feel more comfortable, allowing them to experience the information as more personal, entertaining and facilitating their concentration and personal application to their specific circumstances and needs. These participants referred to the group leader as approachable. This was particularly important when confronting the group members on their level of denial and making them aware of the dangers of their “old behaviour”. The participants also highlighted the effectiveness of the “laizaire faire” leadership style of ensuring group interaction, and further refers to the effectiveness of the more easy-going, passive stance, facilitates interaction amongst the group members, and allows for group discussions to develop. It facilitates the group members to make decisions for themselves, advice to be given by their peers, and not by the group leader.

However some of the participants expressed the need for a more autocratic approach. It appeared that they were not familiar with being given the autonomy over their own decisions and so found it frustrating, and were uncertain that the decisions they were making were correct. They felt that with a more directive

approach they would be assured that they were making progress and thus findings support the use of the didactic approach.

Seven of the participants also highlighted the importance for the group leader to have knowledge of the information discussed. They suggested that this allowed them to have faith in the information that they were being given and the answers they received to their questions.

It can thus be concluded, that these findings support a combination of the active and passive role of the group leader. The “laizaire faire” leadership style is effective in facilitating group interaction, and a sense of autonomy within the group members and the didactic approach allows the information to be considered by the group members as meaningful and reliable. This combined approach leaves the group members feeling comfortable within the group and in approaching the group leader with questions and contributions that they have.

vi) What about the Group Structure was helpful?

Participant J: *“...Just the small groups again worked well coz then we all had a chance to work on our stuff a bit more, and it made the discussions good.”*

The research findings demonstrated that the participants perceived the structure of the groups to have very little significance. They found very little difference in the structure of these groups to that of other groups they had been exposed to previously.

Two participants made specific reference to the size of the groups. They felt that having smaller groups facilitated discussions and ensured that the discussions remained relevant. One participant believed the groups should run more frequently as there was a sense of urgency for him to have all his needs met.

vii) What about the Group Context was helpful?

Participant J: *“...It was good that the room was quiet and allowed for us to feel safe, but then most group rooms are like that. It was big enough; we had what we needed...”*

Most participants saw very little relevance in the group context. They felt it was no different to the group rooms they had previously been in, and felt that the group content was what was significant not the context.

Only a few participants were able to make specific comments about the group context and they felt it was important for the group context to be quiet and private so not to interfere with the group process and facilitate confidentiality. One participant felt that the consistency of the context that was used facilitated the participants in feeling safe within the group.

From the above findings it is evident that the participants' perceived experience of the group programme was positive and that they felt the programme was beneficial, and had identified the above factors, content, group membership, techniques and leadership as being effective in the group programme, but found the group structure and context not to be significant.

4.10.4.3 DID IT HELP ME TO STOP?

This aspect of the study assisted the researcher in establishing the effectiveness of the psycho education programme for individuals suffering from dual diagnosis.

This category identified the opinion of the participants as to how this programme differed from other psycho education programmes they had attended, and whether the programme should be offered to other MHCUs with dual diagnosis as it was, or if changes were needed. It also indicated what the highlight of the programme was for each participant, and whether they would recommend attendance to the programme to other MHCUs.

i) Should this Group Programme be repeated?

Participant G: *"Yes, if there are other people that want to stop and go home and be good, they must come to the groups to stop smoking."*

All participants perceived the group programme as beneficial and believed that the programme should continue. They recognised the positive impact the groups had had in facilitating their understanding of their illness, and their decision to stop using their substance of choice. They felt prepared to cope with both their conditions, and many of the participants were able to see the benefits in the change in their behaviour, in that they had attained ground parole or a discharge from the doctor.

They could identify many other MHCUs that were still using substances and that were not getting well, or reaping the benefits that they were, and thus felt that they too could benefit from attending the programme.

The participants did feel that if the groups were to be repeated, they should remain voluntary. They believed that this impacted on their motivation to attend and participate in the programme, and their investment for meaningful change in their life.

ii) What was the highlight of the group?

Participant G: *“Well definitely the groups with the pictures because it really helped me to see what I’m doing to my brain and my life...”*

Participant F: *“...I think it was also important to discuss stress and how we must change our lives to help us cope...”*

Most participants reported the didactic information on dual diagnosis as the highlight, as they developed clarity and understanding of their condition from this information. They also perceived the sessions on stress management, triggers and the activities health as highlights, as they perceived these sessions helped empower them with skills and understanding of how they can cope with everyday life, and stressful situations.

iii) What should change in the programme?

Participant E: *“No. I think that the groups are very good, and mustn’t change. Everything in the groups must stay the same.”*

Participant F: *“...Maybe more stuff on ourselves could be included?”*

Most participants felt that no changes needed to be made to the group programme. However some participants felt that more time was needed to discuss certain topics. They still felt uncertain whether they would cope at work and suggested that more time be spent on interview and assertiveness skills. Other participants suggested that more emphasis be placed on self-development. They recognised that this can be done in individual therapy, but felt self-esteem could have been further addressed in the group process. They were also aware that if they attend the NA and AA fellowship groups, this would be further addressed in the twelve-step work programme that they will complete with their sponsor in the fellowship. The twelve-step programme is a self-explorative process that allows the individual to develop a deeper insight into themselves, but this perception emphasised the need for the self-subsystem to be addressed more deeply in the group programme, or that the participants needed to be referred to psychological and/or psychodynamic group programmes after this programme, where the self-subsystem would be addressed.

Some participants reported still feeling unprepared for their return home but couldn't suggest how the group could assist them further with this. They recognised that this feeling was associated with the difficulty that one experiences when dealing with change, and was possibly something they just needed to face.

Although the participants expressed no need for the group programme to be changed the three participants that had been exposed to the rehabilitation process before suggested that the group membership be revisited. They suggested that group membership be structured so as to ensure that group members of similar levels of insight be grouped together from the beginning, so that they could move through certain group content faster. Despite these participants finding some of their group members frustrating at some points in the group programme, they didn't want to change their group members in the middle of the group, or have new group members join. Despite their frustration they could also see benefit in that they reinforced their knowledge and decisions, and the importance of the cohesiveness that had developed in the groups. One participant also suggested that the groups be run more frequently to further facilitate an increase in the progress of the group content.

Some participants expressed the need for their families to be given the information that they had received. The participants felt that this may help families to understand their problem, which may assist with a smoother transition from hospital to home.

Some participants could recognise that there was a lot of information that needed to be processed outside of the groups. They could identify that they needed to internalise and apply the information that they had learnt in the group programme, but reported finding this difficult to do on their own. Despite encouragement by the group leader to take the information from the groups to their individual sessions with their therapist, they felt it would be easier to confirm that their decisions, plans, and interpretations of the information with the group leader, as she had the knowledge and familiarity of the terms that they were using. Some of the participants requested an individual session with the group leader to clarify some of their individual applications. Although this opportunity was made available to all the participants, only three participants made use of it. The three participants that utilised this, expressed that they had

found this beneficial and that this was a positive change that was made to the programme. In future it may be valuable to ensure that all participants have an individual session(s) within the group psycho education programme.

iv) How does the Programme differ to other programmes I have attended?

Participant E: *“Well it was different because we were never given the answers. We were told to make the decision for us, and it felt that us, the guys were the boss of the group”*

Some of the participants were able to comment on how this programme differed to groups that they had attended before. Those who had not been exposed to the rehabilitation process before referred to the size of the group being different. The smaller groups in this group programme were experienced by these participants as being more beneficial, as it promoted more active involvement, relevance in group discussions, and a more interactive dynamic. Three participants, that had been to rehabilitation centres before, expressed that this programme focused on dual diagnosis, the development of coping mechanisms, and a specific discharge plan, more than the other programmes they had attended.

This group of participants also reported that in the rehabilitation programme, groups were held more frequently, and thus the content was discussed in more depth. Also previously they were not limited to eight groups to cover so much information.

The participants also felt that the group leader of this study had a less autocratic approach to other group programmes that they had attended, and their opinion was that this facilitated a sense of autonomy, versus in other group programmes where they perceived the group leader as the “boss”. The group leadership in this psycho education programme encouraged the participants to make their own decisions and facilitated group interaction.

The participants with previous exposure to substance related rehabilitation groups also referred to their own attitude towards treatment as being another key influence in the perceived benefit of the programme. They recognised that in the rehabilitation centres they were resistant towards the group facilitators and to the information that they were receiving; hence they stressed the importance of a

participant's motivation and attitude to change, in the effectiveness of any group psycho education programme.

From the findings it is evident that the participants perceived this group psycho education programme, for individuals suffering from dual diagnosis, as being effective. The factors that the participants perceived as effective and non-effective, in improving their level of insight into dual diagnosis were identified, and were in keeping with the literature and came from the Evaluation Framework of Phase 1 of this Study. They were established as, the group membership, leadership style, group techniques and content of the programme, structure of the group, and the group context. The participants' needs of the programme were established, and they perceived these as being met effectively by these factors, as they experienced an improved level of insight into their illnesses. They expressed the awareness of the steps involved in the management of both conditions contributing to their dual diagnosis, and the benefits of the attendance to the programme, confirmed by their feelings that the group programme should be repeated, and that they would recommend other MHCUs suffering from dual diagnosis to attend this programme. The discussion of these findings will be explored further in Chapter 5.

CHAPTER 5

DISCUSSION OF THE EVALUATION OF THE PSYCHO EDUCATION PROGRAMME

This research study was conducted in two parts: the design of a psycho education programme for individuals diagnosed with dual diagnosis to be offered as part of an occupational therapy programme (Objective 1), and then the evaluation of the programme so as to identify the factors, perceived by the participants, as contributing to their improved insight. (Objective 2)

The first part of the study was described and discussed in Chapter 3 but will be considered, together with the results of the second part of the study, as phase 2 of the study resulted in changes in the programme design.

The discussion of the results of this study will be presented in five sections: the first section will discuss how the sample of MHCUs that participated in the study may have implicated the results, while the second section will discuss how the literature reviewed assisted in achieving the improved level of insight, measured by their increased awareness of their illnesses and, the steps required to be taken to manage both conditions contributing to their dual diagnosis. The third section will deal with the factors in the group psycho education programme that the participants identified as useful, or not useful, in helping them gain insight. The forth section will then discuss additions to the psycho education programme that the participants felt would improve the psycho education programme. The final section will summarise the results achieved in this study and the implications, which will be represented in an adapted evaluation framework that incorporates all the findings of this study.

5.1 IMPLICATIONS OF THE SAMPLE ON THE RESULTS OF THIS STUDY

A total of 10 male MHCUs diagnosed with dual diagnosis participated in this study. The sample was small, which is appropriate for a qualitative study; however this can only result in the sample being partly representative. Therefore the sample is only transferrable to other settings of similar demographics and contextual factors, of the South African male MHCU being treated for their mental illness in a long-term

psychiatric institution. ⁽⁶³⁾ As the sample only included males and this may have implications on the relevance of the results being transferable to the South African female MHCUs in a similar context. The sample may also implicate the results of this study, in that the overall results of the participants' evaluation of the programme were positive. This positive evaluation is in keeping with research on factors that determine inpatient satisfaction that stated that male patients have a higher level of "patient satisfaction" than women, and thus positive feedback can be expected. ⁽⁷⁴⁾ Although there was a female participant in phase 1 of this study and research findings of phase 1 did not demonstrate any significant differences in the responses related to gender, phase 2 of this study did not include any female participants. The results therefore, cannot be said to represent the female MHCUs, suffering from dual diagnosis, in an inpatient long-term psychiatric facility.

The overall positive evaluation of the programme could also be influenced by the fact that some participants were forensic patients and were likely to be hospitalised for a long period of time. Literature referring to "patient satisfaction" has listed length of hospitalisation and perceived improvement of health as one of the factors influencing the MHCUs' experience of treatment, ⁽⁷⁴⁾ in that the longer the period of hospitalisation, the higher the perceived sense of improved health within MHCUs. It is also important to note that the results to be discussed below demonstrated the meaningfulness and incentive of participation in the programme, which were experienced by the participants as the need to return home.

The hospital context, in which this research was undertaken, limited the time available for the group programme also, the time to conduct this study was limited by the length of admission of the participants. The researcher thus worked within this timeframe and controlled the time factor by limiting the group programme to eight groups extending over a time period of four weeks. This may also have implications on the positive results obtained in this study, as the literature on "patient satisfaction" referred to the MHCUs' knowledge of the expected length of stay as a factor that positively influences the level of satisfaction experienced. ⁽⁷⁴⁾ The participants who were forensic patients were not going to be discharged, but experienced other benefits. These benefits included ground parole, the ability to participate in the Industrial Therapy, and the opportunity to earn a small income, and with an improvement of the illnesses, the possible

consideration of weekend leave of absence and long-term leave of absence by the multi-disciplinary team.

The results also demonstrated that a previous psycho education and/or experience of intellectual insight of dual diagnosis facilitated the three participants, with previous experience of rehabilitation, in receiving the content of the groups more willingly and, they were able to recognise the necessary links and changes more easily. This is in keeping with the literature on substance use disorders that incorporates a relapse of their substance use into the rehabilitation process. This literature refers to the repetition of the rehabilitation as assisting in the consolidation of intellectual insight and facilitation of the development of affective insight, which results in the necessary behavioural changes being made. ⁽¹⁾ It is also consistent with literature on “patient satisfaction” which refers to previous hospitalisation as having a positive influence on the satisfaction of MHCUs. (75, 76)

Other factors of “patient satisfaction” which may have implications for the overall positive results of this study include that the ten inpatients participated in this study voluntarily. Literature has stated that MHCUs who have “choice” in their treatment, experience higher levels of satisfaction, in addition most studies that deal with “patient satisfaction” have found that “satisfaction” levels are often high in inpatient facilities. (74, 75, 76) It should also be considered that the high level of patient satisfaction achieved in this study may have been influenced by the fact that the effectiveness of the programme was measured just after completion of the programme, and therefore the ‘carry over’, once the participants were discharged, was not measured.

In conclusion, according to research on “patient satisfaction”, the sample selected for this study may have had implications on the overall positive experiences perceived by the participants in this study

5.2 IMPROVED LEVEL OF INSIGHT

The limited timeframe, in which this research study was conducted, resulted in the fact that improvement in affective insight could not be effectively measured by and a long-term study would be more effective in determining whether the behavioural changes

that may have resulted from an increase in intellectual insight were sustained. Although some behavioural changes could be measured by the triangulation of this study (field notes, nurses' reports, ward reports and urine-cannabis tests), these measures were not consistently recorded for the improvement in affective insight to be accurately measured. Thus this study only aimed to achieve, and measure, the improvement in the participants' level of intellectual insight into dual diagnosis.

5.2.1 THE BASELINE LEVEL OF INSIGHT PRIOR TO THE GROUP PSYCHO EDUCATION PROGRAMME

The results showed that the participants' baseline level of intellectual insight varied, however all participants disclosed that their motivation to attend, and their incentives to change, was directed by their doctors. This indicated an external locus of control and their motivation for change came from authority and was not self-directed. All the participants thus had perceived benefits of attending the programme and literature on "patient satisfaction" highlights this as an important factor in determining satisfaction, and therefore further implicating the overall positive evaluation by the participants in this study.⁽⁷⁴⁾ However an external locus of control can have implications on the level of participation in the group programme, as it can limit the reception of information and thus the development of new coping strategies for the management of their illness and thus the short-term and long-term health of the participants.⁽²⁷⁾ An external locus of control can be an indicator of denial in the participant, and the inability to appreciate their responsibility in their illness indicated the participant's poor level of understanding of their illness and their inability to appreciate the consequences their use of substances have had on their mental illness and their quality of life.

The literature on substance abuse group therapy stated that without communication and a shared need, the individuals would fail to gain insight from the information being shared by the therapist and the fellow MHCUs and, the usefulness of the group techniques of confrontation and, group pressure would fail to develop. These specific techniques were referred to as being important in establishing awareness of individuals into the behavioural changes that they need to make.^(19, 58, 59) Thus the level of denial and, the external locus of control of the seven participants, with no and limited insight, implicated their contributions to the group discussions, and their level of motivation for change.

In contrast results showed that previous exposure to substance related rehabilitation facilities facilitates higher levels of insight into substance use and individuals with this experience were found not to be in denial of the problems that result from using substances. They also had a higher level of insight into their mental illness and, were able to draw connections between their non-compliance to their psychiatric treatment and their hospital admissions. Their locus of control was thus internal and their incentives to attend the groups and stop using substances were self-directed. They were motivated to attend the groups, as they believed the groups would assist them in developing the knowledge and the skills to live an improved lifestyle.

These results are in keeping with the substance abuse literature that referred to the motivation to change as an important prerequisite in determining the effectiveness of any programme developed to address insight and, a change in an individual's behaviour and, that attaining insight facilitates the MHCU's motivation to change and shifts the locus of control from external to internal.^(1, 25, 26) This literature states that the internal locus of control influences the will for a change in behaviour to be self-directed rather than directed from authority which can build resentment and lead to relapse into old behaviour.^(25, 26)

As all the participants were motivated to attend the programme, directed externally or by themselves, this may have implications on the overall positive results obtained by the evaluation of all participants. All the participants perceived that the programme helped them achieve a positive shift in their baseline level of insight, and thus the objective of this study, to improve the baseline level of intellectual insight into dual diagnosis was achieved. The participants' motivation to change was also facilitated in this study, and increased the possibilities of a change in behaviour of the participants. The specifics of how this was achieved will be discussed below.

5.2.2 CHANGES IN THE LEVEL OF INSIGHT INTO DUAL DIAGNOSIS AFTER THE PROGRAMME

The results that reflect this change were evident in the first category, "have the groups met my needs?" and the emerging eight subcategories of the second theme, "how did the groups help me to change?"

The indications of improved intellectual insight into dual diagnosis therefore was that the individual was aware of the steps involved in the management of both their conditions and how the two conditions influence each other, whether they should/should not use substances again, the prevention of relapse, and what resources they have available to them. This was the outcome which this study aimed to achieve, as the literature reviewed emphasised, the importance of psychosocial interventions that target these issues: compliance to medication, understanding, and awareness of the symptoms of the illness and awareness of the importance of early intervention, and coping skills. The literature on psychiatry and psycho education stated that it had been shown that long-term pharmacological treatment, combined with psychosocial interventions, have resulted in a better prognosis of MHCUs suffering from dual diagnosis as they obtain better management of their illness and, show improvement in their level of functioning in all aspects of daily living, thus leading to a better quality of life. ^(18, 28, 30, 31)

The participants improved insight was uncovered in the eight sub categories: “Were my needs met?”, “Changes in level of insight into mental illness”, “Changes of level of insight into substance use disorders”, “Do I understand the relationship between my mental illness and substance abuse?”, “Can I use substances again?”, “How can I prevent relapse?”, “What resources are available to me?”, and “How can I cope?”

- **Were my needs met?**

The results showed that “list of goals” was effective in determining that the participants perceived their needs as being met. This is in keeping with the group literature that described the establishment of group goals as important to the successful running of a therapeutic group, as it allows the group members to be aware of the subject matter to be addressed in the groups, and gives the participants a sense of autonomy over the group process being developed within the programme. ^(41, 52)

Some of the participants made references to other needs that were not addressed in the group programme; this will be discussed further below.

- **Improved awareness of their mental illness**

Results show that the shift in the participants’ level of intellectual insight into their mental illness was evident. They were aware of what they are required to do to manage their mental health; compliance to medication, regular follow up with their doctor and necessary support structures, prevention of intoxication and the

maintenance of a balanced lifestyle to manage their stress levels. The dual diagnosis literature stated that non-compliance to medication regimes is a significant problem in MHCUs suffering from dual diagnosis.^(19, 36) The literature states that not only do these MHCUs refuse to take the prescribed medications, but they also continue to use their substance of choice, even after admission to an inpatient psychiatric treatment facility⁽¹⁸⁾, further exacerbating their psychiatric illness and complicating their treatment. Health care professionals are therefore of the opinion that MHCUs suffering from dual diagnosis frequently drop out of treatment, once the crisis that led to the current admission has been stabilised, the MHCU will return to previous behavioural patterns.⁽¹⁹⁾ Hence the literature reviewed assisted in establishing this outcome for the group programme as it prepared the researcher in ensuring that this information was covered within the group psycho education.

- **Improved awareness of their substance use disorder**

The findings demonstrated that all the participants experienced a shift in their level of intellectual insight into their substance use disorder and were able to recognise that their use of substances had become a problem and that they needed to stop. This outcome of the group programme was in keeping with the literature that emphasised the willingness to change, directs the change in behaviour that leads to abstinence of the substance of choice.^(1, 2, 19, 26) Triangulation of the results through the ward reports, nurses' reports, field notes and urine-cannabis tests, confirmed that all the participants had gained the intellectual insight to establish the initial behavioural change to stop using substances.

- **Awareness of the relationship between their mental illness and substance use disorder (dual diagnosis)**

The literature on dual diagnosis emphasised that in order to establish a programme effective in treating dual diagnosis, the MHCU needs to understand the importance of their compliance to treatment of their mental illness and abstinence from their substance of choice. A failure to comply with these would result in a relapse of either or both conditions.^(2, 19) Results showed that the participants' increased awareness of mental illness, and substance use disorders resulted in them all being able to recognise the relationship between their substance use, and mental illness, and had developed insight into their condition of dual diagnosis. The literature reviewed thus guided the group psycho education programme in effectively bridging the gap in developing and improving the level of intellectual insight into dual diagnosis.

How will I cope?

The occupational therapy literature emphasized the importance of establishing a balanced lifestyle in the management of stress. ^(33, 34) Results showed that the participants were aware that stress also impacts on both their conditions contributing to their dual diagnosis, and were able to recognize stress and boredom as a trigger for their use of substances and their mental illness. Thus the occupational therapy literature guided the researcher in including practical procedures in the psycho education programme for each participant to balance their lifestyle, to manage their stress levels and contain boredom. The results also suggested that the participants had a better idea of how work stress, financial stress, social anxiety, and relationship problems, influence and, are influenced by their conditions and what situations, people, things and specific times they needed to avoid. The literature on psycho education and substance abuse emphasized the importance of establishing new and more effective coping strategies ^(1, 19, 21, 28) and throughout the group interactions the participants were introduced to new ideas on how to socialize and use their leisure time more constructively. The participants were also orientated to resources that were available to them after discharge, as the substance abuse and occupational therapy literature stated the importance of establishing the participants' identified need to change their social support network as an important requirement for improved health. ^(19, 21, 33, 34) The group programme therefore introduced them to support groups in their communities, and other resources within their community, to assist them in more constructive leisure time activities such as sport facilities, creative and hobby classes, and group activities like walk-for-life and debating groups. The participants perceived that the programme exposed them to all these resources, and gave them alternatives to overcome transport and/or finances constraints. It can therefore be seen that the group psycho education programme followed the occupational therapy literature that emphasized the importance of maintaining a balanced lifestyle and the resocialisation of the MHCU through activities that promote constructive use of leisure time. ^(33, 34)

It can thus be concluded that the literature reviewed assisted in guiding the group psycho education programme in achieving the participants' improved intellectual insight into dual diagnosis, and the specific steps that they required to take to manage both their conditions. Results demonstrated that the participants' perceived that their knowledge of these aspects had improved.

5.3 FACTORS IN THE GROUP PSYCHO EDUCATION PROGRAMME IDENTIFIED AS USEFUL OR NOT USEFUL FOR HELPING GAIN INSIGHT

This section will discuss the results of this study that identified the factors of the group programme the participants perceived as useful and not useful. The factors perceived by the participants as effective, and non-effective, were established by the analysis of the feedback achieved in the second and third interviews during and after participating in the programme. This assisted in establishing the changes needed to be made to the group psycho education programme and the evaluation framework, to be discussed in the sections that follow.

5.3.1 FACTORS PERCEIVED AS USEFUL IN THE GROUP PSYCHO EDUCATION PROGRAMME

All participants identified knowing what to expect from the groups as an important factor which influenced the effectiveness of the psycho education programme. This factor was not considered within the evaluation framework which was developed to determine the effectiveness of the programme. The participants described that knowing what to expect from the group allowed them to feel prepared for, and motivated them to attend the programme. They were aware that the content of the group would be relevant to them, and would meet their needs. This is in keeping with the group literature that encourages, and advocates the establishment of group goals, as it allows the group members to be aware of the subject matter to be addressed in the groups, and gives the participants a sense of autonomy over the group process being developed within the group. ^(41, 52) Thus the initial interview which was undertaken by the researcher as an assessment process, and to establish a list of goals prior to the group programme commencing, played an unexpected role in establishing motivation of the MHCUs to participate, and complete the group psycho education programme. This verifies the factors referred to in the literature as “group entry” and, “group goals”. ⁽⁵²⁾

The researcher used the literature to incorporate these factors into the group process. It however, did not include them into the Evaluation Framework Developed from Phase 1 of this Study (p70). Hence it can be concluded, that from the results of the main study,

these factors should be included in the evaluation framework as they were perceived as useful.

Results from this study showed that the participants perceived four of the six identified factors in the evaluation framework of phase 1 as useful, and two as not useful. The findings of this will be discussed below.

- **Interaction with the group members**

Results demonstrated that the interaction between the group members contributed to the effectiveness of the programme. This is consistent with the group work literature where communication was reported as being essential in establishing group interactions and dynamics. ^(19, 58, 59) Therefore literature referred to assessing the language capability of group members as important for both the therapist and MHCUs to be able to communicate, and was the reasoning for language being one of the selection criteria, as well as that all participants were to be on the Creative Ability levels of Explorative patient directed to Experimental therapist directed, ^(29, 33, 34) further ensuring effective communication amongst the group members. Literature also stated that group work requires a shared need amongst the group members so as to ensure relevance of the group content for each participant. ^(19, 58, 59) The researcher incorporated this into the selection criteria, ensuring all participants suffered from a psychiatric illness and co morbid substance use disorder (dual diagnosis), concluding that appropriate group membership is an important factor in determining the effectiveness of a group psycho education programme.

Participants identified the technique of allowing each member to share their life story as valuable and this will be discussed further in the section exploring the effective techniques.

The establishment of group norms was also referred to as assisting group cohesiveness as the norms assisted in establishing the group dynamic. This was referred to in the group literature and in stills the importance of adherence to confidentiality by the group members. ^(33, 34, 41, 52) The participants also perceived the group norms as being effective in establishing the sense of safety within the group, and according to the group literature, compliance to group norms allows for group interaction, and group cohesiveness, essential for the usefulness of the group techniques of confrontation and group pressure. ^(19, 33, 34, 41, 58, 59) This was another factor not considered in the evaluation

framework of phase 1 of this study, and hence, was another unexpected factor perceived by the participants as being effective.

The feelings of self-efficacy, developed from the ability for some participants to contribute positively to other group members, allowed for an improved sense of self to begin developing. As a poor sense of self was established as a main cause of the participants' use of substances, the group membership was effective in indirectly addressing this. It established a 'sense of belonging' in individuals who experience difficulty in feeling that they belong in society, and allowed them to feel that they can bring value to others. This is in keeping with van Ommen and Hiram, who both referred to self-efficacy as being an important variable that has been identified within the treatment process and the importance of establishing a therapeutic community. ^(27, 57)

This sense of belonging established in the groups extended outside of the groups where the participants felt supported in the wards too, allowing them to experience the importance of "safe friendship" and gave them the experience of successfully utilising new coping mechanisms and support systems. This is in keeping with the group literature that refers to the importance of group cohesiveness in establishing the therapeutic community. ^(19, 27, 41, 52, 58, 59)

This technique of group confrontation was also highlighted as being effective, and is in keeping with the literature, as the level of cohesiveness established in the group programme allowed for this technique to be effective. According to group literature, there needs to be a strong sense of universality for the participants to consider each other's opinions, and for group pressure to be possible and effective, describes that this technique can be uncomfortable for the group members; however it remains important in imparting information amongst the group members. ^(1, 19, 58, 59) Therefore this result is unexpected. It can be assumed that the five participants, who referred to this technique as useful, were referring to the outcome of the effectiveness of the confrontation in the consolidation of their intellectual insight, and not to the discomfort it may have caused in the group programme. This will be explored further in the section discussing techniques and group leadership.

Previous exposure to rehabilitation centres resulted in mixed perceptions about the group members. Despite some frustration, benefits in this group dynamic were recognized – the development of patience, not to be impulsive, and gaining some ideas

from these group discussions. This is in keeping with the group literature that encourages diversity in the membership of groups, as it facilitates the imparting of information. ^(52, 57)

It can therefore be concluded that in keeping with the literature, establishing group membership and cohesiveness through the techniques of life stories, developing group norms, and confrontation of group members facilitated a sense of belonging effective both in and out of the groups, and assisted in developing intellectual insight in the participants, and a change in behaviour of the participants.

- **Group Content**

Results showed that all the participants found the content of the groups relevant. This result was expected as in the initial interview the researcher had established the participants' needs from the group and a list of group objectives was drawn up. Part of the second interview was also used to establish that the psycho education programme content continued to meet their needs. As the researcher did not receive any feedback concerning content from the external interviewer, who did the second and third interviews, this was not a surprising result.

The researcher used the list of goals to direct the logical flow of the discussions, and for the group members to be aware of where they are in the group process.

Not unexpectedly, previous experience in rehabilitation groups resulted in the content relating to substances and the stages of abuse as being similar to what had been learnt previously, but content was still found to be relevant. They acknowledged that despite being familiar with this information they had failed to make the necessary behaviour changes. Failure to change was largely attributed to the negative attitude towards treatment and the poor level of motivation to change. This is in keeping with Carson in Frude which stated that a treatment programme's success is largely dependent on the addicted MHCUs' motivation for change, which is reflected in their attitude to the substance and the treatment regime. ⁽²⁶⁾

The content on dual diagnosis was beneficial as it was different to previous experiences, and was directed on creating the links between their mental illness and their use of substances. This facilitated the participants' understanding of the concept of dual diagnosis.

All the participants referred to the “pictures” as being the most beneficial aspect of the group content. This was the didactic information that was given on dual diagnosis where the links between the two conditions was addressed. This information addressed the causes of mental illness, the symptoms thereof, and how to manage mental illness, which included abstinence of substances. The similarity between the symptoms of mental illness and the effects of substance use were emphasized. This information also included the importance of managing both conditions, improving their mental health, and quality of life. The participants all expressed that this information made the relationship between mental illness and substance use disorders clearer. This concludes that using diagrams assists with understanding, and, that with an increase in the MHCUs’ level of intellectual insight, an increase in the motivation to change can result. It can also be seen that when imparting scientific information a didactic approach remains effective but, it is necessary that it remain on the MHCUs’ level. This is in keeping with the Swaminath that suggested the health professional use the didactic approach, when imparting scientific information, as it is conceived to be a reliable information source.⁽²⁸⁾

The group content that addressed the “triggers for using substances” was highlighted as this allowed them to understand how to manage their use of substances more effectively. As one of the triggers, identified in the groups, was stress, the importance of the content that addressed stress management was referred to. This result is in keeping with the Crouch and Wegner who both refer to stress management being an important component in the management of both their mental illness and substance use disorder.^(33, 34) With the participants’ increased understanding of dual diagnosis, they were able to appreciate that stress management was an important component to their management of both conditions. Similarly the content that addressed their balanced lifestyle was highlighted as it allowed them to plan their life, come up with new coping strategies to assist in their management of their stress. This gave them a further sense of autonomy to their lives, and left them feeling prepared to return home. Autonomy has been referred to by Hagedorn as an important outcome of treatment in occupational therapy.⁽⁹⁾ Hagedorn and Crouch refer to a balanced activity profile in assisting in stress management, and an individual’s experience of independence in their daily living activities promotes comfort, and satisfaction, and a sense of autonomy.^(9, 33)

It is thus concluded that the content within the programme which was most important was that which established the relationship between both the conditions that addressed the participants' triggers, stress management, and their activities health. This helped empower the participants with the knowledge, and skills to cope with everyday life, and their individual stressful situations which facilitated the motivation for change, and this is an important outcome of a group psycho education programme.^(9, 26, 27, 33, 34)

- **Techniques**

From the results it is evident that the participants did not have clarity between the techniques used, the content of the groups and group leadership. It can thus be concluded that the interview questions did not make the distinctions overt and the results demonstrated this confusion. This resulted in the participants overlapping their perceptions of these three factors. This is in keeping with the group literature that was reviewed which stated the group techniques used in managing the groups are determined by the group facilitator and; the only common role within all groups is that of the group leader.⁽⁵²⁾ Therefore the researcher has analysed the data and found four techniques referred to, by the participants, as being effective: the narratives of the life stories, didactic information, handouts, and personal application of the information.

The technique of the life story narratives, in the first group, has been referred to above as assisting in developing cohesiveness amongst the group members. The unexpected factor of establishing group norms, as discussed above, incorporated by the researcher into the group process, was also perceived in establishing this, and was also referred to as establishing a sense of autonomy within each participant and the literature referred to autonomy as being important as it assists in the participants' sense of self-efficacy and responsibility.^(9, 27) The group literature also referred to the development of group cohesiveness through the group dynamic as important as it allows for the technique of group confrontation to be more effective. The effectiveness of the "laizaire faire" leadership style is also described as important in the development of the sense of autonomy within the group members, and hence facilitating the shift towards an internal locus of control.^(33, 34) This will be discussed below in the section discussing the effectiveness of the group leadership.

Results showed that the participants all referred to the techniques of the didactic information on dual diagnosis, described above, as effective. This included the

techniques of didactic teaching and the use of pictures and handouts. The use of handouts also allows for the information covered in the session to then be taken with the participants and used to consolidate knowledge, and to impart on others, including their families, which was an expressed need of the participants. This is in keeping with the group literature which described the use of handouts and audiovisual material as an effective technique for providing “focused feedback” in the imparting of knowledge as well as, allowing the group members to relay the knowledge that they have gained, from the groups, onto others outside of group. ^(21, 41, 59)

The use of the technique of the personal application of the information perceived as effective. It allowed each participant the understanding of how this information applies to them individually, and how they can implement it after the group programme had ended. This technique of personal application of information was further utilised in the individual sessions offered to all the participants. However only three of the participants utilised these sessions. These three participants all had previous experience to substance abuse related rehabilitation. This further confirms the literature which states, previous education, and therefore the repetition of the rehabilitation, assists in the consolidation of intellectual insight, and the facilitation of the development of affective insight. This results in the necessary behavioural changes being made. ^(1, 33, 34, 74, 75)

It can thus be concluded that the techniques of narratives, didactic information, pictures, and handouts used in the group programme were effective in assisting the participants in the development of intellectual insight. The technique of personal application of information then allowed the increased intellectual insight to be actualised into a plan on how to make the necessary behavioural changes. This potentially facilitated the development of affective insight. This however, was not measured by this study, but results reflect that the facilitated understanding of the information allowed for this information to be consolidated by the participants. The application of the information ensured that each participant understood the information and knew how to take this away with them. This left them feeling autonomous and prepared for the behavioural changes they needed to make.

- **Group Leadership**

The leadership of the group needs to be described, as the researcher adapted this as the group programme progressed. In the first two sessions of the group programme the researcher adopted a more didactic approach of leadership as these were the sessions

where the content involved the imparting of scientific information. This was in keeping with the literature on psycho education, previously discussed which advocates the didactic approach when imparting specific or scientific information.^(28, 33, 34) This approach, which mirrors the role of a teacher, involves a more active stance of the group leader when imparting knowledge.^(33, 34, 52)

After the first and second sessions, the group content required more active participation and discussion amongst the group members. It was here that the researcher adopted the more “laizaire faire” approach. The group literature described this as assisting in the development of the group dynamic, and allows for the technique of group confrontation to be more effective. The effectiveness of this leadership style is also described as important in the development of the sense of autonomy within the group members, and hence facilitating the shift towards an internal locus of control.^(1, 33, 34, 52)

It can thus be seen that the researcher used a combination of leaderships styles, determined by the proposed content of the group session, and literature advocates the combined passive, and active role of the group leader as he/she gently guides, and assists the focus of the group members’ attention on the group content, whilst taking an a more active role when imparting scientific information.^(28, 33, 34, 52)

The leadership style was reported to assist the content in being more discussion based and facilitated group interaction. This allowed for a sense of autonomy to develop, and increased the participants’ motivation to make the “right” decision. As substance abuse literature referred to the importance of the motivation for change and self-efficacy in determining the success of treatment^(1, 26, 27, 41), this was a desired outcome of the group programme. The leader’s approach made the participants feel more comfortable and allowed them to experience the lectures as more entertaining, which facilitated their concentration in the didactic sessions and the group leader as approachable. As stated in the Swaminath and Corey and Corey, the group leader’s personality is important. If the group leader is seen as unreliable or unapproachable it could leave the group members feeling resistant and resentful and thus, impact on their adherence, and consideration of the information discussed, resulting in it having a negative influence on the development of insight.^(21, 28, 52) The literature stated that group members respond well to the willingness of the leader to share themselves with the group, a caring attitude, enthusiasm, openness, and directness, further advocating the “laizaire faire” approach.

The literature advises the leader not to rely on their title or professional accomplishments for respect, but should use the therapeutic techniques, and understand the value of using oneself as an instrument in therapy, to gain respect from group members. This allows the group members to perceive the leader as genuine, sincere and trustworthy, which in turn results in the leader being respected, and optimal group facilitation.^(28, 33, 34, 52) Literature on psycho education also states the importance of the psycho education group leader of having an extensive knowledge base so as to ensure reliability of the information imparted by the therapist.^(20, 21, 28, 57) This was consistent with results that demonstrated the group leader's knowledge allowed the participants to have faith in the information that they were being given, and the answers they received in the group sessions.

The participants also highlighted the effectiveness of the leadership style of ensuring group interaction. This further refers to the effectiveness of the "laizaire faire" approach, as the more easy-going, passive stance, facilitates interaction amongst the group members, and allows for group discussions to develop. Group literature also states it is important in the development of the sense of autonomy within the group members, and hence facilitating the shift towards an internal locus of control.^(33, 34, 52) It facilitates the group members to make decisions for themselves, advice to be given by their peers, and not by the group leader.

It can thus be concluded, that these findings are in keeping with the literature which advocates a combination of the active and passive role of the group leader. The approach described in the literature as the "laizaire faire" leadership style is effective in facilitating group interaction, and a sense of autonomy within the group members. At the same time the group leader needs an extensive knowledge base of the subject matter being discussed so that his/her contributions and information are seen as meaningful. This allows the information to be considered by the group members, and concludes there is room for the approach, described in the literature, as a more didactic approach when specific or scientific information is being imparted and when confronting a group member. This combined approach leaves the group members feeling comfortable within the group and in approaching the group leader with questions and contributions that they have.

5.3.2 FACTORS PERCEIVED AS NOT USEFUL IN THE GROUP PSYCHO EDUCATION PROGRAMME

Results demonstrated that there were very few factors that were perceived as not being useful. This was an expected result due to the results achieved in phase 1 of this study, together with literature on “patient satisfaction”, which have found that “satisfaction” levels recorded are often high in inpatient facilities. The results of this study are thus in keeping with this literature. ^(74, 75, 76) The timing of the evaluation of this study, as previously discussed, may have also influenced the results, as the effectiveness of the factors were only measured during, and directly after the completion of the programme. Thus the long-term and sustained effectiveness of the factors and the effectiveness of these factors in developing affective insight were not measured by this study. As the “patient satisfaction” literature has indicated high results recorded in “patient satisfaction” after discharge from hospital decreases ^(74, 75, 76), the timing of the evaluation of this study has implications on the results achieved. It also indicates that the group leader needs to be self-reflective and analytical in evaluating the group process.

The two factors that the participants perceived as not useful include, group context, and group structure. The participants may have considered these as not important; however these factors are important from a therapy perspective and this was supported by the literature.

The ideal group space was described, by the Larrence, Bramer and Shostran as the context that allows for all group members to feel comfortable and thus share more openly and honestly, therefore facilitating group interaction. ⁽⁴¹⁾ The context should also be quiet thus limiting the external distracting factors which could disturb the group process. This promotes the group norms of privacy and confidentiality, ⁽⁴¹⁾ and this was considered by the researcher in the development of the group programme. The group literature also refers to the factor of group membership needing to be considered in the group structure, and delineates the benefits of both open and closed groups. ^(21, 41) Corey and Corey and Heram also encouraged diversity in the group membership, for effective sharing of information. ^(52, 57) Lowinson and Larrence et al highlighted that a closed group is more advantageous for data accumulation and group cohesiveness. ^(21, 41) Therefore the structure of the groups for the programme of this

study was closed. The timing of the length of the group sessions, and the succession of the group sessions, is described in the literature as important for group success. These factors allow for information to be imparted, group interaction to be achieved, as well as maintaining the intensity of the information and group dynamic. The literature stated that for an effective group dynamic to develop, and information to be shared, the groups need to be structured more than once a week and the context should allow for interaction amongst the group members.^(41, 52) This was therefore considered by the researcher in the structuring of the groups. The results achieved in this study are expected, as the participants were not anticipated to appreciate the value of the group structure and context.

- **Group Structure**

Results showed that the participants perceived group structure as having little significance in the effectiveness of the group programme. The findings did indicate that smaller groups enhance group interaction and allow each member adequate time for their individual needs to be addressed. Results also demonstrated that groups should also be held in regular succession to ensure consistency, and the sustained intensity of the information being covered and that the length of time dedicated to the group programme be extended to include more content regarding the self-subsystem, assertiveness skills, and the management of specific stressful situations, work, and interview skills. These needs could also be addressed in the individual sessions that three participants requested. The need for individual sessions was an unexpected finding as it was not considered in the evaluation framework of phase 1 of this study. Literature did, however, refer to structuring more time for individual sessions or, using the post session technique to allow for integration, and consolidation of the therapeutic work achieved within the group process.^(21, 41) Although the researcher continually encouraged the participants to discuss issues that arose from the groups with their individual therapists, the participants felt that this would be more effective if they could address these issues with the group facilitator as she was more familiar with the subject matter, and was aware of the exact group content, and concepts that they were referring to. It can thus be seen, that although this content can be addressed in other psychodynamic programmes, more time should be structured in the group psycho education programme to meet individual needs, both in the groups, and in the individual post programme sessions, and emphasises the importance of the health care professional in having an established knowledge base of the subject matter.

The need to structure family involvement in the group programme was also highlighted in the results. The hospital context, in which this research was undertaken, limited the time available for the group programme and, the time to conduct this study was limited by the length of admission of the participants. This limited the content that could be covered in these groups. In future psycho education programmes the length of the programme should be extended to include this content and allow for family involvement.

It is thus concluded, when developing a group psycho education programme, it is important to ensure that the group is structured to allow for interaction between group members, to address the group content and include family, and that the groups are in regular succession so as to ensure consistency and intensity of the information being addressed.

- **Group Context**

The research findings reflected that the participants perceived the group context to be insignificant, except that it needs to be quiet and private so not to interfere with the group process, and facilitate confidentiality. It was also reported that the consistency of the context, facilitated the participants in feeling safe within the group. This is in keeping with the group literature referred to above and concludes that the context of a group psycho education programme should be consistent, quiet and ensure privacy, confidentiality, and not allow for external distractions that could interfere with the group process.

- **Group membership**

The results of this were mixed and are in keeping with the literature that is also conflicting. Some of the group literature refers to consistency in the level of insight within group membership as being important to consider in the structure of a group programme; ^(21, 41) however, the substance abuse treatment philosophy encourages diversity. The substance abuse philosophy is more tolerant, and uses the differences in the level of insight between group members to assist in the technique of confrontation of group members, and the consolidation of intellectual insight. ⁽⁵⁷⁾ This was demonstrated in the results in the development of self-efficacy. ^(1, 21) As it is common practice within the field of Occupational Therapy for the group facilitator to consider the participants' level of functioning, ^(33, 34) the researcher did so in the selection of the sample; however

she did not consider the level of denial and insight of the participants when establishing the group membership of each group. This result indicates higher functioning individuals are less tolerant and impatient with those less capable as they are motivated to move on in the group process. Therefore the level of insight should also be considered to enhance the group process; however considering this, results in inconclusive deductions regarding group membership as the results, in keeping with the literature, are conflicted.

- **Group leadership**

The participants also demonstrated a mixed perception on the usefulness of the group leadership. All the participants referred to the group leadership as useful, as discussed above; however under the subcategory of “What should change in the programme?” some mixed results were reflected. Although the benefit of the combined approach of “laizaire faire” approach, and the didactic approach was appreciated, it was expressed that a more directive style would have given more certainty in the progress that was being made in the level of intellectual insight, and the change in behaviour. This highlights the need for affirmation, guidance and feedback regarding the group members’ progress in the groups. It thus emphasises the need to make more use of the didactic approach when giving feedback to the group members and the importance of individual post sessions.

It can thus be concluded that, although the participants perceived little importance in the factors of group structure and group contexts, it can be considered that these are professional technicalities that may be beyond the knowledge and concepts of the participants. Therefore these results are contrary to the literature that advocates for these factors to be considered to ensure active participation of all the group members, group cohesiveness, regular succession so as to ensure consistency, intensity of the information being addressed, and active concentration of the participants. This in turn ensures the effectiveness of a group programme. Mixed perceptions on the factors of group membership and group leadership highlighted the need to consider the selection criteria of group membership. Results also showed that the group leader should make more use of direct feedback to the group members to allow for affirmation and confirmation of the decisions, and behavioural changes that they have made. This will be discussed, together with other factors in the section that follows.

5.4 THE FACTORS PERCEIVED THAT WOULD IMPROVE A PSYCHO EDUCATION PROGRAMME FOR DUAL DIAGNOSIS

The information uncovered in this section was elicited in the subcategory of “What should change in the programme?” As this study researched the factors that contribute to the effectiveness of a group psycho education programme for individuals suffering from dual diagnosis, if this programme is to be repeated, it would be important to consider the findings of this study. It is suggested that it would be beneficial to extend this study in time, and then study both the short-term and long-term effectiveness of the designed programme by measuring the individuals’ improved level of intellectual insight into dual diagnosis, and in sustaining the required behavioural changes (affective insight), improved prognosis of both their conditions, improved family relationships, and reduced service utilisation. The findings of this study would then contribute and would be fundamental in the development of such a study and in bridging the gap that literature has described as existing between the treatment services addressing mental illness and substance use disorders.

- **Content**

All the participants were positive about the group content, as discussed above; however it was perceived that more emphasis on the components of self, needed to be included in the group programme. Most participants experienced difficulties with an accurate sense of self, as their self awareness, ideal self cognitive self, and self-esteem had been negatively influenced by the consequences of both their mental illness, and substance use disorder. Although the components of self were indirectly addressed in the group programme it was evident that this needed further intervention. This would then influence and improve assertiveness skills, and their ability to face stressful situations. Self-awareness, self-esteem, assertiveness skills, work and interview skills are all components of programmes that address psychodynamic issues and the development of life skills. As this programme was addressing psycho education and only aimed at improving intellectual insight, and facilitating affective insight, the additional content, that the participants were requesting, would not be appropriate for this programme; however this result does emphasise the need to refer MHCUs suffering from dual diagnosis to psychological and/or psychodynamic groups, vocational, and life skills programmes so that these needs can be addressed. Alternatively the programme of this

study could be extended beyond the eight sessions to incorporate such content; however one can then argue whether the programme would remain a psycho education programme, or would then overlap with already existing psychodynamic, vocational, and life skills programmes.

- **Individual sessions**

The request for an individual session is in keeping with the group literature that advocates the structuring of more time for individual sessions or using the post session technique so as to allow for integration, and consolidation of the therapeutic work achieved within the group process.^(21, 41) Although individual sessions were included in the programme after feedback was received from the external interviewer in the middle of the programme, it can be seen that more time should be structured in the group programme to meeting individual needs both in the groups and in the individual post sessions. It emphasises the group members' needs for more direct feedback, and the importance of the health care professional to have an established knowledge base of the subject matter. It also concludes that an eight-session group psycho education programme is insufficient in addressing all the participants' needs. In future group programmes, the number of sessions should be extended to allow for inclusion of all subject matter, and include the involvement of the participants' families.

- **Psycho education programme for families**

Results also demonstrated the participants' perception that their family members need to attend a psycho education programme as they feel that it would facilitate their families' understanding of their conditions and thus promote more effective support. This is in keeping with the substance abuse and psycho education literature that referred to the importance to include the MHCU's family and support structures into treatment, and many such programmes already exist.^(19, 21, 28, 30, 31, 32)

As a result of time factors, discussed earlier, and the logistics of the Sterkfontein Hospital, discussed in the previous chapters, this group programme did not address this. Participants were encouraged to make use of their handouts to impart this information, however, as literature suggests, family involvement should be considered in future group psycho education programmes especially if the demographics of the group and the logistics of the institution allow for this.

- **Group membership and interaction between group members**

As referred to in the previous section, the results of this study, and the literature is in conflict with regards to this, as it encourages the consideration of group membership, and highlights the need for shared need amongst the group members, ^(19, 58, 59) while substance abuse literature refers to the need of group members to have differences in their level of insight as it assists in the technique of group confrontation. ^(1, 52, 57)

Therefore the conclusion on whether this should be included in the selection criteria is unclear. It is however clear that the results are in keeping with the literature, that the selection of group membership needs to consider criteria relating to communication, as communication is fundamental in the group interactions, the imparting, developing the group dynamic, and for imparting information to the group members of a psycho education programme. ^(19, 58, 59)

- **Other factors identified in this study**

The results of this section were reflected in the subcategories of “Should this group programme be repeated?” and “How does this programme differ to other programmes I have attended?” These results demonstrated that the group programme was beneficial and that the programme should continue as many people could benefit. Further factors of this study, which were identified, included the importance of the group programme being voluntary. Results showed that voluntary participation was important if the level of motivation to change, and hence the investment of the group members in the programme; involuntary membership may create resistance to the programme and resistance to change and this may hinder the group process. This was confirmed by literature previously referred to on “patient satisfaction”, that highlighted and individual’s “choice” in treatment facilitates satisfaction. ⁽⁷⁴⁾

Results from this study also demonstrated that the gap that exists between the treatment interventions of the psychiatric, and substance use disorder approaches can be bridged. Results showed that this programme focused on dual diagnosis, the development of coping mechanisms, and a specific discharge plan and that this was different to other programmes that had been attended. The level of understanding of dual diagnosis had improved, and there was better preparation, and more awareness of the steps involved in the management of both conditions. The “laizaire faire” leadership style was more effective than the more autocratic approach as it enhanced the motivation for change as

it allowed for the development of a sense of autonomy within the process, and within the decisions to change behaviour.

Results showed that the attitude of the participant to treatment was another key influence to the effectiveness of the programme, as it effects the motivation for change. Hence it can be concluded that it is important to assess, or screen, the group members for their “motivation to change” prior to the group psycho education programme beginning. This is important, as a poor motivation for change creates resistance to treatment, and negatively impacts on the group process and the effectiveness of the programme on the individual themselves, and their fellow group members. ^(1, 26)

These were all unexpected results. They were not reflected in the evaluation framework of phase 1 of this study, and therefore, it can be concluded that it is important to structure more time for individual needs to be addressed within the group process, and after group sessions. This time would require a more didactic approach to allow for more directive feedback to be given. Furthermore MHCUs suffering from dual diagnosis should be referred to already existing psychodynamic, vocational, and life skills programmes to address the individuals’ poor sense of self, assertiveness skills, and specific stressful situations, such as work, as these were identified as considerable triggers to both their mental illness, and use of substances. Alternatively, if availability to such programmes is limited, the programme should be extended beyond eight sessions to include this content.

5.5 THE EVALUATION FRAMEWORK

The evaluation framework has been adapted to include all results of this study. All the results have been summarised and then represented in Figure 2 displayed below. These factors have implications for an occupational therapist, and should be considered when developing a group psycho education programme for individuals suffering from dual diagnosis.

5.5.1 SUMMARY OF RESULTS OF THIS STUDY FOR THE EVALUATION FRAMEWORK

This section makes use of the discussions explored above to identify the factors and the reasoning for these factors to be included in future group psycho education programmes for individuals suffering from dual diagnosis, and thus the evaluation framework (Figure 2) has been adapted to incorporate these results.

To develop an effective group psycho education programme it is important to ensure that the individuals' needs are addressed, and met by the group. This requires the needs of the individuals to be accurately identified before the group programme begins. A list of goals ensures that the participants' personal needs are acknowledged, and the group content remains relevant to them. This list of goals also allows them to develop a sense of universality within the group membership, and a sense of autonomy over the group content, and process. This was seen to improve the individuals' motivation to attend the group programme and compliance to treatment, and thus concludes that a list of group aims should be established in the initial phase of a psycho education group programme and should consider the individuals' needs.

The results of this study also demonstrated the effectiveness of reassessing the participants' needs prior to the group programme ending, as the participants may develop further needs, as a result of attending the group programme, and achieving a shift in insight. This can result in more specific needs being developed, and thus allows the facilitator to make any necessary changes or adaptations to the group programme prior to the group programme ending. Reassessment of the participants needs in this study, allowed for individual sessions to be offered to the participants, who expressed that they were of great benefit. As this was effective it should be included in future group programmes as it also allows the participants to feel that their needs and feelings are considered and further enhances the effectiveness of the programme and the sense of autonomy in the group programme.

This study concluded that group membership needs to be considered closely. Discussed in the previous section, the need for group members to be of a similar level of functioning was established, and the result to have a similar level of insight was inconclusive. This was as the participants perceived that similar levels of insight allows

for more effective confrontation of group members, and enhances the group process; however literature relating to the substance abuse philosophy reports that a difference in level of insight allows for group confrontation. Results showed that developing the group norms early in the programme establishes the milieu of the group dynamic, where the facilitation of interaction between group members is important. Interaction between group members allows for valuable contributions of group members to be made and allows for a sense of self-efficacy to develop, as the individual can see the value and impact that they have on others. Interaction within the group enhances group cohesiveness and establishes a support system useful both in and outside of the group process. It also enhances the participants' sense of belonging; this is important as most of these participants expressed feeling isolated from both their primary and secondary support systems, as a result of the consequences of both their mental illness, and substance abuse.

Group content of future group psycho education programmes should include information on the symptoms, causes, and process of illness, of both mental illness, and substance abuse, so that the relationship between these two conditions can be recognised. Triggers to these conditions should be addressed, and the introduction to new coping mechanisms should be included so as to allow for more effective stress management, assertiveness skills, and work skills. Participants should also be referred to psychodynamic and life skills groups to consolidate these skills. If such groups are not available, content should be included to address individuals' sense of self, to improve their self-esteem, and family involvement in the group programme is imperative, to facilitate support and a greater sense of belonging within the individuals' primary support system.

This study showed that the techniques which allow for a client-centred approach are effective and should be included in a group psycho education programme. These techniques should allow for application of the information discussed, and the "take home" factor, through activities and handouts, that ensure consolidation of the information, and increases the possibility of behavioural changes being made.

The group leadership style adopted should be a combination of the "laizaire faire" and didactic approaches. The "laizaire faire" approach should be utilised in sessions to

facilitate group interaction and allow for individual application of information. It will also promote a sense of autonomy within the group members, and facilitates group cohesiveness. A didactic approach should be adopted when imparting specific and scientific information to ensure that the accurate material is covered. It thus requires the group leader to have an extensive knowledge base of the subject matter which promotes the reliability of the information given. A didactic approach should also be adopted when giving group members direct feedback, as they require affirmation regarding their progress within the group process. And again the need for the availability of the group leader in post sessions is emphasised.

Although group structure bore little significance to the participants; their feedback did conclude that it would be important to consider group structure when developing a group psycho education programme. Results showed that it is important to ensure that the group is structured to allow for interaction between group members. The timing of the group should be structured so as to ensure sufficient time to address the group content and that the groups are in regular succession so as to ensure consistency and intensity of the information being addressed. The programme should also be extended to include specific expressed needs, and individual sessions and family involvement also needs to be structured within the programme to allow for personal application of information and for identified, individual needs to be met. Similarly it was concluded that the context of a group psycho education programme should be consistent, quiet and ensure privacy and confidentiality and not allow for external distractions that could interfere with the group process.

Voluntary participation was established as important in the level of motivation to change and hence the investment of the group members in the programme. Results from this study concluded that it is important to assess or screen the group members for their “readiness to change” prior to the group psycho education programme beginning. This is important as a poor motivation for change creates resistance to treatment and negatively impacts on the group process and the effectiveness of the programme on the individual themselves and their fellow group members.

All these factors have been diagrammatically represented in the adapted evaluation framework below and should be considered when developing a group psycho

educational programme for individuals suffering from dual diagnosis to be incorporated in the occupational therapy treatment programme.

ETD Wits

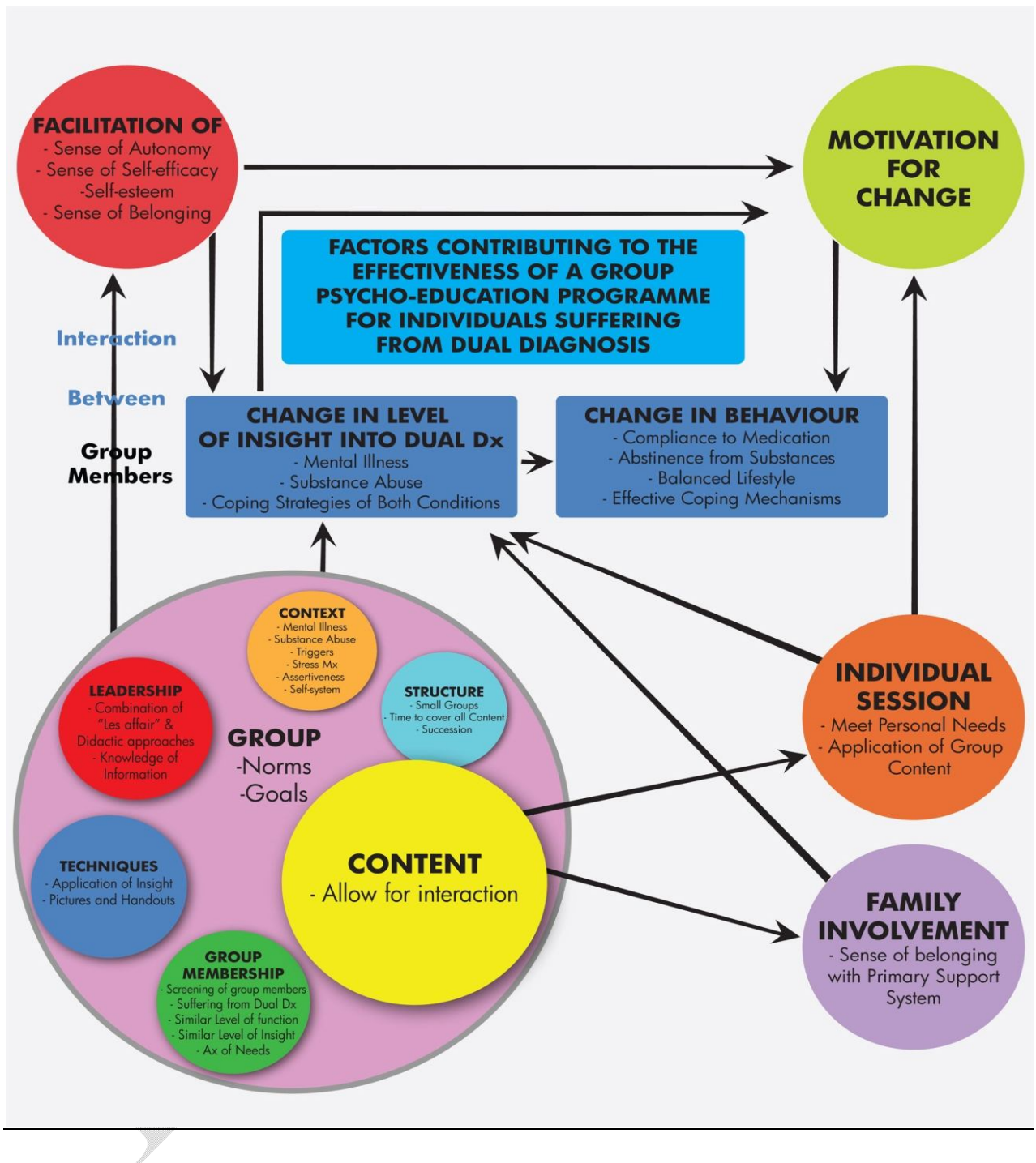


Figure 2: THE EVALUATION FRAMEWORK DEVELOPED FROM THE MAIN STUDY

5.5.2 LIMITATIONS OF THE STUDY

The factors that limited the results of this study have been considered and embedded within the discussion of the results above. They include the demographics of the group participants, group work, the interview process, the interviewee, the predominance of positive feedback which may have influenced the results achieved in this study, bias of the coding used in the data analysis, the time factor, and the fact that there was no family involvement, or the participants' primary support system within this study.

The limitations, that have been discussed below are, the interviewer, the coding of the data, and the predominance of positive feedback.

- **The Interviewer**

The interviewer may not have conducted an identical interview with each participant. This would have been limited by external factors such as availability of time, the mood of the interviewer and the state of mind of the participant. Many of the questions asked in the interviews led to undirected answers and inconclusive statements by the participants which did not contribute to the issues being raised in the study. This limited the structure of the information gained from them. This factor was overcome by providing guidelines for the interviewer (Appendix F) containing direct questions where specific answers were required. The external interviewer was also trained by the researcher and informed of the background of this study, and the information which was required. This ensured that similar information was gained from each participant, and allowed for consistency in the questions asked within each interview.

- **The Coding of the Data**

The organisation of the data was done according to priori coding established from the literature and then confirmed by phase 1 of this study. As a result of the codes being confirmed, the researcher did not make use of an external observer to review the coding and check for bias. This may limit the trustworthiness of the results as they may be biased in the interpretation of the themes. The use of priori codes to some extent pre-empted responses perhaps resulting in data that was not of sufficient depth as expected.

- **Positive Feedback**

The predominance of positive feedback received from the participants can result in the reliability of the results in this study to be questioned. This factor was controlled by reminding each participant of the importance of honest feedback. However, it can be argued that the participants involved in this study had limited exposure to treatment

interventions and due to the consequences of the dual diagnosis, were exposed to limited lifestyles with limited resources and possible institutionalisation. Being offered this experience for treatment, which considered their individual needs, being exposed to an opportunity to have their perceptions and contributions considered important and valuable, may have influenced their feedback. As previous treatment may not have allowed for their needs to be met, and the sense of autonomy to be developed this programme may have had an overwhelmingly positive effect on the participants. This in turn influenced their feedback in being predominantly positive. As discussed earlier, the participants' lack of experience in giving constructive criticism to people in authority, may also have resulted in the data received being questionable. The researcher tried to overcome this limitation through triangulation of the positive feedback with observations made by herself, and other health care practitioner; therefore verifying the reliability of the participants' feedback. This result of the study, as discussed above, is in keeping with the literature referring to "patient satisfaction" that identified factors that determine such high records of satisfaction. The factors identified by the literature include: educational level, prior hospitalisation, length of stay in hospital, the individual's perceived health and expectation of the outcome of treatment, the individual's choice in treatment and that men have been found to record higher levels of satisfaction than women. These factors have been incorporated in the discussions above.

(74, 75, 76)

CHAPTER 6

CONCLUSIONS

This study aimed to develop and evaluate a group psycho education programme to contribute to the treatment of individuals suffering from dual diagnosis.

The first phase of this study was to develop the programme. The needs of a small group of MHCUs with dual diagnosis using a qualitative research methodology were described. An eight session group psycho education programme was developed considering these participants' expressed needs. The participants' perceptions of the factors that contribute to the success of such a programme were described after the outcome of the group programme showed an improved level of insight into the conditions making up the dual diagnosis, and when the MHCUs attained the knowledge of the steps needed for them to stay well on discharge. An evaluation framework was developed from the literature.

The main study used the same qualitative methodology, and aimed to evaluate the factors in the group programme that assisted the participants to develop insight into their condition. Ten participants diagnosed with dual diagnosis completed the group psycho education programme and their perceptions of the factors they considered important in the group process were incorporated into the evaluation framework using two semi structured interviews. The data was analysed using priori codes.

Results showed that the factors the participants perceived as contributing most significantly to the effectiveness of the group psycho education programme were: the group content, group techniques, and leadership style used to facilitate interaction and cohesion, and the knowledge of the group leader about the subject. The group structure and group context were felt by the participants to be of less importance and similar to their former group experiences.

It was the opinion of the group participants that the programme was successful in helping them improve their intellectual insight into knowing what they should do to stay well and maximise their occupational performance, and should be offered to other MHCUs with dual diagnosis. However the participants reported that the group membership is a factor that should be reviewed so that the group members are at the

same level in terms of their ability to deal with the knowledge that is discussed in the groups. The number and frequency of groups was also identified as factors that should be reviewed to allow information explored in the group programme to be covered with deep intensity.

The participants concluded the group programme had allowed them the opportunity to experience the benefit of a 'sense of belonging' and the effectiveness of a support network in achieving their desired change.

Due to time constraints a methodological limitation of this study is that it measured improved intellectual insight during and immediately after participation in the eight series group psycho education programme. It did not study the participant's ability to put their knowledge and intentions into practice after discharge or in the longer term.

It is therefore recommended that further studies be conducted into the short-term and long-term effectiveness of such group psycho education programmes. The research should focus on the effectiveness of the programme to ensure an improved level of affective insight into the individuals' suffering from dual diagnosis after discharge from hospital. Effectiveness should be measured by the sustainability of behavioural changes made by the individuals, the improved prognosis of both their conditions, reduced utilisation of services, and improved quality of life in all areas of occupational performance and daily life. The perceived improvement by their primary, and secondary support systems, and the positive relationships they have developed and maintained would further compliment the measurement of the effectiveness of the programme.

Such a study would further conclude whether the gap that exists between the psychiatric and substance abuse approaches can be bridged by an occupational therapy, group psycho education programme for individuals suffering from dual diagnosis.

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APPENDIX A

PARTICIPANT'S INFORMATION SHEET

Dear Participant

My name is Sarah Lamont, an occupational therapist at Sterkfontein Hospital, who is currently completing her Masters Degree of Occupational Therapy at the University of the Witwatersrand.

The need for psycho education with regards to dual diagnosis has been identified, and thus I have chosen this as my topic for research for my Masters Degree.

My objective of this study is to identify the factors that contribute to the effectiveness of a psycho education programme with individuals that suffer from dual diagnosis. I will thus be running a series of psycho education groups, which the consenting participants will be required to attend and actively participate in. The individuals that consent in participating will be interviewed three times (before, during and after this series of groups) so as to achieve insight into whether the groups have been effective or not. Urine-cannabis tests may also be administered, if the research requires such data for verification of information achieved from the interviews.

The participating individuals will thus be required to give their honest perspectives, both in the groups and the interviews, with regards to their thought, feelings, needs and experiences, so that an accurate evaluation of the effectiveness of the programme can be made. All feedback given by the participating individuals will be considered, and critical feedback will be valued, and will not result in negative consequences to the individual. Honest feedback is important, as data achieved from this research will assist in the establishment of an effective psycho education programme that will be run with individuals suffering from dual diagnosis. As this has been identified as a need, the individuals that are involved will be playing an important role in paving the way to the future for effective treatment with individuals suffering from dual diagnosis.

Individuals that are involved will be assured that all information given will be confidential, and they will remain anonymous throughout this research. The participants of this study will also be given the freedom of withdrawing from the research at any time they may wish to do so. Withdrawal from the research will have no negative consequences to the individual, and they may continue with the group programme without the obligation of continuing with the research.

Your assistance in this research will be greatly appreciated.

I trust that you will consider participating in the programme, and contributing to this research, as you understand the important role that you will be playing in the establishment of effective treatment for individuals suffering from dual diagnosis in the future.

Thank you.

Yours truly,

Sarah Lamont
State Registered Occupational Therapist

APPENDIX B

PARTICIPANT'S CONSENT FORM

I hereby agree that the details of this study have been explained to me, and accept that I wish to participate in it.

I am aware that my participation is voluntary, and that I may withdraw from the study at any such time, may I wish to do so. My withdraw will have no negative consequences, and I may still continue with the group programme after I have withdrawn, without being obligated to continue my participation in the study.

I am aware that the study will require me to participate in interviews, during which I will be giving my perspectives on my experiences. I am aware that this information will be recorded electronically, and hereby give my consent for these sessions to be recorded.

I am aware that the study may require urine – cannabis tests to be administered, and I hereby give my consent for these to be administered.

I am aware that all information given in the group sessions and the interviews will be confidential, and thus I will remain anonymous throughout this programme. My name will not be used in the capturing recordings and publications of this data. I am thus free to give honest feedback, both positive and negative as I am aware that all information given by me, within all sessions within this programme, will be used in establishing a more effective programme. I am aware of my importance in this endeavour.

Sign

Date:

APPENDIX C

QUESTIONS USED IN PHASE 1 INTERVIEWS

THE INITIAL INTERVIEW

1. Do you understand the reason for why you are here today?
2. Tell me about yourself.
3. Tell me about your family.
4. What work do you do?
5. How long have you been working and/not working?
6. Why did you stop working?
7. Why are you in hospital?
8. Do you take medication?
9. Why do you take medication?
10. How has being sick affected you?
11. Do you use drugs?
12. Why do you use drugs?
13. What drug(s) do you use?
14. How long have you been using for?
15. How much did you use?
16. How has drugs affected your life?
17. How often have you been in hospital?
18. Do you think using drugs and being sick are connected?
19. What would you expect from these groups?
20. Is there anything you need from these groups?
21. How often would you want the groups to run?
22. Are you committed to coming to the groups?
23. Do you want to change?

THE SECOND INTERVIEW

1. How have you experienced the groups thus far?
2. Has the content of the groups been helpful?
3. Have the groups met your needs that you told me about in the first interview?
4. What do you think has been most helpful about the groups?

Ask about the factors identified in the literature:

- Group content
- Group techniques
- Group membership
- Group leadership
- Group structure
- Group Context

What stood out for you in the group programme?

5. Do you think you understand your illness better?
6. Do you know more about substances?
7. Do you know more about how to cope?
8. Do you know about what resources are available to you?
9. What do you think should change about the programme?
10. What would you include and what would you exclude?

THE THIRD AND FINAL INTERVIEW

Use the same format as above for the second interview.

APPENDIX D

GROUP PROTOCOLS USED IN PHASE 1 OF THE STUDY

The needs of treatment identified from the initial screening interview of phase 1 of this study were used to establish the following group protocols.

Needs identified

- To define what a drug is and the differences between recreational drugs, and drugs that are prescribed,
- What is the difference between experimentation with substances, substance use, substance abuse, and substance dependence/addiction,
- The process of addiction,
- How have their substances affected them,
- How to cope with stress,
- Triggers for relapse,
- How to cope with these situations that have been identified as triggers,
- How to cope with relapse,
- What resources are out there for them to access,
- Dealing with the guilt,
- Grieving the loss of drugs, and how to replace them.

In all groups a combination of the “laizaire faire” and didactic leadership styles are to be used.

All groups to be held in the group room of the Occupational Therapy Department to ensure, limited external distractions, privacy and containment of the group.

Groups are planned for 90 minutes, with a break of 10 minutes after 45 minutes to be structured if necessary. This is to ensure maximum concentration of all participants.

GROUP PROTOCOLS

GROUP 1

ICE BREAKING

- Setting of norms
- Setting of group needs
- All group members will have an opportunity to share their experiences with substance abuse, and their perspective on how their use of substances has influenced their course of mental illness. The relationship between mental illness and substance abuse should be established.
- Definition of use, abuse and dependency and the process of addiction to be covered by the facilitator

GROUP 2

DUAL DIAGNOSIS DIDACTIC SESSION

- Warm up
Scribble Game
Each member to be asked to make a scribble.
Discuss how scribble has no meaning and makes no sense.
Each member gives scribble to another group member, who then draws something from the scribble.
Discuss how input from others assists us in making sense of a situation.
- Exercise
Divide into two smaller groups to discuss definition of terms (relating to their diagnoses of mental illness and substance abuse) that have been identified by the group members as needing defining.
- Discussion
Coming up with definition of terms that all agree on, and consolidation of the relationship between mental illness and substance abuse.
The facilitator to give a comprehensive overview of how the relationship between the two illnesses impact on each other and negatively affects an individual's prognosis.
Give Handout on Dual Diagnosis

GROUP 3

THE IMPACT OF DUAL DIAGNOSIS ON YOUR LIFE

- Warm up

Scribble Game 2

Each member is asked to make a mark on a page that they feel symbolises them. All papers are passed around simultaneously giving each member an opportunity to make a mark on each other members' page until they receive their original page back.

Discuss how the input from others has affected their original symbol of themselves, and thus how input and feedback from others affects their view of themselves.

- Exercise

Use of Kielhofner's model on how substance use and mental illness has affected lives. ⁽⁹⁾

- Discussion

What aspects of life are affected by substance use and mental illness, and how the two interact with one another?

Allow each individual establish this connection and the negative impact this has had on their lives within all areas of occupational performance.

GROUP 4

TRIGGERS

- Warm up

TV games

Different themes of programmes will be selected from programmes seen on TV e.g. Drama, Action, Comedy.

Each group member is then given a different theme to act out, when the TV control is pressed.

- Exercise

Identification of buttons in themselves that when pushed trigger their substance use and/or result in relapse of mental illness and admission to hospital.

- Discussion

How to identify their triggers, to cope with these and to cope with relapse

GROUP 5

SUPPORT SYSTEMS

- Warm up

Spider web

A ball of wool is used to throw amongst the group members. When throwing, the end of the wool should be held, so that a web can be formed. When group members are throwing the wool, they should identify something that makes them feel supported.

- Exercise

Small groups to identify where support for substance abuse and mental illness can be found within their communities.

- Discussion

Support systems available; primary secondary and facilities available in their communities e.g. NA, AA, CA meetings, Depression, Schizophrenia and Bipolar Support Groups.

GROUP 6

STRESS MANAGEMENT

- Warm up

Group members encouraged to close their eyes, and imagine a situation in which they felt stressed. They will be asked to visualise this situation and become aware of the physical and psychological effects of stress they experienced. They will then be required to take a piece of paper and record the situation and the feelings that they experienced (they can record this through writing or drawing).

Discussion on each member's situation and how he or she experienced their stressful situation.

- Exercise

Group members to discuss and identify situations that are experienced as stressful.

Identify the physical and psychological effects of stress.

Identify coping mechanisms for stress.

- Discussion

Definition of stress and theory of stress provided by facilitator.

Situations that result in stress, and identification of appropriate coping mechanisms. Highlighting that stress was identified as a trigger for relapse and hence the importance of effective stress management

Close group with relaxation exercise.

GROUP 7

ACTIVITIES HEALTH

- Warm up

Tug of war

The group is to play tug of war, initially with teams unbalanced, and then with teams that are evenly balanced.

Discussion on balance, in order for the game to be fair.

- Exercise

Bake a pizza

Divide the pizza into slices that represent the time periods that they are involved in different activities during the 24 hours of an average day.

i.e. draw an activity profile.

- Discussion

Time management, the importance of balance in lifestyle and balance between all occupational performance areas to maintain activities health, and prevent relapse in mental illness and substance abuse. Also important for each individual group member to identify activities that they intend using to replace the time occupied in their use of their substance/s.

GROUP 8

TERMINATION

Art therapy

- Warm up

The group members are encouraged to close their eyes and imagine themselves as a form of transport.

- Exercise

Group members are then encouraged to draw this form of transport, and the road that this vehicle has travelled and is going to travel.

- Discussion

The changes that they have experienced in their level of insight, and how this will affect their plans for the future. Consolidate the identified changes each group member plans on making and how they plan to do this. Discussion around emotions involved in using e.g. guilt and the emotions involved in sobriety and termination of group e.g. grief and loss and dealing with change.

APPENDIX E

GROUP PROTOCOLS USED IN THE MAIN STUDY

The results from phase 1 of this study were used to establish the following group protocols used in the main study. Results of phase 1 resulted in adaptations to the group protocols. These adaptations will be discussed in the specific group protocols below where the changes were made.

Needs identified from the initial interview to be included in the group content of the main study group programme

- To define what a drug is and the differences between recreational drugs, and drugs that are prescribed,
- What is the difference between experimentation with substances, substance use, substance abuse, and substance dependence/addiction,
- The process of addiction,
- How have their substances affected them,
- How to cope with stress,
- Triggers for relapse,
- How to cope with these situations that have been identified as triggers,
- How to cope with relapse,
- What resources are out there for them to access,
- Dealing with the guilt,
- Grieving the loss of drugs, and how to replace them.

In all groups a combination of the “laizaire faire” and didactic leadership styles are to be used.

All groups to be held in the group room of the Occupational Therapy Department to ensure, limited external distractions, privacy and containment of the group.

Groups are planned for 90 minutes, with a break of 10 minutes after 45 minutes to be structured if necessary. This is to ensure maximum concentration of all participants.

GROUP PROTOCOLS

GROUP 1

ICE BREAKING

- Setting of norms
- Setting of group goals
- All group members will have an opportunity to share their experiences with substance abuse, and their perspective on how their use of substances has influenced their course of mental illness. The relationship between mental illness and substance abuse should be established.
- Definition of use, abuse and dependency and the process of addiction to be covered by the facilitator

From the results in phase 1 of this study less time was allocated to the setting of group norms and the group goals, however due to the fact that these were seen as important in establishing the group dynamic and interaction between group members it was important that sufficient time be allocated to this.

More time was given to the sharing of the life stories, as this was suggested in the results of phase 1. This was also necessary, as the number of the group members had now increased from 3 to 5.

From results of phase 1 of this study it was also important to supply the group members with more handouts. Therefore in this group, each participant was given a handout on the differences between use, abuse and dependency, and the process of addiction. ⁽¹⁾

HANDOUT FOR GROUP 1

The definitions and explanations are taken from notes issued in a lecture conducted by SANCA

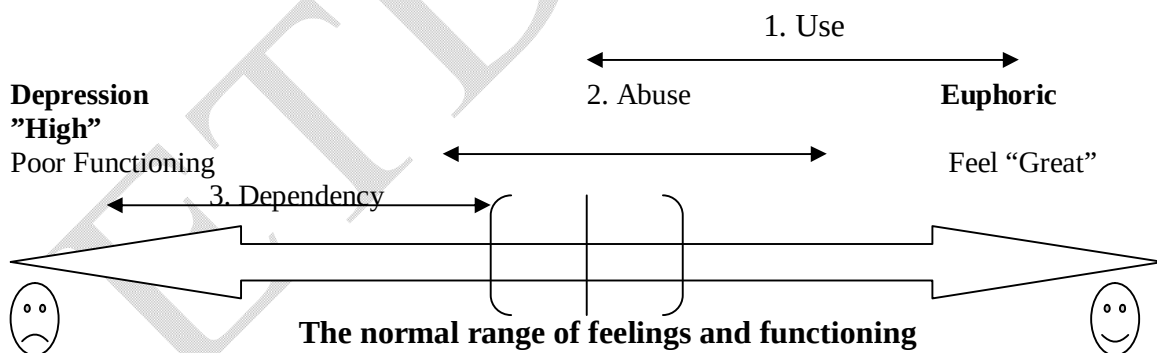
THE DIFFERENCE BETWEEN USE, ABUSE AND DEPENDENCY

Use of substances means I use substances occasionally. My use of substances also has no negative impact on my life; my health, my performance or attendance at work and my relationships with family and friends are not affected by me using. I can still function in life and there are no changes in my level of functioning.

Abuse of substances means my use of substances is starting to have a negative impact on my life. I can start having physical symptoms (pain, energy levels, and physical appearance) and/or my thoughts and feelings are changing. My performance and/or attendance at work has changed and/or my relationships have changed. I may be fighting more with my family and/or friends, and who I socialise with has changed. I may be going out a lot more or I'm not socialising at all and am always alone. My functioning level is dropping.

Dependency is when I am using my substance of choice just to feel normal. If I don't use my substance I can't cope with life and my physical symptoms or the changes in my thoughts and feelings are so bad that I have to use just to feel like I can get through the day and I need to use more and more of my drug to get the same feeling of normal. "I use to live and I live to use" and I can only function if I have taken my drug of choice.

THE PROCESS OF ADDICTION



1. The first time I use substances the "high" is huge, I feel great and get the "euphoric high" and when I come down I can still function normally. **(Use)**
2. I continue using because I want that "high" again but I realise I can't reach that "high" any more. I use more and more to try and get that "high", and when I come down I can still function but it's getting more difficult to cope with life and I'm starting to feel more and more depressed. **(Abuse)**
3. I have been using for so long and/or so much I have to use my drug just to feel and function normally. **(Dependency)**

GROUP 2

DUAL DIAGNOSIS INFORMATION SESSION – DIDACTIC SESSION

- Warm up

The Scribble Game

Each member to be asked to make a scribble.

Discuss how scribble has no meaning and makes no sense.

Each member gives scribble to another group member, who then draws something from the scribble.

Discuss how input from others assists us in making sense of a situation.

- Exercise

Divide into two smaller groups to discuss definition of terms (relating to their diagnoses of mental illness and substance abuse) that have been identified by the group members as needing defining.

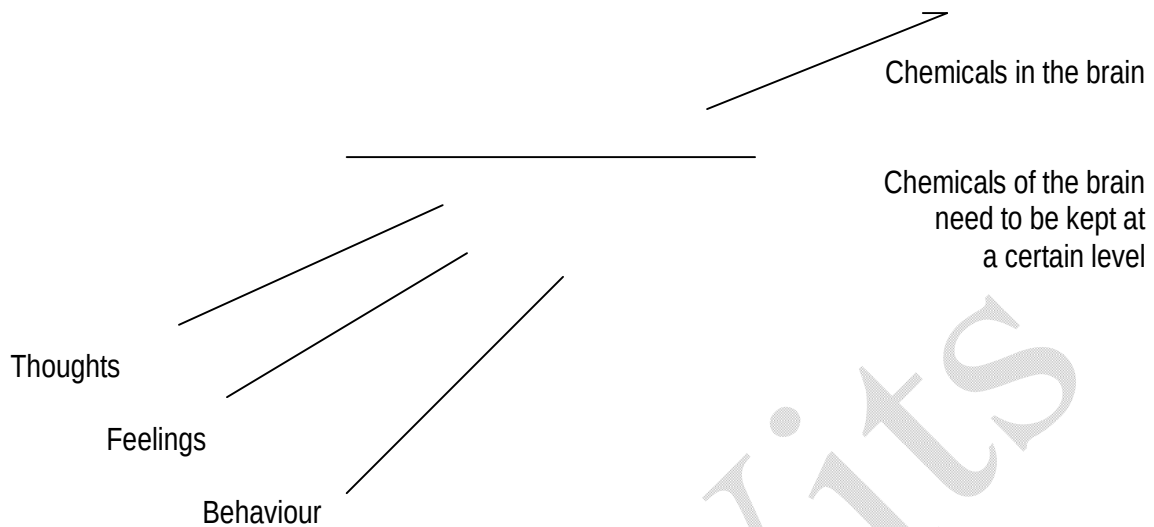
- Discussion

Coming up with definition of terms that all agree on, and consolidation of the relationship between mental illness and substance abuse. The facilitator to give a comprehensive overview of how the relationship between the two illnesses impact on each other and negatively affects an individual's prognosis. This to be achieved by listing the symptoms of both illnesses so that the similarities can be drawn and the relationship between the two illnesses recognised.

From the results of phase 1 of this study more time was allocated to the didactic lecture as all participants had found this useful. The information was also consolidated to include the steps to the management of mental illness, which includes the abstinence of intoxication, thus again addressing the relationship between mental illness and substance abuse. A summary of this information was given to each participant.

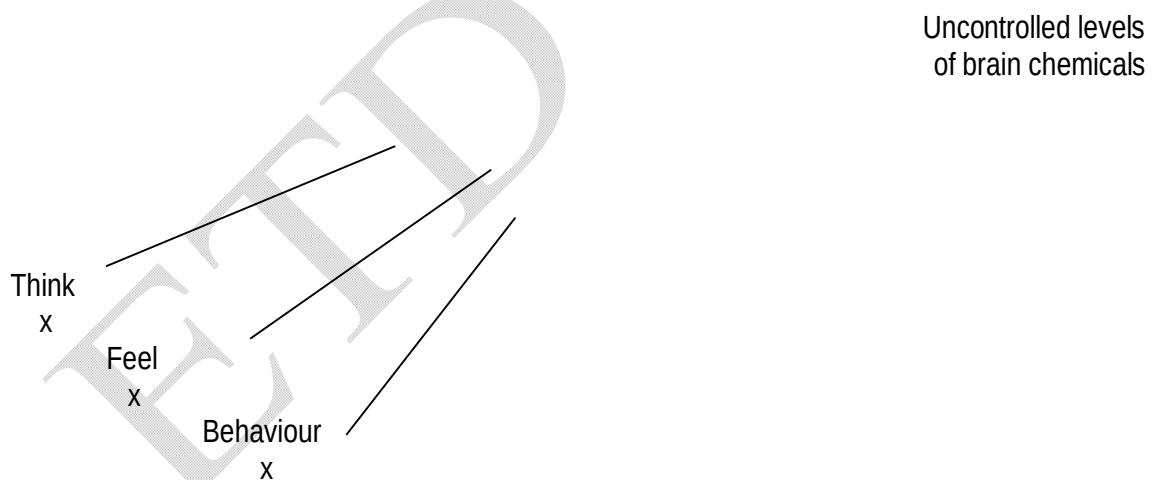
HANDOUT FOR GROUP 2

Mental Illness



Function of the brain: In order for the brain to carry out its functions – namely to allow the person to behave, think and feel appropriately, the brain's chemicals have to be at the right level.

Medication



Mental illness is a disease of the brain:

- Mental illness is an illness of the brain that results in the inability of the brain to maintain the right level of the neurochemicals – or brain chemicals.
- When the chemicals are not at the right level, the person can't think, feel and behave appropriately. That is how we know that somebody is mentally ill. A diagnosis cannot be made unless the person themselves and/or friends and family report a change in thought, feelings and behaviour.
- That is why medication is taken to control the brain's chemicals and return them to the right level.

- Like with diabetes and heart disease, the person needs to keep taking their medication to keep the chemicals at the right level. The medication makes the person better and as long as they stay on their medication, it keeps them better. Nobody would tell a person with diabetes or heart disease to stop taking their pills because they would get sick; it is the same with mental illness.
- The brain needs the medication to keep the chemicals at the right level and to keep the patient thinking, feeling and behaving appropriately.

Steps to stay well:

1. Take your medication

Medication keeps your brain chemicals at the right level and therefore helps you think, feel and behave appropriately; and therefore, out of hospital. Maintenance of medication is crucial to staying well. One must not question medication, nor stop their medication without discussing this with their doctor. If side effects are experienced or any dissatisfaction with medication is endured one must discuss this openly and honestly with the doctor so that the appropriate changes can be made.

2. Follow up with the doctor

Follow up with the doctor is important. This way the doctor can see if the medication is still working, needs to be changed, increased or decreased. If the medication is causing problems you must tell the doctor so that he can change it. If you don't like your medication that can lead you to stop taking it and then you will get sick again. You must only stop taking your medication if and when the doctor says you can. You must understand that you will be taking your medication for a very long time; maybe forever. By going to the doctor he/she can check your medication, because if you start to get sick again, he/she can make changes soon enough before you get too sick and have to come back to hospital. It's your decision, but you must remember if you choose not to take your medication, you are choosing to get sick and come back to hospital so then you can't complain when you are here.

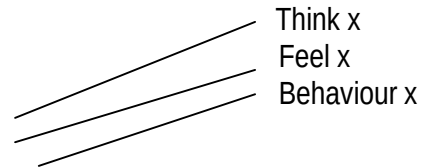
Follow up with a therapist may also be important for support and reducing stress. Remember high levels of stress can cause a relapse and therefore one should consult a therapist to assist with stress management.

3. Don't take drugs or alcohol

Intoxication and withdrawal from drugs or alcohol mimics mental illness. Drugs and alcohol act on the brain chemicals. It changes the levels of the brain chemicals and that's why when you are drunk or high, you think, feel and act differently.

When somebody has mental illness, it is dangerous to play with the levels of the brain chemicals because mental illness is caused by not being able to control these levels. So if you take drugs or alcohol, and the levels of your brain chemicals change, your brain might not be able to make the levels go back to the right level. You can then get sick and have to come back to hospital. Your friends who take drugs and who don't have mental illness don't get sick and that's why they don't have to come to hospital. If you have mental illness, and you still take drugs and alcohol, you are choosing to get sick and to come back to hospital. It's your choice! Just like with medication!

Drugs/Alcohol



If you have mental illness drugs and alcohol can cause a relapse.

4. Healthy, balanced life that makes YOU happy!

Everyone in the world, people with illnesses and those without illnesses, all deserve to live lives that keep them happy, stimulated and satisfied. Everybody's life can be completely stress free, but everyone gets sick if the levels of stress get too much. Because you have a mental illness, if you get too stressed it can cause you to get sick and have a relapse, even if you are taking your medication.

So we have to make our lives as comfortable as we can so that we keep our stress levels at a minimum, or as long as you can control them, so to prevent you from getting sick.

So you must control what you can control and that's our own time and how we choose to use it.

We can't control other people, and people cause stress in our lives, but we can control what we do and who we do it with, so as to make our time/lives happy.

There are 4 areas of live we all need to make time for:

1. Sleep

2. Taking care of ourselves (personal management)

- i. Eating
- ii. Bathing
- iii. Dressing, etc.

3. Work

The activities that we do that make us feel important and that we have to take responsibility for. This is not always a job that we earn money for, but any tasks or activities we are responsible for.

4. Relaxing/FUN

We have to do things to relax and enjoy ourselves.

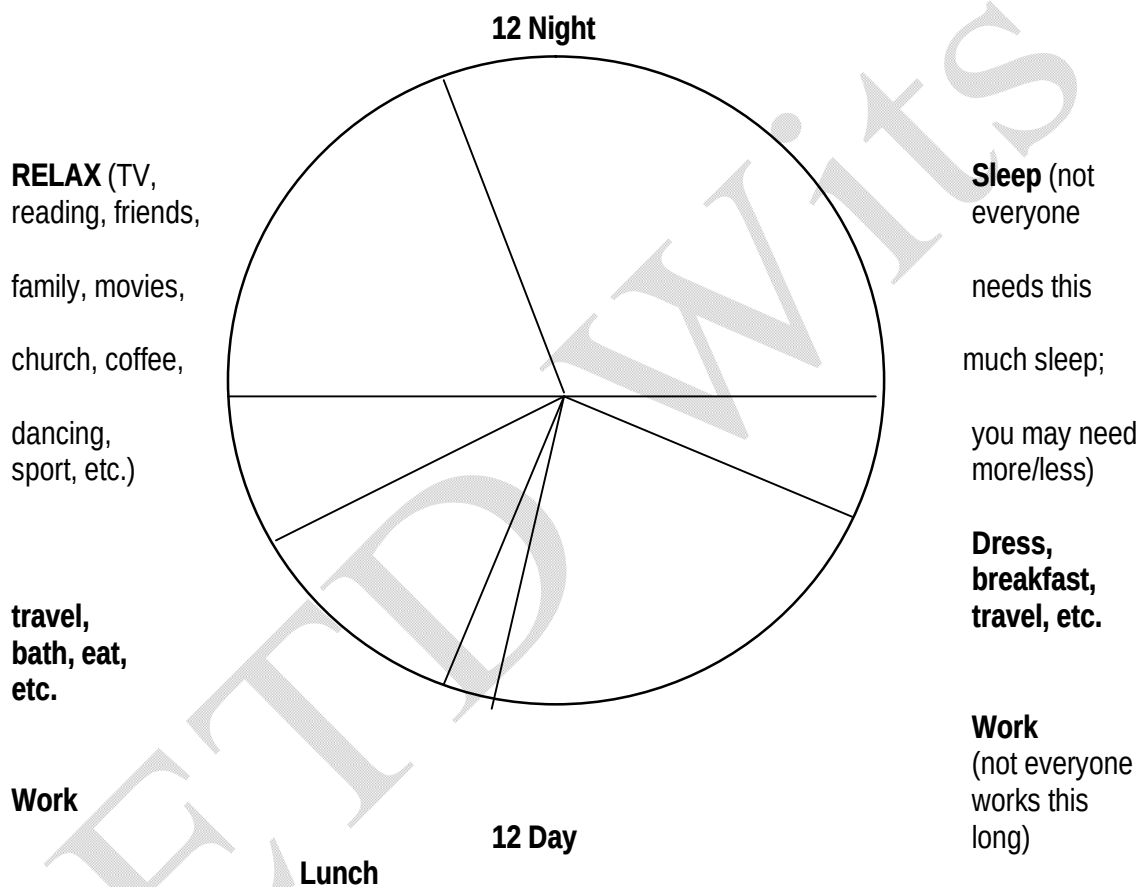
These are things that we do that make us happy – TV, radio, friends, sport, music, church, etc.

Not spending any time relaxing and having fun is as stressful as working too hard.

You need to decide on things that make you happy, you enjoy and you are interested in that keeps you socializing; because nobody likes to be alone all of the time and that involves some physical activity and getting out of the house because everyone needs time to keep you healthy. It is also important to create a balance between social and me-

time. One cannot spend all your time with other people as you then neglect yourself, your needs and feelings and the relationship you have with yourself.
 You need to take time and plan how you are going to spend it. It will be different for everyone because everyone is different. This is your time, so make it your way, arrange it so you are happy and make sure there are changes from day to day; because variety is the spice of life and keeps us from getting bored.

This is just an example and is NOT the answer for everyone:



GOOD LUCK AND STAY HAPPY AND HEALTHY!

Written by: Sarah Lamont

GROUP 3

THE IMPACT OF DUAL DIAGNOSIS ON YOUR LIFE

- Warm up

Scribble Game 2

Each member is asked to make a mark on a page that they feel symbolises them. All papers are passed around simultaneously giving each member an opportunity to make a mark on each other members page until they receive their original page back.

Discuss how the input from others has affected their original symbol of themselves, and thus how input and feedback from others affects their view of themselves.

- Exercise

Use of Kielhofner's model on how substance use and mental illness has affected lives. ⁽⁹⁾

- Discussion

What aspects of life are affected by substance use and mental illness, and how the two interact with one another?

Allow each individual establish this connection and the negative impact this has had on their lives within all areas of occupational performance.

From the results of phase 1 of this study this exercise was completed on a template supplied to each participant so that they could take it with them. This template was a summarised version of Kielhofner's Model to include all the necessary areas of life impacted on by dual diagnosis.

HANDOUT FOR GROUP 3

TEMPLATE OF KIELHOFNER'S MODEL

Tick all the things in the boxes below that you think have changed since you started using drugs, or since you got sick. Draw lines between the things you think are connected. Then write down how you think these have changed.

<u>My Personal Life</u> School: Work: Family: Friends:	<u>My Health</u> Physical: Mental:
<u>My Environment</u> At Home: At Work: Social Life and Relationships:	Do I have control of my life? Yes/No Why?: What is important to me: My Interests:
What I do in my life: The roles I have in life: Am I/ can I do this in the future?	How I live my life: My habits and what I do all day:
My Thoughts: Do I hear voices/see things that are not there? My Feelings: How I feel about me: Good / Bad My Energy levels: How I behave when I am with people: How I talk to people: How I cope with stress:	Do I look after myself? -Bath -Physical Appearance -Money How do I cope at work? What do I do for fun? Who do I socialise with?

GROUP 4

TRIGGERS

- Warm up

TV games

Different themes of programmes will be selected from programmes seen on TV e.g. Drama, Action, Comedy.

Each group member is then given a different theme to act out, when the TV control is pressed.

- Exercise

Identification of buttons in themselves that when pushed trigger their substance use and/or result in relapse of mental illness and admission to hospital.

- Discussion

How to identify their triggers, to cope with these and to cope with relapse

A handout was given to each participant at the beginning of this session to allow them to record the information from the group discussion that they identified with and was relevant to their specific needs. This also allowed the researcher to assess whether each participant was following the group discussion, was applying the information to themselves, and facilitated confrontation of group members.

HANDOUT FOR GROUP 4

My TRIGGERS AND HOW I CAN COPE WITH THESE

<u>MY TRIGGERS</u>	<u>WHAT CAN I DO TO COPE</u>

GROUP 5

SUPPORT SYSTEMS

- Warm up

Spider web

A ball of wool is used to throw amongst the group members. When throwing, the end of the wool should be held, so that a web can be formed. When group members are throwing the wool, they should identify something that makes them feel supported.

- Exercise

Small groups to identify where support for substance abuse and mental illness can be found within their communities.

- Discussion

Support systems available; primary secondary and facilities available in their communities e.g. NA, AA, CA meetings. A Handout was given to each participant so that they can record the information they feel is relevant to them. A Handout with all the details of NA and AA groups were given to each member.

HANDOUT FOR GROUP 5

RESOURCES AVAILABLE TO ME

From the group discussion, write down all the ideas and options that you think you can use in your community when you go home.

See also the list of AA and NA meetings that are attached.

Clinics and Hospitals:

Support Groups:

Sport:

Creative Groups:

Hobbies:

Other Interests: (e.g. Walk-for-Life, Debating Groups)

GROUP 6

STRESS MANAGEMENT

- Warm up

Group members encouraged to close their eyes, and imagine a situation in which they felt stressed. They will be asked to visualise this situation and become aware of the physical and psychological effects of stress they experienced.

They will then be required to take a piece of paper and record the situation and the feelings that they experienced (they can record this through writing or drawing).

Discussion on each member's situation and how he or she experienced their stressful situation.

- Exercise

Divide into small groups and identify situations that are experienced as stressful. Identify the physical and psychological effects of stress.

Identify coping mechanisms for stress.

- Discussion

Definition of stress and theory of stress provided by facilitator.

Situations that result in stress, and identification of appropriate coping mechanisms. Highlighting that stress was identified as a trigger for relapse and hence the importance of effective stress management

Close group with relaxation exercise.

A handout was given to each participant that allowed them to record their “red flag” stress symptoms and the appropriate coping strategies. This information was achieved from the discussion and again assisted the researcher to monitor the performance of each participant.

HANDOUT FOR GROUP 6

STRESS MANAGEMENT

<u>MY “RED FLAG” SYMPTOMS</u>	<u>WHAT I CAN DO TO COPE</u>

GROUP 7

ACTIVITIES HEALTH

- Warm up

Tug of war

The group is to play tug of war, initially with teams unbalanced, and then with teams that are evenly balanced.

Discussion on balance, in order for the game to be fair.

- Exercise

Cutting of a pizza

Divide the pizza into slices that represent the time periods that they are involved in different activities during the 24 hours of an average day.

I.e. draw an activity profile.

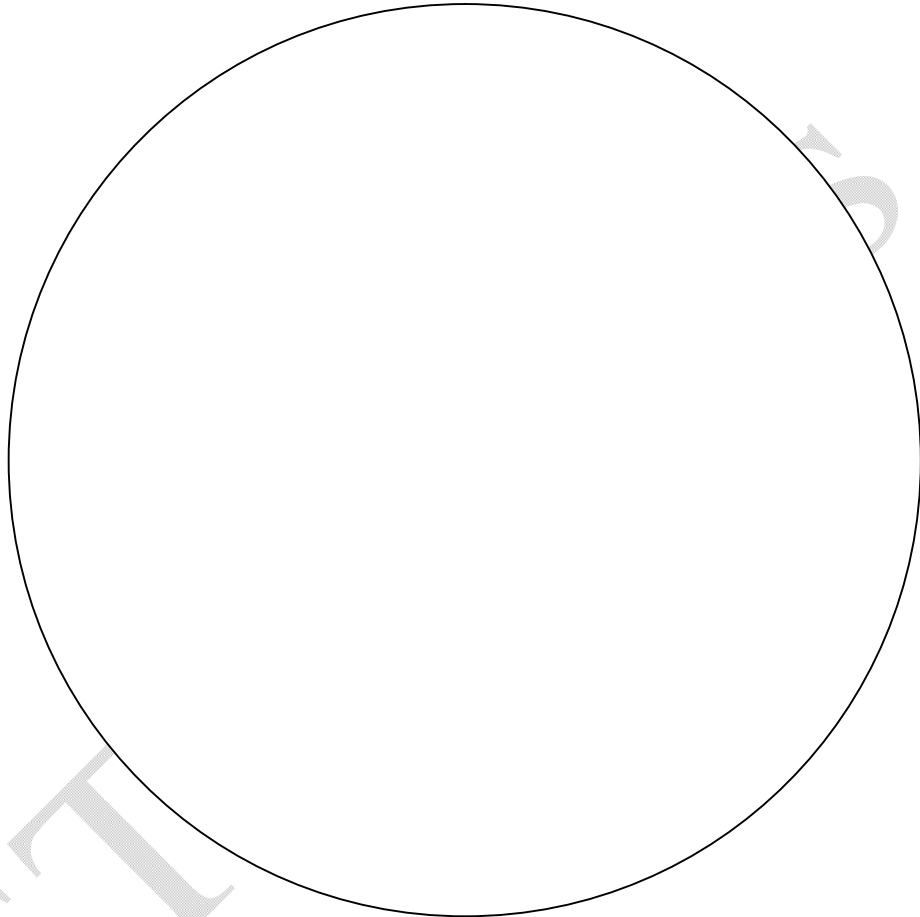
- Discussion

Time management, the importance of balance in lifestyle and balance between all occupational performance areas to maintain activities health, and prevent relapse in mental illness and substance abuse. Also important for each individual group member to identify activities that they intend using to replace the time occupied in their use of their substance/s and to construct their own activity profile.

This group was adapted from phase 1 of this study. Too much time was involved in the baking of the pizza. Therefore in the main study an already prepared pizza was used to slice to depict how time needs to be divided. The toppings of the pizza were used to depict the different areas of daily living that need to be included in their daily plan so as to make their lives interesting and “delicious”. I.e. To combat stress and prevent feelings of being overwhelmed and of boredom.

HANDOUT FOR GROUP 7

MY DAILY PLAN



MY SPECIFIC ACTIVITIES FOR:

WORK

PERSONAL MANAGEMENT

FUN

GROUP 8

TERMINATION

Art therapy

- Warm up

The group members are encouraged to close their eyes and imagine themselves as a form of transport.

- Exercise

Group members are then encouraged to draw this form of transport, and the road that this vehicle has travelled and is going to travel.

- Discussion

The changes that they have experienced in their level of insight, and how this will affect their plans for the future. Consolidate the identified changes each group member plans on making and how they plan to do this. Discussion around emotions involved in using e.g. guilt and the emotions involved in sobriety and termination of group e.g. grief and loss and dealing with change.

A handout to record the summary of their identified changes and the “how to” factor was given to each participant.

HANDOUT FOR GROUP 8

THE CHANGES I WANT TO MAKE

<u>CHANGES I WANT TO MAKE</u>	<u>HOW CAN I DO THIS</u>

APPENDIX F

FORMAT FOR INTERVIEWS USED IN THE MAIN STUDY

The interviews will be semi-structured and the interviewer will use the principles recommended by Seidman, in each interview. ⁽⁷³⁾

- Contextualise the individual's insight into their current condition. As Seidman explains, the interviewer should avoid asking direct questions such as "When did you start using drugs? Or why they started drugging? The interviewer should rather provide the participant the opportunity to place their condition within the context of their life story by the process of reconstructing their past. The researcher asking the participant to explain why they feel that they are here will achieve this, thus using the technique of narrative or storytelling.
- Details of experience. This part of the interview will focus on the details of the participant's present experience, i.e. the experience of his/her psychiatric illness and their drug career, and the issues they are facing in the absence of a programme that addresses these issues simultaneously. The researcher asking the participant to describe the difficulties that they experience as a result of their illness will achieve this.
- Reflection on the meaning. Individuals will be given the opportunity to reflect on the meaning of their experiences. Seidman describes it as a meaning making process that provides the context for the participant to understand his/her experiences. The researcher asking the participant to describe how these experiences affect him, and make him feel, will achieve this. ⁽⁷³⁾

The process of semi structured interviewing will be divided into four phases. ⁽⁷³⁾

Preparing for the interview

- Becoming acquainted: The initial relationship
- Establishing a contractual relationship
- Establishing a relationship of trust
- Terminating the unstructured interview(s)

These four phases will be considered by the researcher when preparing for each interview. She will be aware of what information should be gained from each interview.

In-depth interviewing prescribes that the interview should be spontaneous; however the topics of discussion can be planned for each interview but not exactly determined. ⁽⁷³⁾ The researcher should thus be aware of the information that she requires, and react spontaneously when information is received, so as to further explore these topics, and gain further insight through the participant's experiences.

Development of the phases

The researcher should at all times be aware of the comfort of the interviewee, and introduce herself to the subject. The researcher will begin each interview by asking the participant how he / she feels that day, and address any issues of discomfort or anxiety before the interview begins. This is to allow for an initial relationship to develop. The purpose of the interview will be explained to the interviewee, to allow for the contractual relationship to develop, and anonymity will be ensured so as to allow the participant to develop a sense of trust. The initial relationship, and the attention paid to the participant's initial feelings of discomfort will further ensure the development of a relationship of trust.

The interview will be terminated once the researcher is satisfied that all required information is recorded. The researcher will end each interview by thanking the participant for their participation, and will ask them if there are any questions that they may have, before they depart.

Duration of each interview is approximately 45 minutes.

Preparation for Interview 1

- *The researcher will **introduce herself** to the subject*

Good morning, my name is Sarah.

Thank you for coming.

Please sit down where you feel comfortable.

How are you feeling this morning?

Is there anything that you need before we begin?

- *The individual should be **introduced to the programme**, and details given to ensure their understanding that participation is voluntary, and that they are free to withdraw at any such time, may they wish to do so. Give them letter of Information (Appendix A)*

Do you know why you are here this morning?

Do you know what this is all about?

I am conducting a study into the factors that contribute to the effectiveness of groups for people who suffer from mental illness and substance abuse disorders. This is a personal interest of mine, as I feel it is necessary to establish a programme that addresses both these issues simultaneously. It is important for me to stress that your participation in this study is voluntary, so you do not have to take part if you do not want to. This study will be completed over a period of four weeks, where you will be attending groups, and I will be asking you questions, in two other interviews, to help me discover what it is that you find useful and what you feel is helping meet your needs. If at any time during this period you feel uncomfortable and do not wish to continue, you are free to withdraw. There will be no negative consequences as a result of your withdrawal, and you will be allowed to complete the group programme, without having to participate in the study.

Here is a letter describing everything I have just said. Read it to be sure you understand.

Do you think that you will be comfortable with participating in this study?

Would you like to take part?

- *The **consent form** (Appendix B) should be signed*

Thank you for agreeing to help me in this study. I need you to complete this consent form, so that others are aware that you have agreed to participate. I am sorry if this makes you uncomfortable, but it is necessary so that others are aware that you know the circumstances of this study, and that I have not forced you into participating. Please read the consent form before signing, and you may withdraw if this makes you too uncomfortable.

- **How they might benefit**

The individual's understanding of why they feel they should be involved in this programme should be explored.

Do you know why you should participate in this programme?

Do you think you could benefit from participating in this programme?

- *The individual's level of insight into their condition should be established*

Why do you think the team decided that you might wish to take part in this programme?

And what do you think?

Do you agree with the team's decision?

- *The individual's **life story** and background history should be taken*

Tell me how this all began

And your family, where are they?

How has this affected you life?

How has this affected your work?

- *The **individual's needs** from the programme should then be established*

If you are going to take part in these groups, what would you want to gain out of them?

What needs do you hope to achieve through these groups?

- *The individual's **level of motivation** to attend the programme and their motivation for change should then be established.*

Do you think that these groups will help you?

If these groups are aimed at helping you with what we have discussed today, how do you feel about the programme?

How often a week do you feel these groups should be run?

Preparation for Interview 2

The second interview will be conducted at the end of the second week of study, in the middle of the group process by an external interviewer.

- *The external interviewer will **welcome** the interviewee and make them feel comfortable*

Good morning.

How are you feeling this morning?

Please sit down where you feel comfortable.

Well thank you for coming this morning and agreeing to continue with this study.

Using the principles recommended by Seidman.⁽⁷¹⁾ If you are comfortable, can we begin? Is there anything that you need before we begin?

- *The individual should be **encouraged to give honest feedback**, and be made aware of the importance and value of their honest and accurate perspective.*

Before we begin I would like to remind you of the importance of your honesty in the feedback. The success of this study strongly relies on the accurate account of your experiences and feelings, and only you can give that. I thus need you to be entirely honest about what you are thinking, feeling and your experiences, even if they are negative. Remember no negative consequences will result if the feedback that you give is critical and negative. In fact both positive and negative feedback will be helpful.

- *Their **feelings and experiences** about the groups they have attended thus far should be established.*

How have you found the groups so far?

How have you found the other group members?

How have you found the content of the group discussions?

Which techniques have you enjoyed thus far?

How have you found the leadership style of the group facilitator?

How have you found the structure of the group?

Do you feel that the group is large enough to gain adequate insight from others?

Do you feel that the context in which the group is held is conducive to the content of the group?

- *It should be established whether they feel their **needs** and experiences have been considered. Do they feel that your needs are being **successfully met thus far**?*

How is the group meeting your needs that you expressed in the first interview?

How they have benefited thus far?

- *What they have found beneficial should be noted*

What have you found useful in the group?

What about the other the group members have you found helpful?

How has the content of the group discussions assisted you in meeting your needs?

How has the group facilitator helped you?

What in the structure and context of the group has been of benefit to you?

- *Necessary **changes in the group process** should be identified*

Is there anything that you would like to change in the group?

Is there anything about the group facilitator, or how the group is run that you would change?

Is there anything about the context of the group that you would wish to change?

Which techniques do you feel should not be repeated?

What have you found irrelevant or unhelpful in the group?

Is there anything that you have experienced that has made you feel uncomfortable?

- *The **changes in the participant's level of insight** should be established*

If you can think back to the first interview, can you see any changes in how you feel about the relationship between substance abuse and mental illness?

Do you think that substance abuse has affected your mental illness?

Do you feel that use of substances in the future will influence your course of mental illness?

How can you prevent yourself from being readmitted to hospital?

- *Have their **needs changed**, or have they identified **new needs** since commencement of this programme.*

When we look at the needs that you expressed in the first interview, are there any that you would wish to change or add, or even delete?

Can we just recap whether there are any needs that you feel have been completely achieved thus far?

Are there any needs that you feel have not been considered or touched on thus far?

Are there any needs that you feel will not be met by the group before this programme is completed?

This any significant feedback to be given to the researcher so as to allow any necessary changes to be made to the programme, and for this significant feedback to be used within the following groups to ensure the meeting of the participants expressed needs.

Significant feedback would include anything that you feel would benefit the participants in the programme. Feedback must be given in overall, general terms and at no time should personal or any identifying information be given to the researcher as this may compromise confidentiality of the participants.

Preparation for Interview 3

This interview should be conducted by the external interviewer once the group programme has terminated, after a period of four weeks.

- *The external interviewer will **welcome** the interviewee and make them feel comfortable*

Good morning.

How are you feeling this morning?

Please sit down where you feel comfortable.

Well thank you for coming this morning and agreeing to continue with this study. Is there anything that you need before we begin? If you are comfortable, can we begin?

- *The individual should be **encouraged to give honest feedback**, and be made aware of the importance and value of their honest and accurate perspective to the aims of this programme.*

Before we begin I would like to remind you of the importance of your honesty in the feedback. The success of this study strongly relies on an accurate account of your experiences and feelings, and you can only give that. I thus need you to be entirely honest about what you are thinking, feeling and your experiences, even if they are negative. Remember no negative consequences will result if the feedback that you give is critical and negative. In fact both positive and negative feedback will be helpful.

- *The **changes in the participant's level of insight** should be established*

If you can think back to the first two interviews, can you see any changes in how you feel about the relationship between substance abuse and mental illness?

Do you think that substance abuse has affected your mental illness?

Do you feel that use of substances in the future will influence your course of mental illness?

How can you prevent yourself from being readmitted to hospital?

Do you feel that you will use substances again?

If so, what substances do you feel are safe to use?

How can you prevent relapse?

What resources are available to you in your community to support you?

What resources do you think you will use?

- *Their perspectives on their **experiences** should be established.*
- How did you find the group programme?
- Tell me how do you feel now that the group is over?
- Tell me how you experienced the programme?
- *Their perspective of whether their **needs have been met** should be established.*
- How did the group meet your needs that you expressed in our first two interviews?
- **What they have found beneficial**
- *What they found helpful should be highlighted.*
- What did you find helpful in the groups?
- *Whether they feel this programme was useful, and should be repeated, should be established*
- *How should this programme be prioritised in the treatment that you have received whilst in hospital?*
- So you feel that this programme should be repeated for other patients?
- If so, do you feel it necessary for you to attend the groups again?
- So would you recommend a person to attend these groups?
- Who would you recommend to attend these groups?
- *What did they enjoy in the group? What techniques they found helpful should be noted.*
- What was the highlight of the programme for you?
- What activities do you feel best assisted you in meeting your need?
- *What they didn't enjoy, and **didn't find useful**, should be highlighted.*
- What do you feel could have been different?
- What was uncomfortable for you or was not of any benefit for you?
- Can you suggest how this could be changed in group to be run in the future?
- **What was different (positive or negative) about this programme from other programmes that they may have attended? How is the group meeting your needs that you expressed in our first interview?**

How did this differ from other programmes that you have attended?

Was it more beneficial?

Why?

What was missing from these groups that you have experienced in other programmes?

The data will then be analysed and used to assist in establishing a programme that will further attempt to meet the needs of individuals suffering from dual diagnosis, establish the factors that were perceived as effective in the group programme and will attempt to establish a programme effective in bridging the gap between the treatment of mental illness and substance use disorders.

APPENDIX G

ETHICAL CLEARANCE CERTIFICATE

ETD Wits

APPENDIX H

LETTER OF PERMISSION TO CONDUCT RESEARCH FROM STERKFORTEIN HOSPITAL

ETD Wits

ETD Wits

ETD Wits