Tallaght Drugs Task Force

SEMINAR PROCEEDINGS

WORKING WITH DUAL DIAGNOSIS CLIENTS

OCT 20th 2010, MALDRON HOTEL, TALLAGHT

Organised by Gráinne O'Kane, Tallaght Local Drugs Force

Funded by Tallaght Local Drugs Force

Rapporteur: Fran Giaquinto BSc PhD

AGENDA FOR THE SEMINAR

9.00-9.30 Registration

9.30- 10.00 Opening Address
Richard Lakeman, Dublin City University

10.00-10.20 Martin Rogan
Assistant National Director, Mental Health

10.20-11.00 Dr. Bobby Smyth
Consultant Psychiatrist, Tallaght Addiction Services

11.00-11.15 Break

11.15-11.55 Dr. Peter Whitty
Consultant Psychiatrist, Tallaght Adult Mental Health Services

11.55 -12.3 5 Community Outreach Work, Tallaght
Des Caprani HSE Outreach
Lisa Glassett, Probation Services
Simon Monds, Tallaght Housing Advice Unit

12.35 – 1.00 Plenary
Closing Remarks with Richard Lakeman

CONTENTS

Certificate of Continuing Medical Education Accreditation

The seminar received Continuing Medical Education Accreditation from the Irish College of General Practitioners.

Applicant: Gráinne O Kane,
Tallaght Drugs Task Force, Dodder Valley Partnership, Killinarden Enterprise Centre, Tallaght, D 24

Dear Grainne,

I wish to confirm that the ICGP has approved your application for CME Accreditation in respect of your seminar as detailed below:

Date	Venue	Title	Date Approved /Confirmed	CME Sessions Approved	CPD Credits Approved	ICGP Reference
20th October 2010	The Maldron Hotel, Tallaght, Dublin	Working with Clients with Dual Diagnosis Seminar	02/12/2010	1	3	2300

Kind regards,

Carol.

For the purposes of meeting/course material/advertisements, etc. only the following wording is permitted 'CME Accredited'.

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1. INTRODUCTION TO THE SEMINAR

This report documents the findings of a seminar held at the Maldron Hotel in Tallaght in October 2010 which brought together experts in the fields of mental health and substance misuse to share learning in the field of dual diagnosis. It was attended by representatives from the HSE, including Tallaght Hospital and HSE mental health and addiction services, community drug services, other community services, housing organisations, South Dublin City County Council, rehabilitation services, probation services and service users.

The seminar was funded by Tallaght Drugs Task Force which has been instrumental in setting up the Dual Diagnosis Network (DDN) which was set up in 2008 in response to the needs of services users who present with combined substance misuse and mental health issues.

1.1 Aims of seminar proceedings

The seminar proceedings aim to:

- Provide an accurate and concise record of the main themes of the conference
- Create a dialogue on co-occurring disorders for shared clients
- Promote networking

1.2 Participants

140 participants attended the seminar. Participants were seated at 12 tables and a facilitator and note taker was appointed for each table. At the end of each presentation, the speaker presented one or two key questions to the participants who were given a few minutes to prepare a response. Because of time constraints, it was not possible to share responses in detail; however, all responses were received in writing and they are presented in these proceedings. A rapporteur was appointed to record the presentations and discussion during the seminar.

1.3 Introduction from Anna Lee, Chairperson Dodder Valley Partnership

Anna Lee opened the seminar by explaining that the Dual Diagnosis Network (DDN) was set up in 2008 in response to the needs of services users with addiction and mental health issues. Tallaght Drugs Task Force (TDTF) has resourced and supported the DDN, initially by providing training from the Central Mental Health Hospital. Since then, practitioners working with clients with dual diagnosis have met as members of the network with the aim to add value to their collective and individual work.

The key objective of the network is the promotion of good practice and interagency collaboration to support people with dual diagnosis. The network focuses on creating awareness of the issues through seminars and workshops, establishing care pathways through collaborative partnerships and exploring protocols which promote information exchange and shared care between services.

Anna Lee highlighted the objectives of the seminar, as follows:

- Create dialogue between practitioners to build effective working relationships
- Share learning about the challenges of working with dual diagnosis
- Identify gaps and recognise opportunities to improve service provision

She welcomed the speakers and audience and emphasised that the knowledge, experience and skill of all participants were most welcome. She concluded by saying that DDN hoped the seminar would:

- Provide information on protocols and services in both mental health and addiction services in Tallaght
- Assist in the understanding of the profile of clients with severe mental health and addiction issues
- Create a picture of the needs and challenges of dual diagnosis clients and provide a forum for services to network and collaborate

2 HIGHLIGHTS OF PRESENTATIONS

Dr Richard Lakeman, opening address

- Dual diagnosis clients are likely to present to services with multiple difficulties and, in general, they have poorer treatment outcomes
- We know there is a link between substance misuse and mental health but we do not know exactly how
- The most effective approach to treating dual diagnosis is integrated service provision: it is possible to provide concurrent treatment of both
- For this to be achieved, it is necessary to have:
  - Co-operation between mental health and substance misuse services
  - A harm reduction model
  - Engagement and retention in treatment
  - Interventions matched to clients' stages of change
  - Continuing staff education and support
  - Services with expertise in one area and competence in the other
- Strategies for inter-agency co-ordination for dual diagnosis that can be readily implemented

Professor Martin Rogan

- Mental health is a dynamic process
- There are currently 200,000 people in Ireland suffering from depression. Is alcohol and drug misuse DIY psychiatry?
- 67% of the prison population in Ireland have experienced psychosis
- The head shop phenomenon reflects the extent to which people want respite from not being happy.
- The number of hospital beds for mental health disorders in Ireland has gone from 22,000 to 650
- The *Vision for Change*'s commitment to specialist teams is unrealistic
- We need all teams to bring their capacity together; in other words, the issues of dual diagnosis, mental health and addiction have to be tackled together.

Dr Bobby Smyth

- Cannabis use in adolescence can cause mental health issues in later life. The risk is definitely increased but it is not inevitable.
- Drugs sold in head shops have a particular propensity to cause mental health problems
- The implications for people with dual diagnosis are severe, including increased risk of homelessness, suicide, HIV, violence; more complex intervention strategies, and increased cost and use of services
- People with needs in both substance misuse and mental health domains should be actively treated for both at the same time
- This requires shared understanding, integration, shared care plans & joint working
- Addiction services have reasonable but geographically variable capacities to manage mental health problems
- Patient outcomes will improve with integrated services and resources will be saved

Dr Peter Whitty

- Tallaght Mental Health service has a homecare team, acute day hospital, day centre, OPD Mary Mercer Centre & an in-patient unit. It has 23.5 staff.
- The predominant mental health issues are schizophrenia (34%) and depression (29%)
- Most patients who initially present with psychosis will move into major mental illness within 4 years (eg schizophrenia). It is essential they are tracked.
- Mental Health services face many challenges:
  - Scarce resources
  - Tracking patients with dual diagnosis
  - Substance misuse in in-patient units
  - Replication of medication by different services
  - Lack of capacity to address substance misuse
  - Limited capacity to identify the symptoms of internet/head shop drugs
  - Limited capacity for preventative work
- Mental health services want to improve their relationship with addiction services through effective communication and shared learning

Community outreach

- Outreach provides the first port of call for vulnerable people; the aim is to meet people *"where they're at";* engage them; help them reduce the harm they may be doing to themselves and link them into services
- It can be very difficult for dual diagnosis clients who are homeless because treatment is catchment area based
- In prison, women are generally more marginalised with more complex needs than men.
- There is a big improvement in half way supports for people leaving prison but there is still a huge need for safe housing, without which people may find it very difficult to improve their way of life
- Outreach includes family support, eg mothers of those in prison
- There is an ongoing need for a housing support mental health worker in Tallaght
- More effective working relationships between services will greatly improve outcomes for dual diagnosis clients engaged through outreach

3. REPORT ON PRESENTATIONS

3.1 Dr Richard Lakeman, Dublin City University
Opening Address

Dr Lakeman explained that his clinical background involved setting up assertive community treatment teams which made no distinction between substance misuse and other problems. He was based in Australia in a town with a population of 160,000 and a large catchment area which included a high proportion of indigenous people with problems associated with alcohol and street drinking. Amphetamine and methamphetamine misuse was common in the area but opiate use was low.

Dr Lakeman's team comprised an occupational therapist, social worker, psychologist and psychiatrist. Their target group were people with complex needs, the 20% of the population who were consuming 80% of the resources of mental health and substance misuse services. The team aimed to provide an integrated service which worked effectively across disciplines.

Clients were targeted carefully and each case manager had no more than 5 clients. The clients were treated as an integrated part of the team. Assertive outreach was developed in a respectful, assertive manner and efforts were made to strike a balance between excessive use of services by clients and losing clients for lack of services. The approach was so successful that after 2 years, most of the team's clients were able to live independently in the community.

The effect of dual diagnosis on clients is complex. Compared with people who have a mental illness only, people with dual diagnosis, on average, experience:

- Earlier onset of mental illness
- A worse course of mental illness
- More severe signs and symptoms
- More prominent positive symptoms
- More frequent hospital admissions
- Greater use of emergency services
- Poorer rehabilitation outcomes
- Higher rates of unemployment
- Higher rates of homelessness
- Higher rates if incarceration
- Higher rates of suicide

What is the relationship between substance misuse and mental health? Dr Lakeman explained that experts have been grappling with this question for a long time. Which comes first or do they occur concurrently? Is there such a phenomenon as cannabis-induced psychosis? Do mental health issues lead to substance misuse? Does one disorder increase the risk of another? Does mental illness predispose a person to substance misuse?

Dr Lakeman explained the different models which attempt to explain the relationship of dual disorders. The **parallel model** states that disorders occur concurrently but are independent of each; they have no common aetiology and they do no influence each other.

The **causation model** suggests that one disorder causes a secondary disorder. The **risk model** states that one disorder increases the risk that another disorder will occur, without directly causing it. The **modifier model** states that when disorders occur together they influence the other even though they are not closely related.

Finally, **Berkson's Law** states that disorders which are seemingly unrelated occur together because these people present more often for help.

Dr Lakeman emphasised that the response to dual diagnosis raises similar questions. For example, is mental illness the primary problem and substance misuse secondary? Do people with mental illness self-medicate by using substances and, if so, what are the implications for treatment? Should we treat mental illness first or second?

It is well known that substance misuse can lead to mental illness, for example alcohol misuse can lead to depression. However, other factors must be considered, eg sexual abuse can lead to post traumatic stress and substance misuse, and people may self medicate to alleviate symptoms of mental illness.

Dr Lakeman noted that during his work in Australia, the team were co-located with community mental health, sexual health and addiction services. Staff moved between services on a regular basis but they would still say that they couldn't deal with a clients' mental health issues until they had been treated for addiction and vice versa. In conclusion, it is evident that most clients present with issues that are not easily resolved and with symptoms that do not readily fit into the criteria of our current service provision. This can often result in attempts to refer clients to the "other service" into which the clients' problems also do not fit.

Dr Lakeman presented two slides on the Locus of Care. He explained that Locus of Care 1 represents primary health care settings. It is appropriate for clients with low severity mental health and/or substance misuse. Locus of Care 2 represents the mental health system and is appropriate for clients with severe mental health issues (and low severity substance misuse). Locus of Care 3 represents substance misuse services. It is appropriate for clients with severe substance misuse issues but only mild mental health issues. Locus of Care 4 represents hospitals, prisons, substance misuse, mental health and emergency services. They are appropriate for people with severe mental health and substance misuse difficulties.

The second part of the presentation focused on the benefits of integrated service provision. The national strategy *Vision for Change* states that specialist substance misuse services will be established in catchment areas of 300,000, each consisting of specialist teams. In Dr Lakeman's view, this will not promote integrated service provision. Integrated service provision improves access to services by ensuring substance misuse and mental health provision are in the same setting. In other words, it is important to build a system around individuals and not to try and fit individuals into a system. We need one integrated service or, alternatively, both substance misuse and mental health services should provide joint provision with seamless and effective referral between services.

He presented a slide which showed that it is possible to provide concurrent treatment of both mental health and substance misuse disorders by:

- Service provider having skills and knowledge in both areas
- Conjoint service provision by both mental health and substance misuse services, either by one integrated service or by both services delivering care in an approach which is integrated and co-ordinated
- Effective and seamless referrals between services.

- For this to be achieved, it is necessary to have:
- Co-operation between mental health and substance misuse services
- A harm reduction model
- Engagement and retention in treatment
- Interventions matched to clients' stages of change
- Continuing staff education and support
- Services with expertise in one area and competence in the other

Dr Lakeman continued by describing eight steps to develop an inter-service strategy (Figure 1).

Figure 1 8 inter-service strategies for responding to dual diagnosis clients

He showed a slide describing a study conducted by Drake et al (2008) which systematically reviewed the effectiveness of psycho-social interventions for people with dual diagnosis (Figure 2). The findings suggest that group counselling, case management, residential treatment and contingency management are important interventions to consider for dual diagnosis clients.

Figure 2 Effectiveness of psycho-social interventions

Intervention	Substance use outcomes	Mental health outcomes	Other outcomes
Individual counselling	3/7	2/4	2/5
Group counselling	7/8	2/6	7/8
Family interventions	1/1	1/1	1/1
Case management	6/10	3/8	9/11
Residential treatment	7/12	3/10	11/12
Intensive outpatient rehabilitation	1/2	0/2	1/2
Contingency management	4/5	0/2	4/4
Legal interventions	1/4	4/4	4/5

Dr Lakeman concluded his presentation by describing a study in New York (Tsemberis, 2004) on 225 dual diagnosis homeless people. It was found that those who were offered immediate housing

regardless of compliance or sobriety had a greater housing stability with 80% remaining housed, compared to those whose housing was contingent on treatment and compliance.

3.2 Mr Martin Rogan, Assistant National Director, Mental health.

Martin Rogan introduced his presentation by saying that in the past there was a strong message that drugs lead to the road to ruin. This has been a widespread expectation even though it's not true in many young people's experience. Does the message stack up? What is the attraction of drugs, especially if these scare messages abound along with widespread education about drugs?

Recent research in Europe asked young people if they were happy with *"who they are".* Fifty one percent of 8-11 year olds said they were happy but this figure dropped by half for 12-17 year olds. When broken down by gender, 53.5% of boys and 37% of girls aged 8-11 years said they were happy whereas 37% of young boys and 18% of girls said they were happy between ages 12-17 years. Mr Rogan said that education, exercise and other activities can be devised in an attempt to raise happiness levels among young people, but it is apparent that some will try chemical solutions (ie drugs, alcohol).

In another piece of research conducted in urban and rural areas of USA, Europe and Africa, it was found that 60% of the population were flourishing and enjoying life; this percentage was the same in the 3 continents. Fifty four percent enjoyed moderate mental health. Another, smaller proportion was diagnosed with mental health issues and in treatment, and there was another proportion that was "languishing". The proportion of the population for whom life was a struggle varied between continents.

The research was repeated 10 years later. The findings showed the same proportions of the population who were flourishing versus languishing. However, the results also showed that mental health is a dynamic process: over a period of 10 years, many people moved through different states of mental health. This research indicates that the model which suggests there are two types of people: strong and vulnerable is much too simplistic.

In Ireland, at present, 200,000 people are suffering from depression although not all are in treatment. Some of this depression is due to substance misuse which raises the question: is substance misuse DIY psychiatry? Alcohol use and misuse are extremely widespread in Ireland, it is our favourite drug. The number of people who resort to alcohol is huge and there is a cultural message that encourages us to drink. This is not a safe message.

If young people start to use drugs and alcohol early, it is likely they will progress towards a more exotic range of products as they get older. The consequences for physical and mental health are considerable. Last year, the cost of alcohol was reduced by 20% which makes it even more available. Illicit drugs and prescribed drugs such as benzodiazepines are widely available. Young people presenting to mental health services with psychosis have often had experience of street drugs. In Ireland, the prison population has grown rapidly to 4500 in recent years, 67% of whom have psychoses. However, it is very difficult to provide mental health services in a prison setting.

Which comes first, the chicken or the egg; mental illness or substance misuse? Should we treat mental illness such as depression first, then address addiction or vice versa? Because our services tend to be discreet entities, we try to carve people up into specific services and with dual diagnosis, this doesn't work well. We need an integrated model of service provision.

When people with addiction issues present to mental health services, they are often very depressed and this has a significant impact on the whole family. If they are able to stay away from drugs, the prognosis can be good but if they return to their old communities and ways of life, it can be very difficult. Mood altering drugs are everywhere. The mood altering industry is as large as the textile and oil industries. The head shop phenomenon reflects the extent to which people want respite from not being happy.

Professor Rogan emphasised that in *Vision for Change*, there are many recommendations from different departments so it is important that we work together and collaborate effectively.

He continued by saying that there is still widespread stigma associated with mental illness. Many people will avoid mental health services because the social cost can be high. This means that self-medication through substance use/misuse can be an attractive option. In the past, Ireland had the world's biggest mental health service. We had 22,000 beds for alcohol related conditions and hospitalised 50% of those presenting to services. Recently, the number of beds was reduced from 12000 to 1200. *Vision for Change* recommends a further 50% reduction to 650.

The 2001 Mental Health Act went live in 2006 and this changed the landscape dramatically with a new focus on community based services. There are 16 community based mental health projects being established around the country but it isn't sufficiently resourced. The government committed to 21million Euros each year but this was available for the first two years only and not the following three. Funds are unlikely to be made available in 2011 which means the vision is unrealistic. The vision of specialist teams in catchment areas of 300,000 is also unrealistic. We need all teams to bring their capacity together; in other words, the issues of dual diagnosis, mental health and addiction have to be tackled together.

Professor Rogan concluded by saying that we like to think of mental health services in the community, reflecting the community they support. But some people live in very difficult circumstances trying to deal with a myriad of issues such as unemployment and poverty. Mental health services try to focus on areas of disadvantage but their resource level is very low. Also, mental health services meet community resistance when attempts are made to establish service provision, particularly in South Dublin County.

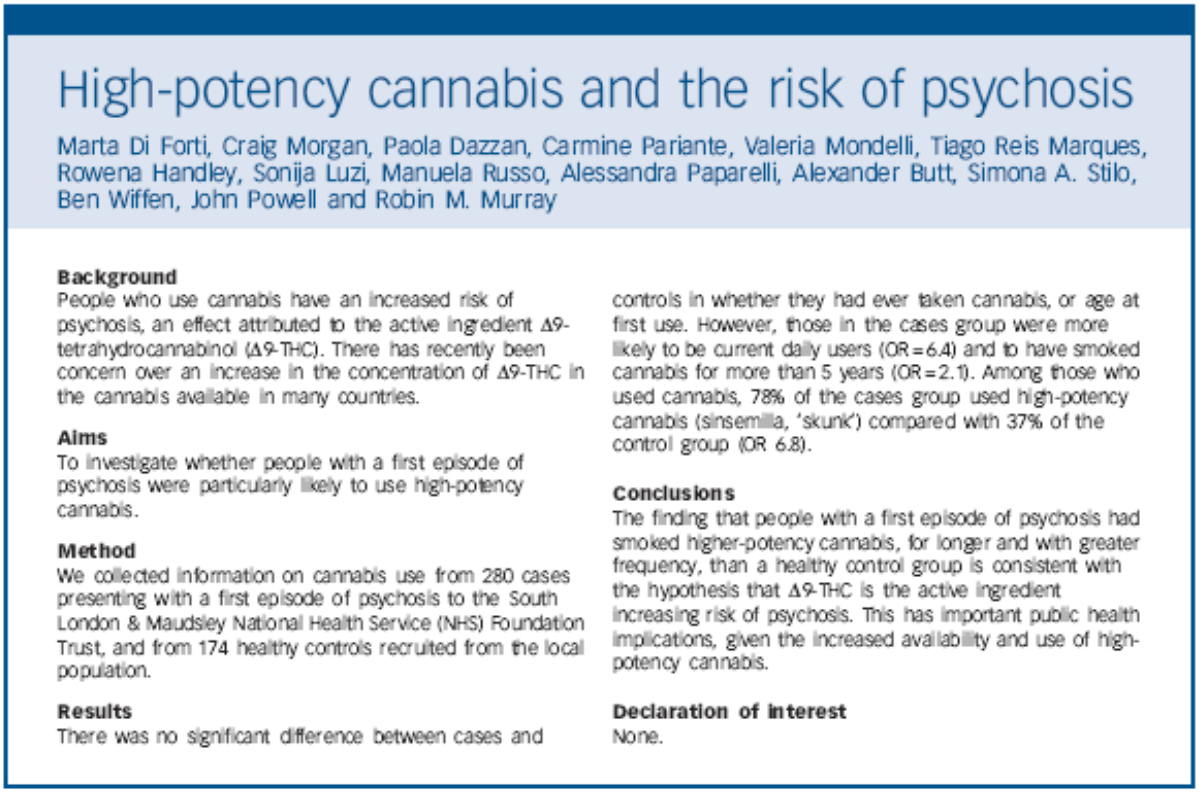
3.3 Dr Bobby Smyth. Consultant psychiatrist, Tallaght Addiction Services
Responding to the needs of people with dual diagnosis

Dr Smyth opened his presentation by saying that the previous speakers had given a good overview of dual diagnosis and he would focus on the structures, strengths and weaknesses of service provision.

Dual diagnosis can range from alcohol use combined with low grade mental health issues to severe alcohol/drug misuse and mental illness. The topic of dual diagnosis has been driven by researchers but Dr Smyth emphasised that medical doctors understand dual diagnosis in the same way as managing any chronic illness. Many people have more than one chronic illness, for example a fractured hip and hypertension. In the health services, doctors manage both chronic illnesses together and rarely have to move a patient to a completely different service. He said: "*We deal with them together and even if we do seek the advice of an expert, the patient tends to lie in the same bed. This means that there are existing systems to deal with co-existing health problems".*

The link between high potency cannabis (such as skunk), schizophrenia and psychosis has attracted much interest. The findings of Di Forti et al (2009) suggest that people presenting with first episode psychosis were more likely to have used high potency cannabis than a control group (Figure 3). Tetrahydrocannabinol is the active ingredient thought to increase the risk of psychosis.

Figure 3 Findings of a study which links high potency cannabis and psychosis



High-potency cannabis and the risk of psychosis

Marta Di Forti, Craig Morgan, Paola Dazzan, Carmine Pariante, Valeria Mondelli, Tiago Reis Marques, Rowena Handley, Sonija Luzi, Manuela Russo, Alessandra Paparelli, Alexander Butt, Simona A. Stilo, Ben Wiffen, John Powell and Robin M. Murray

Background
People who use cannabis have an increased risk of psychosis, an effect attributed to the active ingredient Δ9-tetrahydrocannabinol (Δ9-THC). There has recently been concern over an increase in the concentration of Δ9-THC in the cannabis available in many countries.

Aims
To investigate whether people with a first episode of psychosis were particularly likely to use high-potency cannabis.

Method
We collected information on cannabis use from 280 cases presenting with a first episode of psychosis to the South London & Maudsley National Health Service (NHS) Foundation Trust, and from 174 healthy controls recruited from the local population.

Results
There was no significant difference between cases and controls in whether they had ever taken cannabis, or age at first use. However, those in the cases group were more likely to be current daily users (OR = 6.4) and to have smoked cannabis for more than 5 years (OR = 2.1). Among those who used cannabis, 78% of the cases group used high-potency cannabis (sinsemilla, 'skunk') compared with 37% of the control group (OR 6.8).

Conclusions
The finding that people with a first episode of psychosis had smoked higher-potency cannabis, for longer and with greater frequency, than a healthy control group is consistent with the hypothesis that Δ9-THC is the active ingredient increasing risk of psychosis. This has important public health implications, given the increased availability and use of high-potency cannabis.

Declaration of interest
None.

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Arseneault et al (2004) conducted research which suggested that cannabis use in adolescence leads to a 2-3 fold increase risk of schizophrenia in adulthood. People who start to use cannabis at a young age and people who use large quantities are at increased risk of schizophrenia. Other studies indicate that 15% of schizophrenics would not have developed the condition if they hadn't smoked cannabis.

The type of cannabis smoked has an influence on the negative interaction between cannabis and schizophrenia. Skunk-type products have 4 times the level of THC as the original home grown form. Higher THC levels mean that people are much more likely to develop psychotic reactions.

Drugs sold in head shops and on the internet have a particular propensity to cause mental health problems during intoxication and afterwards, including depression, anxiety and acute deterioration in mood. These products mimic the effect of cannabis and can lead to schizophrenia and other psychotic effects. However, natural cannabis contains THC plus cannabidinol. Cannabidinol has an anti-psychotic effect. Head shop drugs, on the other hand, contain only THC without the anti-psychotic cannabidinol and this means they have a greater capacity to cause psychosis.

Dr Smyth concluded that there is strong evidence for a causative link between high potency cannabis, psychosis and schizophrenia but the research is not conclusive. Either way, cannabis use does lead to more difficult treatment and Dr Smyth emphasised that the important thing is to manage both issues.

Dr Smyth presented a slide of the effect of drugs on the brain. The images were cross sections of the brain taken by a functional MRI scan which measures brain activity. The scans showed a normal brain exposed to a stimulus. Ten days after cocaine consumption, brain activity was markedly reduced when exposed to the same stimulus. 100 days afterwards, brain activity had almost recovered but it was not back to normal. Dr Smyth explained that our understanding of the brain is very modest even when it is working well; indeed, it is the most poorly understood organ in the body. However, it is becoming clear that repeated use of mood altering substances have an enduring and negative effect on brain activity.

Just in the same way as our bodies change according to the environment (for example, we tan in the sun), the brain changes. This may explain why cannabis use during adolescence can cause enduring change because adolescence is a time when the brain is still developing.

It's important to give people proportionate messages. Cannabis use in adolescence can cause mental health issues later in life; the risk is definitely increased but it is not inevitable.

Dr Smyth continued his talk by explaining the implications of dual diagnosis which he summarised as follows:

- Exacerbation of symptoms
- Non compliance with treatment or medication
- Increased rates of Tardive Dyskinesia
- Increased relapse rates and severity
- Increased costs and use of services
- Increased risk of violence
- Increased risk of suicide
- Increased homelessness
- Increased risk of HIV
- More complex intervention strategies
- Increased burden on carers and families
- Rejection of psychiatric services
- Rejection by drug services
- More positive/less negative symptoms
- Greater complexity in diagnosis and assessment

A number of research studies give a picture of the extent of dual diagnosis. Reiger et al (1990) conducted a study of 5 communities in the USA involving 20,000 individuals. They showed that 53% of those who misused drugs and 37% of those who misused alcohol had a lifetime prevalence of one form of mental disorder. Also, 15% of those with a mental health disorder had a lifetime

history of drug misuse or dependence rising to 28% in those with schizophrenia. In the UK, Farrell et al (2001) examined psychological wellbeing and its relationship with substance misuse. They found that psychological morbidity was present in 12% of non-dependent individuals; 30% of alcohol dependent individuals and 45% of drug dependent individuals.

In Ireland, there is a lack of specific research. However, one study (Karmali et al, 2000) indicated that 39% of a cohort of individuals with schizophrenia had a lifetime history of substance misuse (primarily alcohol and cannabis). Another study of people attending the Drug Treatment Centre Board (2006) showed that 43% of those assessed had a psychiatric disorder.

Dr Smyth concluded this part of the talk by saying that we drink more in Ireland than most other countries. Our per capita consumption in 2001 was 14 litres per person although this fell to 11 litres per person in 2006. This equates to a bottle of whisky per person per week. As alcohol consumption rose from the 19790s, so did the suicide rate. It is too simplistic to link the two together too closely but there are links. The majority of young males under the age of 30 who commit suicide are intoxicated at the time of suicide. Alcohol has an unpredictable effect on mood.

Dr Smyth continued by drawing attention to a statement in *Vision for* Change: *"The major responsibility for care of people with addiction lies outside the mental health system"* which, he said *"goes against practice and policy throughout the world".*

He described 3 strategies for treatment (also explained by Richard Lakeman): serial; parallel and integrated. He emphasised that we need a parallel model of treatment NOT a serial model. People with needs in both domains should be actively treated for both at the same time. This will lead to shared understanding, integration, shared care plans and joint working. Dr Smyth said he would like to see staff members divide their time between mental health and substance misuse services, sharing their knowledge, skill and understanding of the patient to both services.

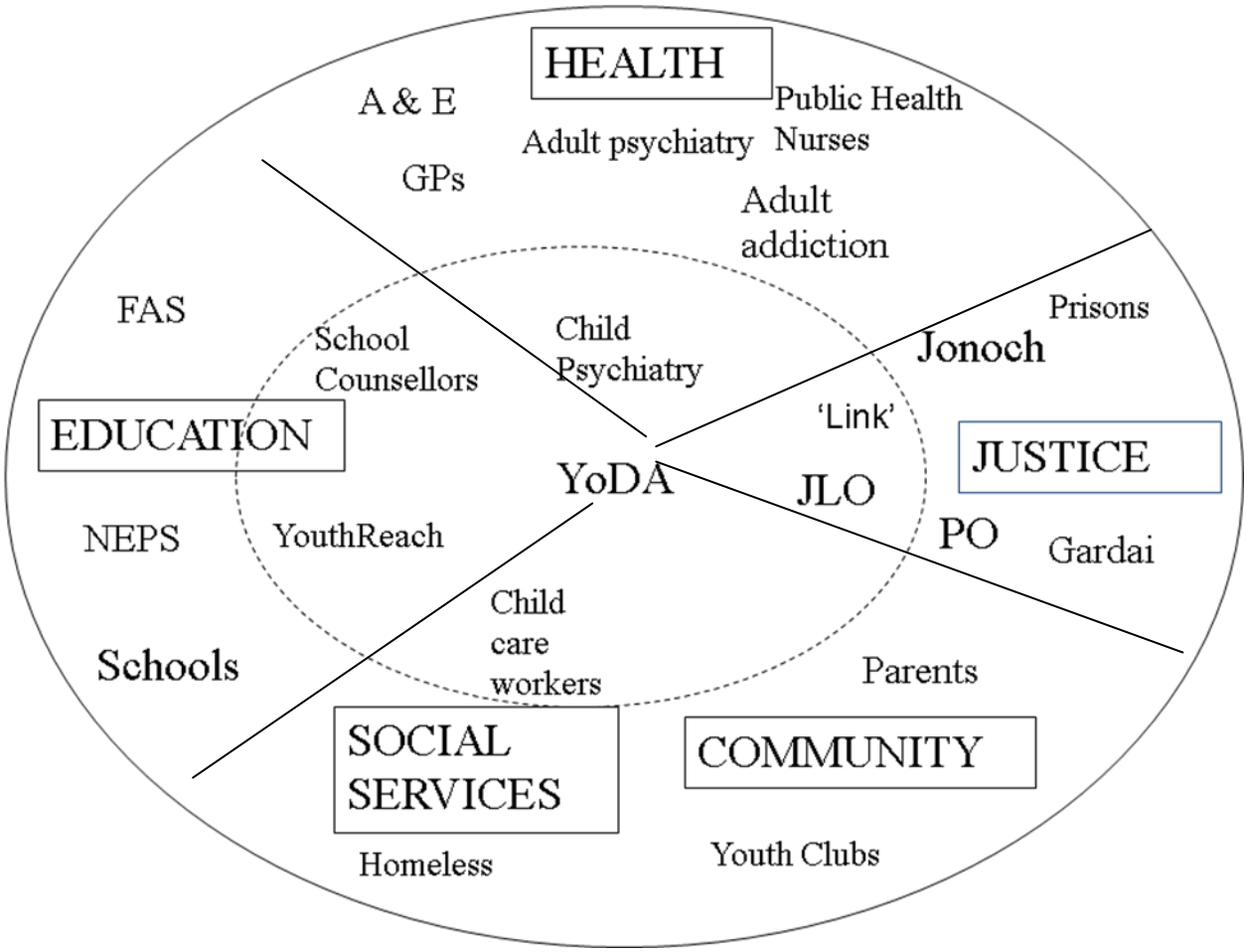
He expressed concern that the *Vision for Change* recommendation to set up specialist teams per catchment population of 300,000 may lead to people being *"bunkered"* in a third service. If mental health, substance misuse and dual diagnosis teams are set up, Dr Smyth would be concerned that the specialists in the dual diagnosis teams would further de-skill both addiction and mental health services.

Dr Smyth showed the relationship YODA has with other services in the area as a way of explaining integrated service provision (Figure 4).

Dr Smyth continued by describing substance misuse services in Tallaght which consist of:

- Large clinics eg Belgard Rd
- Community based clinics eg JADD
- Satellite clinics eg CARP
- Community GPs

Figure 4 Integrated service provision, using YODA as an example



In Tallaght, 95% of addiction services are focused on opiate users. Tallaght has a range of services, including GPs, the HSE clinic at Belgard Rd and satellite and community clinics. Mental health needs of clients are treated by GPs in the community but GPs may not have the knowledge or training to effectively address mental health issues. Also, there are limitations in the way that substance misuse services can detect and treat mental health problems. At Belgard Road, clients are primarily treated by GPs who may seek the advice of the psychologist but it is not a psychiatric led service. Nurses are not trained in mental health and there is no requirement for GPs specialising in substance misuse to have mental health training.

So, does this mean that we can't manage mental health issues in substance misuse services? No, it doesn't. People with moderate mental health can be treated at Belgard Rd clinic but there is a lower threshold for providing treatment in community and satellite clinics. There are many clients who exceed our capacity to respond. This means that we must have a parallel model. We need responsive services that recognise and address the fact that people's mental health is dynamic and changes.

Dr Smyth pointed out that addiction tends to run a chronic relapsing course whereas mental health problems are often persistent. The needs of dual diagnosis clients tend to "*wax and wane".* The challenge to our services is to deliver interventions of appropriate intensity, handing over the lead from substance misuse services to mental health services and back again in response to changing needs. An integrated and parallel model of treatment is essential for this to occur.

Dr Smyth concluded by saying that:

- Dual diagnosis is very common
- Prognosis is poorer in dual diagnosis
- Addiction services have reasonable but a geographically variable capacity to manage mental health problems
- If further improvements can be achieved in joint working between mental health and addiction services, this should improve patient outcome and save scarce resources.

3.4 Dr Peter Whitty, Consultant Psychiatrist in General Adult Psychiatry in Tallaght Adult Mental Health Services.

Dual Diagnosis and General Adult Psychiatry

Dr Whitty opened his presentation by saying that he would focus on the daily work of General Adult Psychiatry in Tallaght; provide a profile of clients, and examine how adult mental health services can work more effectively with Tallaght Drugs Task Force.

Tallaght Mental Health services include a homecare team, acute day hospital, day centre, OPD Mary Mercer Health Centre and an in-patient unit (AMNCH). The team consists of the following staff:

- Medical: 3 consultants with NCHD's
- Social Workers: 2
- Occupational therapists: 2
- Psychologists: 1.5
- Dietician: 1
- Nursing staff: Homecare (6), Day hospital (3), Day centre (2), CNMH (3)

The facilities are as follows:
Homecare team: patients tend to be revolving door admissions to hospital, ie people who lapse on a course of treatment. The homecare team will visit patients in the home on a regular basis, ensuring that treatment is adhered to. The aim of the team from a hospital perspective is to limit use of inpatient resources. 25 patients attend the homecare service at any one time. They may be presenting for the first time or they have relapsed. Some patients will be known and may be on a continuous day programme, attending once every 1-2 weeks.

Acute day hospital at Sheath House. Patients come on a daily basis Monday to Friday. The aim from a hospital perspective is to limit use of inpatient resources. There are 15 patients at any one time.

Day centre at Sheath House: Caters for people who may have been in psychiatric hospital previously. It provides low grade social activity and regular patient contact, providing structure to the day. Patients tend to be vulnerable with a limited capacity to look after themselves. There are 12-15 patients at any one time.

Mary Mercer Centre: Outpatient unit which takes 800 patients at any one time

In patient unit: 50 psychiatric beds are available. Dr Whitty reported that 10 are taken at any one time.

Patients referred to adult mental health services present with a variety of mental health conditions. The ratio is as follows:

- Schizophrenia 34%
- Bipolar disorder 7%
- Depression 29%
- Drug induced psychosis 2%
- Anxiety disorders 14%
- Alcohol and substance misuse 1%
- Other 23% (eg eating disorders, dementia, mixed diagnoses)

Dr Whitty reported on a patient tracking study he conducted over 4 years. The majority of patients who had initially presented with psychosis had moved into a major mental health condition, eg schizophrenia, after 4 years. He emphasised the importance of closely tracking these clients.

Dr Whitty continued by saying that there are many challenges facing mental health services. Referral is restricted to medical referrals (eg GPs, Tallaght hospital); otherwise it would be impossible to cope with the numbers who would be referred.

The in-patient unit experiences difficulties with substance misuse. Dr Whitty described a patient who presented to the unit in crisis. She was attending addiction services and she was on the methadone protocol. She was admitted. The following day a second patient presented with similar symptoms. As part of routine admission, cannabis was found on her possession and she explained that she had brought it for the patient admitted the day before. Dr Whitty said "*we battle to maintain vulnerable patients on the ward from the harmful effect of drugs".*

When someone attends A&E, there is usually a follow up. A large proportion of those who don't attend follow up appointments have substance misuse issues but Dr Whitty explained that mental health services are not good at tracking them. It is certainly a challenge for the service.

Many dual diagnosis patients present to the service, ie those with low grade chronic drug use (eg cannabis) and mental health issues. However, mental health services are limited in their capacity in how they deal with these clients: *"We can educate but we are not good at stopping them using drugs".* Dr Whitty welcomed advice and response from the audience as to how adult mental health services can address the issues these patients present with.

The fourth challenge for mental health services is medication. When a patient attends different treatment programmes s/he may get a range of medications, sometimes double doses of the same medication. An effective way to deal with this is by co-managing with good lines of communication. One example would be to ensure that only one treatment centre prescribes (for example the GP at a drug treatment centre).

Dr Whitty explained that adult mental health services are also limited in their capacity to detect patients who use head shop or internet drugs.

He pointed out that the service has not adopted a preventative approach.

3.5 Presentations from Community Outreach

Three people gave short presentations on different aspects of community outreach: Des Caprani, HSE Outreach; Lisa Glassett Probation Services, and Simon Monds Tallaght Housing Advice Unit (THAU).

3.5.1 Des Caprani HSE Outreach Belgard Road

This talk focused on client work from an outreach perspective. Outreach is a fundamental role within the multi-disciplinary team working out of the HSE clinic at Belgard Road. The aim of the outreach team is to engage with active drug users in and out of treatment. Outreach provides the main referral route into services. Mr Caprani explained that the main role of outreach is to engage drug users, accompany them to treatment services on their first visit if appropriate and then follow up.

Most frequently, outreach engages with young men in their mid twenties who are polydrug users and in danger of homelessness. They often present with behavioural difficulties which may be due to substance misuse or mental health. They are generally in a chaotic state.

Often, they become identifiable through their peer group, often it will be another drug user who will let Outreach know that another is in trouble. Family members also refer someone who is in trouble. Self referral is also common; drug users know through their peer groups that HSE Outreach workers are reliable and trustworthy and available to help.

Statutory services, nurses and the Gardai will also alert the Outreach team to people who may be in trouble.

HSE Outreach makes contact with vulnerable people in a number of ways. Tallaght has 3 needle exchanges, several drop in centres operating from community drug services and 7 community drug projects. Some of the drug projects provide washing and laundry facilities which are accessed by drug users at risk of homelessness.

Des Caprani pointed out that Outreach are "*in a unique position to meet individuals wherever they want us to meet and whatever their need".*

Mr Caprani continued by saying: *"drug users tend to accumulate in groups, so when we meet someone we try and get them on their own and find out what's going on for them. Very often, people can be very distant, very anxious and depressed so we may not get very far at the first meeting. We try to arrange another meeting or get a contact number so we meet them again. When we meet, we find out what the client is looking for. We operate primarily through the harm reduction model, looking to reduce the harm they are doing to themselves. We establish what substances they are using, including prescribed medication. We find out if they are linked to mental health services and if they are keeping appointments. It's important to build the relationship quickly and we make them aware that we're there to help them and reduce the chaos in their lives".*

Outreach refers mainly to the HSE Addiction service at Belgard Rd. Referrals are also made to GPs or a member of the Outreach team may accompany someone to A&E if necessary. Referrals are also made to the Tallaght Homeless Advice Unity (THAU). For legal matters, Outreach liaise closely with criminal justice and probation services.

Mr Capraini said "*Outreach is about networking, finding out what services are available and how we can best help".*

Mr Caprani pointed out that families of drug users are likely to be in crisis, too, so there are family support services operating from most drug projects in Tallaght. The Outreach team also have close links with the local Social Work teams.

Mr Caprani explained that Outreach's intended outcomes are to bring some level of stability to drug users' chaos; assist with finding treatment, housing and community involvement. Outreach staff listen to what the person wants and offer ongoing support. Dual diagnosis clients often get passed from one service to another. That is starting to change and with greater communication and collaboration, outcomes can only improve. It can be very difficult for dual diagnosis clients who are homeless because treatment is catchment area based. In these cases, homeless people are generally referred to the inner city. This is not a great outcome and often they get lost. Sheltered accommodation is difficult to get and long term accommodation even more difficult.

3.5.2 Lisa Glassett, Outreach worker Tallaght Probation Project

Ms Glassett opened her presentation by explaining that her work is primarily in prison settings; she covers all prisons in Dublin, St Patricks, Mountjoy male and female, Wheatfield, Cloverhill, the Midlands and Shelton Abbey.

Working in a prison setting can be difficult because of access. Access is staff dependent and if there is no prison officer available the outreach worker is not allowed to see her clients. Outreach workers don't work alone; their job is to know what services are available for clients and how to get clients to them. There are 4 sources of referrals: the probation team, concerned parents, self referral through an intermediary in the prison, or concerned others.

Ms Glassett explained: "*Prison is a frightening place and clients can become very fragile, often coming down from chaotic drug misuse. They stand out in prison and often become victims. It can be very difficult for those with combined substance misuse and mental health issues".*

When she meets a client, she makes a brief assessment. Usually, she already knows her prison clients and her job is to alert prison services to the support they may need. She pointed out that short sentences can be quite difficult because clients may refuse interventions.

23 hour lock up is quite common. People may be put into 23 hour lock up if they are deemed a risk to themselves or others; occasionally it is through choice. They have access to the gym or yard for 1 hour a day. This cannot be helpful for positive mental health.

In 2006, a study in Docas prison showed that women are marginalised with more complex needs than men. Many have spent time in residential units as children, they will have been formally diagnosed with mental illness and they are poly addicted with heroin, alcohol and benzodiazepines. Many have been victims of crime and they are at risk of homelessness on release. Their crimes tend to be on the low level of index. Many women see the prison setting as a respite from their chaotic lives.

There are huge improvements in the release pathways. Clients are no longer released on Friday evenings with nowhere to go and Outreach services can readily liaise with statutory agencies to offer support. But Outreach cannot offer safe housing on their release and without this, the whole cycle is likely start again.

Mothers are the main supports to people in prison and Ms Glassett said that she also offers support to them with basic help such as linking them to prison chaplains, facilitating meetings and arranging three way meetings with the client, his/her mother and probation services. Sometimes it becomes clear that the client can't go home on release because of home or other family issues.

3.5.3 Simon Monds, Project co-ordinator, THAU

Mr Monds opened his presentation by saying that people with severe dual diagnosis often end up in hospital and can be difficult for services to deal with.

The Tallaght Homeless Advice Unit (THAU) is a drop-in service in Tallaght village with a broad remit with respect to client group. When a person attends for the first time, a 2 page assessment is completed to identify accommodation issues, what services they are already linked with, welfare payments they receive and the pressing issues they experience.

THAU's expertise lies in housing but the service recognises that there are underlying reasons to homelessness and housing issues. THAU refers appropriately to other services and aims to achieve a balance between "passive neglect" and being over pushy. The service works with statutory and community services, especially the local authority for housing issues and community services.

THAU was set up 17 years ago in response to the needs of rough sleepers. The service was able to secure funding for a housing support mental health worker in recognition that many of their clients have underlying mental health issues. This is a part time post and it will be lost at the end of the year. Thau's conclusion from having this post is that there is definite need to provide this kind of expertise for those with combined housing and mental health issues.

Dual diagnosis clients will present with different housing needs. They may have been released from prison or hospital and generally the only option is to find them hostel or B&B accommodation in the city centre. In these situations, they are often placed in close proximity to other individuals with complex needs and there is a constant danger that they will fall through the gaps and the cycle will continue. It can be difficult to find private rented accommodation for clients who do not present well. Rent support for single people without children is low and this means THAU may be forced to send their clients to bedsits in the city centre. Long term supported accommodation is mostly in the city centre and can be hard to access.

In conclusion, Mr Monds said that THAU would like to see closer working partnerships between services; a renewed focus on procedures as well as personalities; further development of the dual diagnosis forum and creation of a virtual multi disciplinary team to address clients' needs.

4. CONCLUDING REMARKS, DR RICHARD LAKEMAN

Dr Lakeman thanked all participants for the interesting and informative meeting. In conclusion, he identified 8 steps that can be taken to establish more effective interagency co-ordination and co-operation which will lead to better outcomes for dual diagnosis clients, as follows:

- Encourage the growth and development of the Tallaght Dual Diagnosis forum
- Document and review interagency protocols and linkage agreements
- Create and maintain informal networks outside of crisis
- Establish case management, clinical reviews and other arrangements for joint consultation
- Develop co-operative models between agencies for joint service delivery
- Educate “the other” service provider by reciprocal and joint training
- Provide information
- Establish brief agency placements. Mental health staff in substance misuse services and vice versa

5 AUDIENCE RESPONSES TO SPEAKERS' QUESTIONS

At the end of each presentation, the speakers posed 1 or 2 key questions to the audience. Responses were recorded by the notetaker and submitted to the rapporteur at the end of the meeting. Audience responses are given below.

1. How can we get better at detecting mental health and addiction problems?

There were requests for training in detection and assessment of mental health issues, possibly through organisations such as AWARE and Schizophrenia Ireland. Several Tables[1] emphasised that training is empowering, valuable and very important to forge better understanding about dual diagnosis within and across services. It was also suggested that further education training in mental health should always include core modules on substance misuse. Likewise training in community development/substance misuse should include a significant component on mental health. Two participants recommended more workshops where people from different disciplines can network and share learning.

How does your service currently deal with dual diagnosis? What is your first response?

Community addiction services reported that vulnerable people often become engaged in treatment via drop-ins. Staff will endeavour to engage with a vulnerable person attending drop-in and obtain background information. An assessment is made; a key worker allocated and a treatment plan is drawn up. Where appropriate, the client is referred to other services. One Table reported that mental health issues often become apparent at the stabilisation stage of drug treatment. Another Table reported that family support services are essential for clients with dual diagnosis. Participants from 4 Tables reported that it can be very difficult to refer vulnerable clients from community addiction services to mental health services and there are often long delays before a comprehensive mental health assessment is made. These delays are often detrimental to clients, their families and, ultimately, may lead to increased risk in the local community.

Three Tables reported that clients with dual diagnosis may experience fear, isolation and a lack of knowledge about services that can help them; they may be very vulnerable and can fall through the gaps because they don't know how to get help. Therefore, it is very important that staff are vigilant in all front line services. They require training to detect dual diagnosis in order to effectively and sensitively engage with these high risk clients and treat or refer appropriately.

How can your service better engage patients with complex dual diagnosis, ie psychotic symptoms, drug abuse and criminal behaviour?

This question generated a considerable response from the audience. From the responses, 2 main themes could be identified:

- **GPs need to become more involved.** One Table reported that accessing mental health services can be extremely difficult. A representative from a local housing agency reported that he found it challenging to advocate on behalf of a client with dual diagnosis and received no support from either mental health or addiction services. Confidentiality became an issue with the client's GPs unwilling to disclose information. Several representatives from other services also reported that although there are generally good relationships with GPs, it can be difficult to encourage GPs to refer appropriately. Participants from one Table noted the low turnout of GPs at the seminar.

- **Inter-agency working.** The majority of Tables reported that engagement and treatment of dual diagnosis clients will be more successful if there is more effective inter-agency working. Referral procedures, inter-agency protocols, confidentiality and information sharing agreements and case management approaches are all required.

[1] Participants sat at 12 Tables and responses were submitted for each Table.

One Table reported that agency-agency links which cut-out GPs are necessary. One Table suggested that Models of Care has provided a useful framework for inter-agency working in mental health and addiction services in the UK and it should be considered for use in Ireland.

One Table emphasised that effective and seamless referral procedures are essential, based on shared understanding. For example, mental health services could be more pro-active and effective in their referral to addiction services.

Many comments from the Tables called for greater collaboration between services. For example, one Table suggested improved links between prisons and drug treatment services in line with the National Drugs Strategy. Another suggested that community psychology could act as a link between substance misuse and mental health services; another recommended more involvement from community nurses. One Table highlighted the need for a clear, high level structure that ensures the best treatment is available for dual diagnosis clients; this requires buy-in from Government, policy makers and service managers. One Table said *"greater collaboration means better outcomes".* Another said *"communication barriers start at the top".*

What are the problems facing services dealing with dual diagnosis issues?

Most Tables reported that dual diagnosis clients can be difficult to engage and they may take up a lot of time. Service catchment restrictions and a client's address can negatively affect treatment options. Dual diagnosis clients may be very vulnerable, chaotic and unsure of where to get help.

They may also lack motivation. Because it is a client's responsibility to attend mental health appointments, there is a risk that they will not attend and not be followed up. They may need additional support to reach appointments at the allocated time which could be facilitated by substance misuse services.

Other difficulties reported included

- territorial behaviour among services
- problems because of lack of understanding about appropriate procedures for sharing information without breaching confidentiality
- lack of information sharing
- lack of client-centredness which puts the client first to ensure they get the best treatment available
- Insufficient resources and insufficient availability of in-patient beds

One Table said that services *"pass the buck",* dealing only with clients they want to deal with and dealing only with priority issues. Another said that clients may get passed around between services with no service taking responsibility.

What difficulties are there in the relationship between adult psychiatry and addiction services?

The overall view from the Tables indicated that there is too much separation between mental health and substance misuse services which has led to poor co-operation and communication. More communication with interagency care planning with full service user involvement is required. One Table suggested this may resolve the current difficulties around confidentiality. In response, one of the speakers said that confidentiality is a "*real world constraint"* and that "*we need to look at practical ways to share information without breaching confidentiality".*

Some Tables reported that access to mental health services can be difficult and time consuming with slow communication and difficult relationships. Poor communication has been exacerbated by the economic downturn and resulting staff shortages which are leading to less time for networking and careful referrals.

There was also a general view that the statutory sector does not recognise the skills and expertise of staff in the community and voluntary sectors. One Table said that the statutory sector needs to learn that the skills, qualifications and professionalism in the community and voluntary sector are very high. One Table said that one of the main problems currently hampering good practice in dual diagnosis is that statutory services do not refer to community and voluntary services.

How do we improve communication between services?

There was a considerable response to this question.

There was a strong call for attitudes to change**.** Several Tables expressed hope that better understanding and co-operation between services will help to change out-dated attitudes towards mental health and substance misuse. It was suggested again that services undertake shared learning and network together informally and through the Dual Diagnosis Forum. One Table suggested that an online forum would be a useful tool for communication. Another Table recommended that senior personnel in mental health and addiction services are encouraged to get involved in the Forum. Several Tables reported the need for improved communication with GPs; protocols for information sharing are urgently required.

Some specific suggestions were made. One Table suggested that integration of services should become a core module in college. Another recommended multi-agency outreach. One Table suggested that addiction services link with the Mental Health Homecare Team. Three Tables encouraged mental health services to accept referrals directly from community services. This would require community services to undertake training to ensure that referrals to mental health services were priority cases and appropriate.

Five Tables emphasised the need for inter-agency protocols for collaboration, shared learning and information sharing. Shared referral protocols were suggested. It was also suggested that an appropriate case management structure should be put in place to allow collaboration between agencies.

6. EVALUATION OF SEMINAR

Participants were invited to complete the following feedback form at the end of the seminar.

6.1 Feedback Form

We welcome your feedback on the 'working with dual diagnosis clients seminar'

Was the content of the seminar what you expected?
Yes No

In your opinion, were the presentations relevant to the seminar theme?
Yes No

Did the seminar deliver information and opportunities relevant to your work/profession
Yes No
If yes, how will the learning from the seminar impact your work?
_____

Did you feel you had the opportunity to network?
Yes No

Was the networking opportunity relevant to your work?
Yes No

If Yes, how _____

Could the networking opportunity be improved
Yes No

If Yes, How _____

Did you feel you had the opportunity to discuss issues and recommendations arising from your work?
Yes No

Were the discussion groups beneficial?
Yes No

Is there anything we could have done better throughout the day?
Yes No
If Yes, Please explain, _____

In your view, will today contribute toward better support and progressions for clients with dual diagnosis?
Yes No

PTO: Additional Comments

6.2 Feedback

Participants were invited to complete a feedback form at the end of the seminar; 71 forms were returned. The data were analysed using ACCESS. The findings are as follows.

1 Question: Was the content of the seminar what you expected? Yes/No

Sixty two (87%) responded yes; 9 responded no. The main criticism among those who said no related to an expectation that there would be more practical information on protocols, patient referral and links between services. One respondent said: *"There seemed to be a reiteration of problems. The speakers asked the audience questions but the audience had come to hear the answers to the questions."*

2 Question: In your opinion were the presentations relevant to the seminar theme?

Sixty six (93%) responded yes; 5 responded no.

3 Question: Did the seminar deliver information and opportunities relevant to your work/profession?

Sixty six (93%) responded yes; 5 responded no.

Thirty four respondents described how the seminar may impact on their work. Seventeen said it had given them a greater understanding about dual diagnosis, and how mental health issues affect people experiencing substance misuse. Four said they had learnt more about mental health services and 14 said they had enhanced awareness of all service provision in the area. Six reported that the seminar had motivated them to make more effort to network.

One negative response was: *"There were too many speakers and not enough time for feedback which is why we all came".*

4 Question: Did you feel you had the opportunity to network?

Sixty three (92%) responded yes; 8 responded no.

5 Question: Was the networking relevant to your work?

Sixty (84%) responded yes; 11 responded no.

6 Question: Could the networking be improved?

Seventeen (24%) said yes; 54 (76%) said no.

The majority of participants felt the networking opportunities during the seminar were adequate. Twenty four percent would have liked more. Twelve respondents asked for more time to share information about different services (in the form of short presentations) and six respondents asked for a menu of all available services with contact details of relevant staff. Another respondent recommended that addiction and mental health services take time to visit each other to learn more about the different types of provision available in different settings.

7 Question: Did you feel you had the opportunity to discuss issues and recommendations arising from your work?

Fifty six (79%) said yes; 15 said no.

8 Question: Were the discussion groups beneficial?

Sixty one (86%) said yes; 10 said no.

Six said there was not enough time allocated for the group work. Three respondents said that the layout of the room was poor with the pillars obstructing the view. One respondent said that discussions sometimes went in the wrong direction. One respondent said: *"There is a lot of anger towards HSE mental health service due to lack of access."*

9 Question: is there anything we could have done better throughout the day?
Twenty seven (38%) said yes; 44 (62%) said no.
Many respondents felt they seminar was too short and more time was needed for discussion, feedback and networking. Twelve suggested that the seminar should have been more practical with detailed plans for improving links between addiction and mental health services. One respondent said that a network organised on the day would have helped to integrate different services. Three respondents asked for handouts of the presentations or a link to a website where they can be downloaded.

10 Question: In our view, will today contribute toward better support and progressions for clients with dual diagnosis?
61 (86%) said yes: 10 said no.

The majority felt positive about the seminar:

"The 3 presentations from the outreach team were a brilliant way to let people give an overview of their work. I feel every organisation should be given the same opportunity in future meetings"

"It was very comprehensive and informative"

"The quality of the speakers' presentations was really excellent. Richard Lakeman helped to demystify the whole issue of dual diagnosis"

"Overall a very good seminar. I will bring back some of the ideas so that drug projects in the north inner city may educate themselves on dual diagnosis"

The following comments and suggestions for improvement reflect the views of those who felt the seminar did not go far enough:

"*We wanted services to address the gaps by looking at boundary issues. This is particularly relevant to the mental health service which appears to approach the role from the position of gate keeper rather than bridge maker"*

"We should have had a professional giving examples of working successfully with clients with dual diagnosis"

"The challenges all remain but what I take from today is that training and exchange of knowledge and good practice is essential. Well done to TLDTF – this was a very good approach"

"Too ambitious given the time constraints. Not enough time for questions and answers"

"I think everyone in their own special field is doing their job to the best of their ability. But I feel a directory of more networking needs to be done"

"Agencies can get round the confidentiality problem by drafting a simple one page statement giving consent to sharing information. Usually a client is informed each time information is shared unless there is a crisis situation"

"There needs to be practical follow up for service integration. There is currently a jigsaw project being set up to integrate mental health services for 12-24 year olds. Why can't a similar thing be done for all adult services?"

"Questions raised by speakers were complex and generated much discussion at our table. With a little more time I think more points may have been made but generally people here are in agreement as to what is needed to improve services for dual diagnosis clients"

6.3 Summary of feedback

Overall there was very positive participant feedback about the seminar. Respondents reported that the seminar was relevant and provided a valuable opportunity to learn and network across addiction and mental health services. The majority felt that adequate time was provided for discussion and group discussions were beneficial. Eighty six percent said that the seminar will contribute positively to their work.

There was some disappointment that the seminar was too academic without sufficient attention paid to tangible service improvement. Others said that there was not enough time to address practical solutions to gaps in current service provision and build inter-agency links between addiction and mental health services. Many participants suggested that in a future meeting, representatives from all relevant services should be given a 15 minute slot to explain the work of their organisations. This may significantly improve understanding and communication between services.

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