DUAL RECOVERY

A qualitative exploration of the views of stakeholders working in mental health, substance use and homelessness in Ireland on the barriers to recovery for individuals with a Dual Diagnosis

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Mental Health Reform
Promoting Improved Mental Health Services

Seirbhís Sláinte Níos Fearr á Forbairt
Building a Better Health Service

ABOUT MENTAL HEALTH REFORM

Mental Health Reform (MHR) is Ireland’s leading national coalition on mental health. Our vision is of an Ireland where everyone can access the support they need in their community, to achieve their best possible mental health. In line with this vision, we drive the progressive reform of mental health services and supports, through coordination and policy development, research and innovation, accountability and collective advocacy. With over 75 member organisations and thousands of individual supporters, Mental Health Reform provides a unified voice to Government, its agencies, the Oireachtas and the general public on mental health issues.

ABOUT THIS RESEARCH

Ensuring mental health services and supports are inclusive to the needs of marginalised groups is a policy priority for Mental Health Reform. In Ireland, it is widely acknowledged that there is a substantial prevalence of co-occurring mental health difficulties and substance use disorder and that as a result, this cohort faces considerably greater challenges in gaining and maintaining recovery. In 2021, thanks to the support of the HSE, Mental Health Reform engaged external researchers to conduct qualitative research on the meaning of dual recovery, in the context of Dual Diagnosis, and the barriers to achieving that goal.

Ireland’s mental health policy, Sharing the Vision indicates a new chapter for Dual Diagnosis in Ireland with a clearly articulated commitment to improving health outcomes for people with dual diagnosis by ensuring greater collaboration between mental health and other relevant services. The implementation plan also commits to developing a tiered model of Dual Diagnosis service provision. Mental Health Reform hopes that the findings and recommendations of this study will be reflected in the development of these much needed services and supports.

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GLOSSARY OF TERMS USED

AUD	Alcohol Use Disorder
BZD	Benzodiazepine
CAMHS	Child and Adolescent Mental Health Services
CHO	Community Healthcare Organisations
CMHTs	Community Mental Health Teams
CVS	Community Voluntary Sector
DHLGH	Department of Housing, Local Government and Heritage
DPHLG	Department of Planning, Housing and Local Government
DCRGA	Department of Community, Rural and Gaeltacht Affairs
DECLG	Department of Environment, Community and Local Government
DRHE	Dublin Regional Homeless Executive
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ETHOS	European Typology on Homelessness and Housing Exclusion
FEANSTA	European Federation of National Organisations Working with the Homeless
GDPR	General Data Protection Regulation
GP	General Practitioner
HRB	Health Research Board
HSE	Health Service Executive
HIV	Human Immunodeficiency Virus
JLO	Juvenile Liaison Officer
LDATF	Local Drug and Alcohol Taskforce
MQI	Merchants Quay Ireland
MHR	Mental Health Reform
MMT	Methadone Maintenance Treatment
NACD	National Advisory Committee on Drugs
NGO	Non-Governmental Organisation

OCD	Obsessive Compulsive Disorder
NVivo	Qualitative Research Software
OST	Opioid Substitution Treatment
PIL	Participant Information Leaflet
PSUD	Poly-Substance Use Disorder
PCCC	Primary and Continuing Community Care
PPI	Public Patient Involvement
SUD	Substance Use Disorder
UN	United Nations
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
WHO	World Health Organisation

'I don't think there's a common understanding of recovery. I don't think there's a common understanding of addiction. I don't think there's a common understanding of mental health and I definitely don't think there's a common understanding of dual diagnosis.'
(Caroline, Statutory Agency).

'Mental health teams need to be trained in addiction and addiction teams need to be trained in mental health – there has to be an understanding there. You don't have to know how to fix it, but you have to know where to go to get help. You have to have an understanding about how that affects the person and what they do.'
(Amy, Substance Use Disorder/Alcohol Use Disorder led NGO).

'A Vision for Change was a disaster. It was [a manual on] how not to have dual diagnosis services. It was a mandate for showing the door to drug users for fifteen years. Pathways were just completely shut. There's a hundred and eighty degree turn with Sharing the Vision, with mandates for dual diagnosis. That's not enough because in Ireland we're very good at making policies but we're not so good at implementing them.'
(Colm, a participant from a Substance Use Disorder/Alcohol Use Disorder Community/Voluntary Agency talks about the failure of Irish policy to support individuals with a dual diagnosis).

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DUAL RECOVERY

1.0

REPORT OVERVIEW

1.0 REPORT OVERVIEW

This qualitative research study explores the concept of dual recovery as understood by stakeholders and senior stakeholders operating within the fields of mental health, addiction and homelessness in Ireland, and seeks to uncover barriers that impede recovery for individuals with a dual diagnosis. Dual diagnosis in this instance refers to people accessing services with co-presenting mental health difficulties and either Substance Use Disorder (SUD) and/or Alcohol Use Disorder (AUD). As a result, they may also be experiencing Homelessness or Housing Insecurity (HHI).

Care of this population in Ireland is provided by a number of statutory (Health Service Executive [HSE]/Department of Health [DOH]) and non- statutory organisations (Non-Governmental Organisations, [NGO], voluntary, community) who provide front line services to people presenting with dual diagnosis as well as organisations providing policy oversight and advocacy.

The concept of dual recovery is evolving over time from a medical model (abstinence based in the case of people with SUD/AUD) to a more holistic approach as an individual attainment of personal goals for individuals with both mental health difficulty and SUD/AUD.

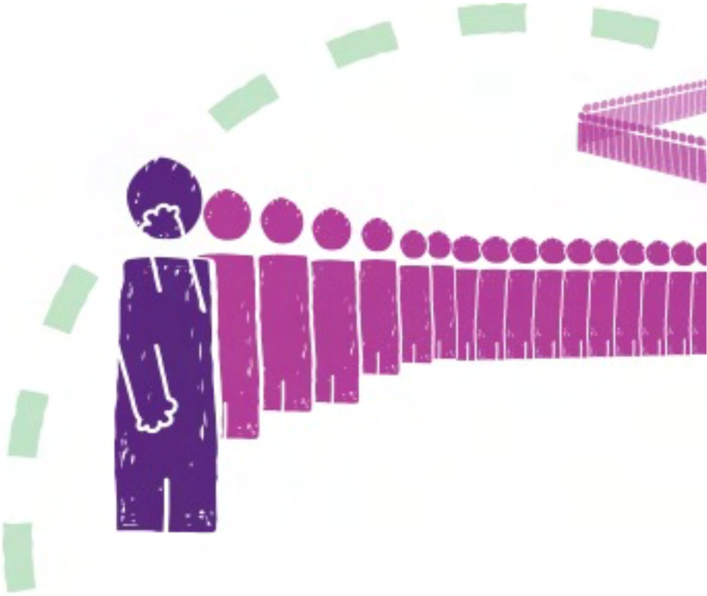
The first chapter examines the understanding of dual diagnosis and provides an overview of historic and current Irish policy on mental health, SUD/AUD and homelessness. In doing so, it allows for an examination of what is required to achieve dual recovery for people who present seeking help and support to live meaningful lives, based on national and international literature.

The second chapter outlines the methodological approach to the study and documents the methods used in the study as well as the research instruments.

The third chapter presents the findings of the study, providing an analysis of the participants' discourse on recovery, care pathways, service user engagement and finally on the concept of what is needed to achieve and maintain dual recovery.

The fourth chapter places these findings in the context of existing literature on the issues, both at a national and international level.

The fifth and final chapter provides a conclusion and recommendations, based on the input from, and analysis of, the interviews with the study participants.



2.0

LITERATURE REVIEW

2.0 LITERATURE REVIEW

2.1 Introduction

This chapter provides an overview of the understanding of dual diagnosis in the context of existing literature and policy. In doing so, it provides a brief review of both historic and more recent Irish policy on mental health difficulty, SUD/AUD and HHI. By placing dual diagnosis in this context, the chapter seeks to explore issues around the concept of dual recovery and barriers to its achievement for people experiencing mental health difficulty and SUD/AUD.

2.2 Dual Diagnosis – a Working Definition

One form of dual diagnosis is defined as existing within an individual who presents with both mental health difficulty and SUD/AUD, and treatment options must address both (Department of Health [DOH] 2017).

The risk to an individual of developing a mental health difficulty does not occur in a vacuum and can be influenced by the socioeconomic factors in which they find themselves, including their living and working conditions, access to healthcare, housing and education. Multiple factors are at play over the life course, including an individual's own biological and psychological well-being and mental health and, as such, is an important determinant of overall health (Health Service Executive [HSE] 2020).

SUD/PSUD (Polysubstance Use Disorder) and/or AUD is increasingly viewed as a multi determined long term or chronic condition (Zgierska et al. 2021), suggesting that recovery is a process that occurs over time rather than a specific event and is linked to a series of gains in overall quality of life (Grigson 2018; Laudet and White 2010).

Long term SUD/AUD is often accompanied by poor mental health (depression and anxiety) and clients presenting for SUD/AUD often experience mental health difficulties (Iro and O'Connor 2009; Lyne et al. 2010). Equally, for those with more enduring or severe mental health difficulty (Schizoaffective and associated disorders) there is evidence of a high level of substance use over a long period of time (Kamali et al. 2000).

As both issues show a high degree of co-occurrence (Landheim et al. 2006; Mueser et al. 2003) there has been growing acknowledgement that there is a need for integrated treatment for individuals with a dual diagnosis (Laudet and White 2010; Grigson 2018). However, in Ireland, lack of coherent policy on SUD/AUD, coupled with an absence of any real mental health policy on the issue left the care of individuals with a dual diagnosis in a vacuum, unable to access services supposedly available at community health level either for mental health difficulties or for addiction. This left individuals with a dual diagnosis often cycling between services and receiving no treatment at all (Department of Health 2017; Mental Health Reform 2015; Proudfoot, Mac Gabhann and Phelan 2019).

There is also a high level of correlation between SUD/AUD, mental health difficulty and homelessness or housing insecurity. The main drivers associated with homelessness are individual (mental health issues, SUD/AUD, relationship breakdown, domestic violence) and structural (loss of employment, poverty, lack of

affordable, stable housing) (Focus Ireland 2020). The three issues are, in many instances, inextricably linked. While one may appear to influence the onset of the other (homelessness leading to mental health difficulty or vice versa), it is equally clear that once in motion, there is a non-linear relationship between mental health difficulty, SUD/AUD and homelessness, with each factor playing a role in the onset or exacerbation of the other (Murphy, Mitchell and McDaid 2017).

Research in the UK is moving towards coupling the term complex needs with the term dual diagnosis to reflect the multiplicity of issues faced by individuals with a dual diagnosis. Within that understanding, a person with complex needs is defined as having two or more needs (including mental health difficulty, SUD/AUD and HHI amongst others) which directly affect their physical, mental, social or financial wellbeing (Turning Point 2016).

People who are homeless often have significant and complex needs, tend to have poorer mental and physical health and a higher rate of prevalence of SUD/AUD than the general population (Miler 2021). This is also the case in mental health difficulties where half of the homeless population report a diagnosis of depression, nearly one-third have expressed suicidal ideation and one in four have tried to die by suicide in their lifetime (Glynn 2016; O’Carroll 2021).

Homelessness affects overall health and quality of life and, as such, is seen as a social determinant of health in that the health and future health outcomes of individuals are directly impacted by the conditions of their daily lives and the resources available to them (Whitehead and Dahlgreen 1991; World Health Organisation [WHO] 2013). People experiencing HHI tend to utilise healthcare in an unplanned manner and have significant prevalence of SUD/AUD as well as a lower rate of assessed psychiatric disorders than people who are housed (Cheallaigh et al. 2017; McLoughlin, Feeney, and Cooney 2020).

Rates of mortality are much higher in the homeless population due to a number of factors including excess morbidity, SUD/AUD, violent or accidental death, poverty, childhood adversity and suicidality (Keogh et al. 2015; Prinsolo, Parr and Denton 2012). The median age of death for homeless people over the period 2011 to 2015 was 42 years for homeless men and 36 years for homeless women (Ivers and Barry 2018).

2.3 Policy Overview

Mental Health Policy

Ireland, having once had the highest number of in-patient psychiatric beds in Europe, pursued a period of deinstitutionalisation, which resulted in most acute psychiatric care being provided in general hospital units (Walsh 2015).

As deinstitutionalisation progressed in the mid-1980s, the Department of Health set up a study group to plan a framework for psychiatric services in Ireland. Recommendations in this report concluded that psychiatric needs should largely be based in the community, and this included people with ‘alcohol and drug-related problems.’ (DOH 1984).

However, a comprehensive Irish policy on mental health did not emerge until 2006 with the publication of Ireland's first mental health policy, 'A Vision for Change' (HSE 2006). This framework envisaged that mental health care would be addressed predominantly within communities, with the establishment of a number of Community Mental Health Care Teams (CMHTs) for adults, and Child and Adolescent Mental Health Services (CAMHS) for younger people (HSE 2006). It also referred to the concept of dual diagnosis for the first time, following on from recommendations by the National Advisory Committee on Drugs (NACD) (MacGabhann et al. 2004).

While recognising at this point that specific care was needed for individuals with a dual diagnosis, it essentially maintained the existing 'dual standpoint' by separating provision of, and therefore access to, routes of care. *'The major responsibility for care of people with addiction lies outside the mental health system. These services have their own funding structure within Primary and Continuing Community Care (PCCC) in the HSE. The responsibility of community mental health services is to respond to the needs of people with both problems of addiction and serious mental health disorders'* (DOH, A Vision for Change p. 146).

The strategy also acknowledged the high level of correlation between mental health difficulty and homelessness, noting that there was 'negligible' provision of housing by statutory housing authorities, and recommended that a range of suitable and affordable options should be made available to '*prevent the mentally ill becoming homeless*.' (DOH, A Vision for Change p. 146).

A decade on, the rate of implementation of 'A Vision for Change' was criticised as being too slow and inconsistent (Kelly 2015). The intended implementation of the strategy coincided with the onset of an economic recession, which led to loss of staff. This, coupled with the restructuring of the health service at a national level, meant that funding ceased for a period of time. A review of the strategy a number of years later found that many targets had not been met, and that there was evidence of inequity around variations in service models, delivery and choice (Mental Health Reform 2015). In addition to issues of funding, key factors fundamental to successful implementation which appeared to be absent included authoritative and accountable leadership as well as methods of identifying and addressing main resistors to change (Johnson 2014).

Even allowing for economic recession and statutory reorganisation, Ireland has historically had a low national spend on mental health services, accounting for only 5.1% of the overall health budget in 2021 (Mental Health Reform 2021). This compares unfavourably with other countries such as the UK, where the figure is 12.0% and it is widely acknowledged that mental health services are underfunded in Ireland (O'Connor et al. 2020).

In 2020, a newly launched policy 'Sharing the Vision' (DOH 2020) seeks to prioritise mental health difficulty as a major societal issue. It has at its core, key deliverables in terms of prevention of mental health difficulties as well as an expansion of services to address a broad spectrum of needs, taking a life cycle approach and noting that health outcomes for individuals with a dual diagnosis are improved by ensuring greater levels of collaboration between mental health and other services (DOH 2020).

In doing so, it reverses the recommendations in earlier policy (A Vision for Change) which stated that specialist mental health services should only support individuals *'whose primary difficulty is mental health'* (DOH 2020, p. 53).

This policy has an organising framework with a number of service delivery principles which comprise four domains: prevention and early intervention; access to and co-ordination of services; social inclusion and accountability. Underpinning its service philosophy are a number of core values, including respect, compassion, equity and hope. This focus on person centred care is based on a recovery framework which is trauma informed and has a human rights approach (DOH 2020). While recognising that mental health difficulties and SUD/AUD can negatively impact on each other, it nonetheless acknowledges that access to primary care for individuals with a dual diagnosis is complicated (DOH 2020).

Substance Use Policy

The response to SUD was initially rooted in the Criminal Justice System with the publication of legislation (Misuse of Drugs Act 1977). The advent of the first 'heroin epidemic' in the late 1980s, which resulted in large numbers of drug related deaths prompted the establishment of Government led initiatives based on an abstinence model. Most drug treatment programmes were hospital based and there was strong emphasis on a criminal justice approach to the illegality of substance use (Butler 2017).

This attitude continued into the 1990s, although there was a shift towards a harm reduction approach with the discovery of Human Immunodeficiency Virus (HIV) leading to the introduction of opioid substitution treatment (OST). While there was a health focus on reducing harm for injecting heroin users, a further aim was the reduction of associated criminal activity (acquisitive crime) and organised crime. SUD/AUD therefore remained primarily an issue for the criminal justice system (Butler 2017; O'Gorman 1998). The absence of health-focussed support led to a strong community response prompting Government to act locally, with policy endorsement emerging at a much later point in time (European Monitoring Centre for Drugs and Drug Addiction [EMCDDA] 2016).

Initial drug policy in Ireland focused on illicit substances and its associated health issues (Department of Community, Rural and Gaeltacht Affairs 2001). Subsequent policy documents made reference to dual diagnosis, noting that 'a significant number of people have coexistent mental health and substance misuse problems.' (Department of Rural, Community and Gaeltacht Affairs [DRCGA] 2007 Working Group on Drugs Rehabilitation 2007, p. 18). A further report recommended that individuals with a dual diagnosis within residential drug and alcohol services should have clear pathways into support where needed (Corrigan and O'Gorman 2007).

Alongside SUD, is widespread acceptance that problem alcohol use is a considerable public health issue in Ireland with an estimated 1.35m people in Ireland classified as harmful drinkers (Health Research Board [HRB] 2016). Despite this and its links to morbidity, health issues and suicide (HRB 2014), it was not until 2009 that alcohol was included as part of a strategy on harmful substance use (Department of Community, Rural and Gaeltacht Affairs 2009).

A report on this strategy highlighted a number of issues on treatment of individuals with a dual diagnosis, including problems with assessment, collaboration between mental health and substance use services as well as treatment approaches (Garbare 2015).

More recent policy, 'Reducing Harm, Supporting Recovery', recognises the health and social problems associated with harmful illicit substances as well as alcohol use and focuses on a health led response (DOH 2017). As such, it acknowledges that people experiencing these issues need a comprehensive range of services to enable them to live meaningful lives (Mayock, Butler and Hoey 2018).

Lying within the remit of the Social Inclusion Division of the HSE, this new policy proposes a 'continuum of care model' where the emphasis is less on treatment and more on social care (family supports, housing, educational, criminal justice and healthcare supports) and acknowledges the need for an 'integrated care pathway 'and as such can be viewed as employing a human rights based approach (DOH 2017). It also recognises that people experiencing homelessness are at a far higher risk of SUD/AUD than people in secure housing, and that while SUD/AUD can lead to homelessness, the experience of homelessness can also contribute to the development of SUD/AUD (DOH 2017).

In noting during public consultation on the strategy a concern about access to services for individuals with a dual diagnosis, the policy recognises the importance of timely access to appropriate treatment and it is at this stage that the first reference is made to the potential development of a model of care as a joint collaboration between the mental health division of the HSE and the Clinical Strategy Programmes Division. Referred to as a Mental Health Clinical Programme called 'Dual Diagnosis: mental illness and co-morbid substance misuse' (HSE 2019), the aim was to develop a *"…standardised evidence based approach to the identification, assessment and treatment of co-morbid mental illness and substance* misuse" based mental health policy of the time (Vision for Change) (Department of Health 2017, Reducing Harm, Supporting Recovery p. 45).

Housing Policy

Housing in Ireland is covered by a number of legislative Acts and has at its core a narrow definition of homelessness, defined under specific circumstances (including those in emergency accommodation or on the streets, those who become homeless as a result of economic difficulty or under the threat of violence (Dublin Regional Homeless Executive [DRHE] 2019). This is at variance with the more inclusive European Typology on Homelessness and Housing Exclusion (ETHOS) interpretation of homelessness developed at European level, which also includes insecure or unsuitable housing (European Federation of National Organisations work with the Homeless [FEANSTA] 2014).

HHI is driven by a number of factors (Focus Ireland 2020) and is identified as an important social determinant of health. Thus, secure housing is seen as central to the health of individuals directly impacted by their conditions of daily living and the level of resources available to them as a result (Whitehead and Dahlgreen 1991; WHO 2013). In recognising that those with complex health needs would need a combined governmental response, the HSE proposed an integrated approach to homelessness and addiction. This involved a number of key stakeholders (DOH, Department of Housing, Planning and Local Government, [DHPLG], Local Authorities, HSE) in the adaptation of a Housing First model in line with policy (Government of Ireland 2016). However, due to an inadequate supply of social/affordable housing, that policy was largely seen as a failure, and homelessness figures have increased year-on-year (Hearne 2020; Social Justice Ireland 2020) in spite of the fact that secure housing is seen as crucial to the stability of adult individuals with a dual diagnosis (Padgett et al. 2006).

In ratifying the United Nations Convention on Rights for Persons with Disabilities (UNCRPD 2006) in 2018, Ireland committed to meeting its obligations under the Convention on a number of key areas, including the right to adequate housing and being included in the community under Article 19 (UN 2006).

Alongside general housing strategy, policy was specifically developed to address the needs of people living with a disability to ensure that they had access to secure, appropriate housing. This policy included the needs of people with mental health difficulty, recognising that such difficulty could lead to challenges securing and maintaining appropriate housing. Viewed as a key element in the continuum of care for people with mental health difficulty and providing a pathway to recovery, the policy sought the development of a management framework between relevant housing agencies aligned with the provision of community based supports (Department of the Environment, Community and Local Government [DECLG] 2011).

More recent housing strategy for people with disabilities is committed to the provision of Housing First tenancies for those with complex needs and typically with a history of use of emergency accommodation supported by additional one-bed social housing units. It also commits to strengthening integrated pathways for people who are homeless with chronic health need based on an inclusion health model (Department of Housing, Local Government and Heritage [DHLGH] 2022).

This commitment is also contained in more general Irish housing policy - ‘Housing for All’ (DHLGH 2021) - which has strategies for both the prevention of homelessness as well as the provision of support services for homeless people, especially those with complex issues. Amongst its targets is the achievement of 1,200 new Housing First tenancies over a five-year period, which it is envisaged will be achieved by a number of joint initiatives between government departments in housing and health liaising with local authorities and NGOs (DHLGH 2021).

2.4 Recovery Philosophies

The focus on an understanding of recovery as a personal and social process that goes beyond symptom reduction in both SUD/AUD and mental health difficulty and reflects a move away from medical or criminal justice models towards a broader acceptance that recovery exists within the individual as they operate within their social environment (Brekke et al. 2017).

Recovery, then, is defined as a process whereby a person can regain a meaningful sense of community belonging, coupled with a positive sense of identity that is apart from one’s condition while rebuilding a life in spite of, or within the limitations of, that condition (Davidson et al. 2007).

Recovery in Mental Health Difficulty

Moving from institutionalisation towards care in the community affected societal views of mental health difficulties and saw a shift from a predominantly medical model to a more holistic model (Walsh 2015), with an acknowledgement that recovery was less about 'cure' and more about social functioning (Morant 1998).

This move away from a medical model is reflected in current Irish policy where recovery in mental health is seen as the attainment of personal goals:

'Recovery means people experiencing and living with mental health issues while pursuing the personal goals they want to achieve in life, regardless of the presence or severity of those mental health difficulties … this is best achieved through the primacy of personal decision making, supported by informed clinical best practice and lived mental health experience.' (DOH 2020 Sharing the Vision, p. 17).

Recovery in SUD/AUD

Recovery in SUD/AUD, contained in Irish policy 'Reducing Harm, Supporting Recovery' has an emphasis on viewing the issue of SUD/AUD as one that affects communities and families, as well as individuals. It aims to help those with drug or alcohol problems to *'address their personal health needs and improve their health, well-being and quality of life'* (Department of Health 2017, pp8). As such, it has a focus on the individual recovery goals determined by the person presenting for support.

Recovery as Based Within a Human Rights Framework

Both of these recovery goals are based on a human rights framework (UNCRPD 2006) and reflects a shift in the recognition of the equal right of people living with psychosocial disabilities replacing *'the dualistic model of capacity versus incapacity with an equality based model that complements full legal rights to individual autonomy and self-determination with entitlement to support when needed.'* (Minkowitz 2007, p. 408). Such values are contained in the concept of personal recovery (as opposed to clinical recovery) where change occurs as part of a connection to community, and is characterised by partnership, equality and choice (Watson et al. 2014).

Recovery Capital

The achievement of recovery therefore is best placed within the framework of Cloud and Granfield's (2008) concept of Recovery Capital, which refers to the totality of resources necessary to initiate and maintain recovery. Initially conceptualised as a framework for recovery in SUD/AUD, the key components of recovery capital apply equally to individuals with a dual diagnosis in that it has a focus on four key areas required for recovery:

- Social capital (relationships/family)
- Physical capital (employment, housing)
- Human capital (skills, education, positive health)
- Cultural capital (the ability to belong to predominant social groupings).

Recovery has significant implications for the wider physical and lived community in that it exists not just within the person themselves. This concept provides a mechanism for continued and ongoing care (Best and Laudet 2010). Equally, achieving some or all of the tenets of recovery capital enhances resilience, reduces stress levels and improves quality of life. As such, higher levels of recovery capital can predict sustained recovery (Laudet and White 2010).

2.5 Perspectives on Recovery

Individual Perspectives on Recovery

Recovery in mental health is seen as both as a process and as an outcome. It has been described by service users as being dynamic, albeit with a heavy emphasis on the concepts associated with medical models (i.e., being discharged from hospital settings, levels of medication etc) (McCabe et al 2018).

Recovery in SUD/AUD has a variety of meanings to individuals and ranges from complete abstinence to medically assisted recovery, with a number of points in between. For service users, recovery is seen as a multidimensional process, of which abstinence is just one aspect, with a need for continuing commitment to the recovery journey (Costello et al. 2020).

The recovery journey is viewed as a move through a number of phases – from a traumatic past, through an episode of change, and into an ongoing recovery phase (Stott and Priest 2018).

A review of qualitative studies on the concept of recovery for individuals with a dual diagnosis suggests that it has a number of focuses including the ability to participate in the community, holistic individualised treatment, personal ownership of one’s own life as well as meaningful activities (De Ruysscher et al. 2017).

Stakeholder Perspectives on Dual Recovery

Despite the growing evidence and call for integration between mental health and addiction services in recovery oriented practice, there has been a range of long-standing historical, political, ideological, professional, structural, and practical barriers which act as impediments to dual recovery (Brekke et al. 2018; Davidson and White 2007). Notably, this integration entails stakeholders with differing perspectives, philosophies and understandings of recovery coming together (Baldacchino et al. 2011; Davidson and White 2007; James et al. 2013, Leamy et al. 2011).

There are three separate treatment systems involved in dual recovery in Ireland - Mental Health Services, Primary Care Services and Addiction Services (including Community-based Organisations) (HSE 2019), each with its own and often polarising philosophies and approaches to care from abstinence to substance use acceptance/ harm reduction (Brekke et al. 2018; Garbare 2015; Laudet 2008; Roberts and Bell 2013). As a result, barriers exist with the professionals involved, which include: lack of professional commitment; poor communication; trust issues; confidentiality concerns as well as the availability of resources. All of these have the capacity to hinder the implementation of effective Interagency work, which is seen as crucial to attaining dual recovery (Armstrong and Barry 2014; Atkinson et al. 2005; Baker et al. 2007; Cameron et al. 2014; Carra et al. 2014; Duggan and Corrigan 2009; Garbare 2015). There is a concerted call for a joining of disciplines and philosophies through joint training to enhance relevant stakeholders’ knowledge and understanding of each other's perspectives and treatment approaches to dual recovery (Brekke et al 2018; Cameron et al 2014; James et al 2014; Prendergast et al 2015).

Individuals with lived experience of dual diagnosis often disagree with services' perspectives of recovery and sometimes feel professionals believe that they should not have a role to play in their own recovery planning (Deegan and Drake 2005).

2.6 Models of Care and Service Integration

Models of Care

Models of care for individuals with a dual diagnosis have been shown to occur as either sequential or parallel processes. In sequential (also known as serial) models, service users receive intensive SUD/AUD treatment (typically inpatient) with less intensive treatment for mental health difficulty afterwards (Darke et al 2009). A useful approach in instances where there is, for example, a medically complicated withdrawal, it often fails to take into account the interactive nature of dual diagnosis (DeVido and Weiss 2012). In serial service provision models, there may also be an issue with treatment for one disorder and not the other for a variety of reasons including exclusion criteria (such as excluding an individual from accessing mental health supports because of substance or alcohol use), clinician belief or lack of education (Garbare 2015).

Parallel approaches involve simultaneous treatment of both disorders from separate services using disease specific treatments (Woody 1996). As an alternative to the serial treatment approach, it may seem ideal but can be difficult to achieve given lack of collaboration and divergent treatment philosophies (Mueser et al. 2003).

Given the complexity of dual diagnosis and the multiplicity of interventions that may be required, an integrated model of care is deemed most appropriate. Integrated treatment is defined in this instance as a combination of treatments from SUD/AUD and mental health service providers, delivered in the same treatment programme or by the same treatment provider (Ziedonis et al. 2005). In this way, there is no need for coordination of services, both disorders are viewed as primary and philosophical differences are reduced (Meuser et al. 2003). Integrated approaches face some barriers, particularly around increased demands on care teams, the need for cross-training as well as issues around monitoring and evaluation of such programmes (Thylstrup and Johansen 2009).

Regardless of the framework used, the most appropriate treatment approach for individuals with a dual diagnosis should be based on their individual needs. So, while integrated treatment may be most effective in the management of severe dual disorders (Psychosis co-presenting with SUD/AUD or Schizoaffective Disorder with SUD/AUD), a parallel or sequential model of care may be appropriate for those with low risk of re-occurrence and where the mutual influence of each disorder is of less importance (Garbare 2015).

In conceptualising a response to client need, a common approach is to employ a four quadrant framework where the severity of disorder determines the level of care needed. In such frameworks, an occasional user of illicit substances who starts to struggle with depression after weekend use would be placed in a quadrant where their locus of care would be in primary health care settings. Where both mental health difficulty and substance use is more severe the locus of care is centred in formal psychiatric services and predominantly in hospital settings (Garbare 2015).

Service Integration

There is a clear consensus that integration between addiction and mental health services is long overdue (Davidson and White 2007; Druss and Golmand 2018). Health and social care systems are often not equipped to deal with more than one problem at the same time so support has existed for only one need – either SUD/AUD or mental health. Separate providers deliver separate services and often have separate funding streams and therefore competing outcome measures. As a result, people's needs remain unmet due to 'service rejection' (Turning Point 2016).

Current policy recognises that there is a significant overlap between the two conditions (Department of Health 2017). However, the historic structures of separate mental health and addiction services limit their capacity to provide a system that will serve those with dual diagnosis. These structures are restricted by their focus on the specifics of mental health difficulty or SUD/AUD, as opposed to taking a realist approach (Minyard et al. 2019). Research in Ireland examining the problems around addressing dual diagnosis found that in some instances even referral proved problematic, with mental health services only accepting referral via general practitioners (GPs) while addiction services accepted referrals from a wide variety of sources including self-referral. A further barrier to provision of services was the fact that exclusion criteria applied to those presenting with dual diagnosis – for example people with SUD/AUD were excluded from accessing mental health services and vice versa (Long 2005).

Recognising that a dual approach would serve this cohort better, both the HSE and the College of Psychiatrists of Ireland began developing a Model of Care based on the 'A Vision for Change' mental health policy. Developed within the confines of that strategy and psychiatrist led, its focus was on people with severe mental health difficulty and SUD. It excluded those with AUD completely. It envisaged the care of individuals with a dual diagnosis as being within the remit of the mental health services only, excluding people presenting with AUD and employed a top-down development of a model of care (HSE 2018).

2.7 Considerations for a dual recovery approach

Recovery as a Social Process

There is a widespread acceptance that recovery should be seen as a personal and social process that goes beyond symptom reduction in the fields of mental health and SUD/AUD and the individual is considered the central actor and decision maker in their own recovery journey. In this understanding, both personal and structural factors are recognised, and day-to-day life is the central area for change (Brekke et al. 2018).

As part of recognising these personal and structural factors, such dimensions are echoed in further studies, with inappropriate or insecure housing and financial limitations seen as major obstacles to that recovery journey (Brekke et al. 2017; Skogens, von Greiff and Topor 2017).

Complexity of Care Systems

There is little doubt from the literature that recovery is facilitated by a number of factors, but equally that there are a number of barriers that serve to impede a recovery journey. Barriers include lack of individualised help and the complexity of care systems where individuals find that services are uncoordinated (Ness, Borg and Davidson 2014). Within care systems themselves, there is a need for trust and meaningful relationships with care teams as well as integration of treatment and organisation of care (Brekke, Lien and Biong 2017; van Wamel, Lempens and Neven 2021). Central to care relationships is the need for continuation of care, as it correlates to commitment to treatment, improved service satisfaction and community engagement (McCallum et al. 2015).

2.8 Social Issues Around Dual Diagnosis

There are a number of social issues existing around dual diagnosis which act as barriers to dual recovery.

Homelessness and Housing Insecurity

Homelessness is viewed as an extreme form of social exclusion, with evidence of more complex needs, higher levels of SUD/AUD and mental health difficulty than in the general population. Individuals with a dual diagnosis are more likely to experience chronic homelessness than the general population (Tsemberis, Gulcur and Nakae 2004).

Individuals with mental health difficulty, SUD/AUD and or/homelessness are over-represented in the Irish criminal justice system, with early research putting rates of (typically) SUD/AUD at between 61.0% and 79.0% of all prisoners (Kennedy et al. 2005). There is also over-representation of severe mental health difficulty in prisons, with affective disorders and psychosis accounting for 7.9% of the prison population (Gulati et al. 2019) and psychosis is almost ten times the rate seen outside the criminal justice system (Linehan et al. 2005). Homelessness, inextricably linked with both mental health difficulty and SUD/AUD, accounted for 17.4% of all criminal committals (Gulati et al. 2019).

The development of a Housing First model is based on the concept of housing as a basic human right, although this is not currently enshrined in Irish law (Social Justice Ireland 2021), with housing being provided irrespective of psychiatric treatment and/or SUD/AUD sobriety. This model also envisages support, including treatment, as well as other services designed to connect the individual with their community and social networks. This continuity of care in housing is seen as crucial for engaging in recovery as well as enabling positive effects on residential stability and no exacerbation of either psychiatric or substance use for dual-diagnosed individuals (Tsemberis, Gulcur and Nakae 2004).
As discussed earlier (Section 2.3) while there is a Housing First approach included in recent Irish policy, it is seen to be problematic and underfunded (Social Justice Ireland 2020).

Social Exclusion

Social exclusion refers to a lack of full participation in society and is considered a driving force in health inequality. There is evidence that there is an association between high levels of social exclusion (and thereby low levels of social inclusion) and mental health outcomes (van Bergen et al. 2019).

Both mental health difficulty and SUD/AUD on their own are considered a form of social exclusion. Disruption in family relationships is prevalent, often permanent, and hugely disruptive to family and social networks (Copello et al. 2010; Duggan 2012; Orford et al. 2010; Rossow and Hauge 2004; Von Kardoff et al. 2016).

People experiencing mental health difficulty place great importance on social connections (Wang et al. 2017) while also experiencing greater levels of social exclusion and smaller social networks than the general population (Clinton et al. 1998). This can further exacerbate mental health difficulty (Goldsmith et al. 2002; Richman and Sokolove 1992; White et al. 2000).

Equally, people with SUD/AUD report limited social and family connections, lower levels of employment and higher levels of social exclusion (Schafer 2007; Stewart et al. 2007).

Homelessness represents the most extreme form of social exclusion as many of the characteristics of homelessness are also components of social exclusion (lack of housing, poor social support, poverty) (Anderberg and Dahlberg 2019; European Commission 2010; Fazel et al. 2014; Vrooman and Hoff 2013).

Stigma

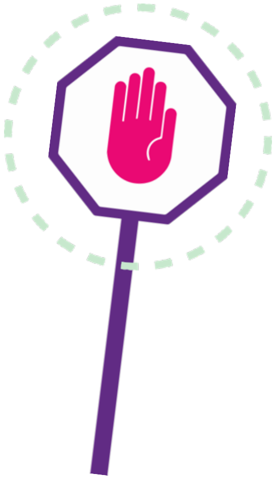
Stigma is generally referred to as a social process, which is characterised by adverse social judgment of either a person or a group, leading to exclusion, rejection, blame or devaluation (Weiss, Ramakrishna and Somma 2006). Stigma (and as a result, discrimination) can be evident in personal relationships as well as in wider settings such as work, healthcare and housing.

Stigma and discrimination against people with SUD/AUD or mental health difficulty is common and has a significant negative impact on people’s lives (Evans-Lacko and Thornicroft 2010).

The role that stigma and discrimination has in the lives of individuals with a dual diagnosis is not well researched. However, there is evidence that such people experience higher levels of structural discrimination in healthcare settings, face more barriers to receiving appropriate care, and that their quality of care is worse than those with either SUD/AUD or mental health difficulty alone (Evans-Lacko and Thornicroft 2010). Social contact has been found to be an effective intervention to improve attitudes and knowledge around such stigma (Thornicroft et al. 2016).

2.9 Overcoming Integration Barriers

Research in Ireland employing a rapid realist review of evidence-based approaches to the identification, assessment and treatment of individuals with a dual diagnosis made a number of recommendations within a four-level framework that seeks to provide a structure to integrate services in the provision of support to individuals with a dual diagnosis. These included the following: Policy/Systems (where alignment of resources is the key focus); Organisations/Providers (where building a knowledgeable workforce is key); Service/Treatment (where shared knowledge is key) and Individual/Family (involved in co-production in the development of each level of the system) (Minyard et al. 2019).



Components of this review emerged around integration of services, access to services and treatment. A critical aspect of this is linked to common language, dialogue competence and service provider confidence. As a result, initial steps towards integration of SUD/AUD and mental health services to provide care for individuals with a dual diagnosis is seen to be the development of a common language that is shared and understood by all involved in the process – from service providers to service users and families. This would allow for comprehensive dialogue which, combined with training programmes, can result in competencies that are understood and accepted by all involved. This rapid realist review also found a need to incorporate the lived experiences of service users in providing training so that staff knowledge and skills are enriched and have capacity to change (Minyard et al. 2019).

Funding infrastructure in Ireland was also seen to be a potential barrier to integration, with two separate structures in existence. Traditionally, mental health is directly funded by the DOH and the HSE. Treatment for SUD/AUD is largely funded (with the exception of OST Clinics and some detox units) by a combination of grants and fundraising, often via community-based Local Drug and Alcohol Task Forces (LDATFs), to a range of voluntary, community and NGO service providers (O'Gorman et al. 2016). This leads to not just to a barrier to alignment from a funding point of view, but also from other resources required (such as low numbers of psychologists within the system) (Minyard et al. 2019).

2.10 COVID-19 and the Beginning of Integrated Services?

The declaration of COVID-19 as a pandemic on March 11th 2020 by the World Health Organisation (WHO 2020) led to dramatic organisational change in healthcare delivery in Ireland as the country introduced wide ranging restrictions to combat the spread of the disease (HSE 2020). Defined as a vulnerable group early on in the pandemic, considerable effort was put into the provision of a coordinated response to those experiencing homeless as well as people with SUD/AUD. This involved the combined working of a number of agencies providing support to this cohort (O'Carroll, Duffin and Collins 2020).

A Winter Plan was drafted for 2020/2021 to ensure that people with complex issues could experience a 'continuity of care' during the pandemic, though much of the funding was based on physical rather than mental health (HSE 2020). A new plan for Winter 2021/2022 focusses on pathways for care over the period for people experiencing social exclusion (mental health difficulty, SUD/AUD and homelessness) and seeks to both continue treatment and housing initiatives as well as enhanced case management and integrated care for this vulnerable group (HSE 2021).

However, it is also clear that, as in many other countries, the mental health impact of the pandemic was left largely unattended and there is clear evidence that psychiatric care was neglected (Torales et al. 2020; Xiang et al. 2020). Research carried out in 2020 (in the early stages of the pandemic) with a cohort of people in Dublin experiencing mental health difficulty, SUD/AUD and or HHI showed increased levels of mental health difficulty and lapses in SUD/AUD (Merchants Quay Ireland [MQI] 2020).

2.11 Towards Dual Recovery

There is little doubt that SUD/AUD and mental health difficulty as separate experiences create a high level of demands on individuals, services and society. Combined, the situation becomes more demanding (Thylstrup and Johansen 2009) and individuals with a dual diagnosis experience a wide variety of negative outcomes, including increased physical ill-health, exacerbation of symptoms, higher rates of relapse as well as violent behaviour, suicide and homelessness (MacGabhann et al. 2004).

In spite of this, there is evidence to suggest that there is significant lack of care for this population. Across six European countries (France, Finland, Scotland, Poland, England and Denmark), services that were aimed exclusively at dual diagnosis accounted for only 1.2% of all centres, while SUD/AUD treatment accounts for 21.4% of services and mental health 34.1% (Baldacchino et al. 2011). There was some evidence of networking, but less than one third of the services had a joint care agreement with another centre (Baldacchino et al. 2011).

A study in Norway explored coordination between SUD/AUD and mental health services for individuals with a dual diagnosis and found that there was fragmentation in services, unclear perceptions of the work and expertise of other service providers as well as poor information exchange that generally occurred in written format – leading to the creation of stereotypes both within and between services (Bjorkquist and Hansen 2018). At present Ireland operates six services specifically for individuals with a dual diagnosis that engage in local integration efforts between mental health and SUD/AUD services (Minyard et al. 2019; Oppeboen, O'Driscoll and Ryan 2015).

The recently published 'Sharing the Vision' implementation plan for the next two years makes the following recommendation on dual diagnosis: 'A tiered model of integrated service provisions for individuals with a dual diagnosis (e.g. substance misuse with mental illness) should be developed to ensure that pathways to care are clear.' (HSE 2022, p. 87). The aim is to develop a specific framework across HSE a number of HSE divisions including primary care, mental health and acute hospitals so that individuals with a dual diagnosis can engage with a single service for focussed treatment. Community-based addiction services are to be developed or enhanced with psychiatry input as required (HSE 2022).

3.0

METHODOLOGY

3.0 MEDTHODOLOGY

3.1 Introduction

This chapter documents the methodological approach to the study as well the specific methods used. In doing so, it provides details of the research design, sampling and recruitment and data protection issues.

3.2 Study Background

Mental Health Reform (MHR), which funded this study, is a leading provider of the promotion of mental health in the voluntary sector in Ireland. As a National Coalition on mental health, MHR has 77 member organisations representing a broad range of interests and provides a unified voice in campaigning for the progressive reform of mental health services and support.

As an advocate for people with mental health difficulty, the organisation has a good understanding of the often inextricable link between mental health difficulty and SUD/AUD as well as homelessness. MHR hosted an online roundtable discussion on the concept of dual diagnosis and specifically dual recovery (16.11.2021), which was attended by 29 members from a range of organisations (both statutory and non-statutory). This qualitative study sought to provide further exploration of the issues raised at the roundtable discussion.

3.3 Study Aims and Objectives

This research piece is a qualitative analysis of the concept of dual recovery, its meaning as well as the barriers to achieving dual recovery for individuals with a dual diagnosis as perceived by service providers in the field of mental health difficulty, SUD/AUD, homelessness and dual diagnosis.

Specifically, the research aims to achieve the following:

- To explore recovery philosophies in mental health difficulty and SUD/AUD amongst service providers
- To describe existing care pathways and access to care
- To understand how service providers experience training
- To examine how service users are engaged in care planning
- To identify gaps in service that impede dual recovery

3.4 Research Design

This study used a qualitative approach, which allowed participants to explore their own views and understanding, from both a personal and organisational perspective, of the meaning of dual recovery and what is needed to achieve that aim.

A semi-structured, open-ended interview schedule was used. This allowed participants to move between narratives as they explored their understanding of the issues. Topics included recovery, care pathways, engagement of service users as well as barriers that operate in the space which have the potential to negatively impact dual recovery. Collecting data in this way allows for presentation of findings in an explanatory manner (Charmaz 2007; Corbin and Strauss 2014).

Sampling

Purposive sampling was used in this study in order to ensure that the data collected represents a broad range of voices from organisations involved in the direct or indirect care of individuals with a dual diagnosis. Specifically, the researchers sought to elicit the views of four distinct groups, all of whom were already providing some level of cross-sector care. This included organisations providing care in the following areas:

- Predominantly in the area of mental health difficulty (but including addiction and/or housing services)
- Predominantly in SUD/AUD (but including mental health difficulty and/or housing services),
- Predominantly in the area of Housing/Homelessness (but including support for mental health difficulty and/or SUD/AUD)

In addition to:

- Senior Stakeholders involved at policy or advocacy level in the provision of care for individuals with a dual diagnosis

3.5 Recruitment and Consent

Initial email and phone contact was made by MHR following the roundtable discussion, and participants who were working in the area of service provision as well as those involved in dual diagnosis at policy level were asked if they wished to participate in further research, or to identify someone in their organisation who would be placed to do so. In total, twelve (n=12) participants were initially contacted by email and invited to take part in the study.

A Participant Information Leaflet (PIL) and Consent Form (See Appendix 1) were attached to the email and potential participants were given a period of one week to decide on whether or not to participate. Consent forms were returned to the assigned researcher prior to interview.

More than half (n=7) of those contacted in this way either agreed to interview or proposed a member of their organisation to participate. The remaining five (n=5) participants were recruited as a result of recommendations by the initial participants as the interviews progressed.

In total, twelve (n=12) participants agreed to interview. The majority (n=9) were from three different organisations who predominantly provide services to those with mental health difficulty, SUD/AUD and housing (but also provide cross-care). The remaining participants (n=3) provide support for individuals with a dual diagnosis at policy or advocacy level.

3.6 Data Collection

Interviews were conducted over the period of 26.11.2021 to 10.12.2021. Interviewees were given the option to be interviewed by phone, by Zoom or in person. The majority (n=11) opted to be interviewed via Zoom and one participant stated a preference for an in-person interview which was facilitated at a safe location and which operated within COVID-19 guidelines.

Interviews were divided between the two researchers on the project. In instances where one researcher had previously been engaged in research for any particular organisation, the second researcher conducted the interview in order to eliminate bias. Interviews lasted between 22:03 and 46:22 minutes and were on average 36:00 minutes in length.

Data Analysis and Anonymisation

Interviews were transcribed verbatim and all potentially identifying information was removed from the transcripts. Each participant was assigned an alpha-numeric code and data was fully anonymised. Each participant was assigned a pseudonym for use in the final report. Participants are referred to as representatives of their agencies using broad terms.

Interviews were analysed using NVivo (Version 1.5.2) (a software programme widely used for analysis of qualitative data). Utilising the Framework Method, which has been in use since the 1980s and developed by Ritchie and Spencer (Ritchie et al. 2003), allowed for the creation of an analytical framework whereby data was organised into categories that were jointly developed by the researchers. This created a new structure for the data that allowed for analysis in such a way that it was helpful in answering the research questions. In identifying commonalities and differences in the data, the researchers were able to draw descriptive explanations clustered around themes (Gale et al. 2013). This allowed for a lucid, synthesised and valid interpretation of the data provided in the interviews.

Data Protection

Where interviews were conducted using Zoom, a separate recording device was used to record the interviews. All identifying information was removed during transcription, and all transcripts were held using an alpha-numeric code. The key to this code was held separately. All laptops and recording devices were double-encrypted and stored in a secure, locked office. Consent forms were stored in paper format in a locked filing cabinet in a locked, secured office. All GDPR guidelines were strictly adhered to, and only the immediate members of the research team had access to the study materials.

Payment

No payment was offered for participation.

3.7 Challenges with the Study

COVID-19 Restrictions

Restrictions around COVID-19 meant that the majority of interviews (n=11) were conducted online via Zoom.

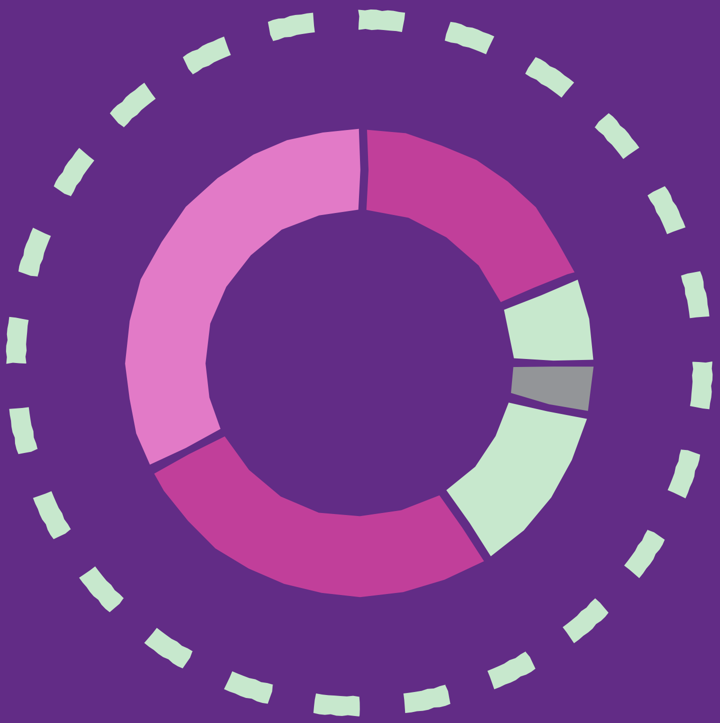
Recruitment

The initial decision to recruit organisations that provide a level of cross care meant that those engaged in the provision of care for one exclusive cohort (i.e. providers for those with mental-ill health without SUD/AUD) did not participate in this study. As a result, the experiences of those agencies are absent from the study.

Sample Size and Generalisability

The project aimed initially to interview between 9 and 12 participants providing a range of services, or engaged in policy, for individuals with a dual diagnosis. Qualitative research is not aimed at making generalisations to a larger population but is concerned with induction and is emergent in the nature of its findings (Charmaz 1999). As a result, there is no ideal sample size, and data collection is deemed to be complete where no new or relevant data emerges (Mason 2010). This concept of data saturation is widely accepted as a methodological principle in qualitative research (Saunders et al. 2018). Evidence from studies using a qualitative approach has a role to play in adding value to reviews of policy and practice (Noyes et al. 2015).

> **..The project aimed initially to interview between 9 and 12 participants providing a range of services, or engaged in policy, for individuals with a dual diagnosis..**



4.0

FINDINGS

4.0 FINDINGS

This chapter presents the views of the participants in this research study on their understanding of recovery, models of care and barriers to the achievement of dual recovery. Themes that emerged from the interviews reflected a number of issues around differing philosophies of recovery, which in turn led to divergent models of care for individuals with a dual diagnosis. This divergence has led to the creation of a number of barriers to the provision of care for this cohort, including problems in collaboration, training and access to planned and continuing care for individuals with a dual diagnosis. Participants also pinpointed a number of social barriers that exist including homelessness and housing insecurity, social exclusion and Participants also discussed the impact of COVID-19 restrictions on the provision of care to individuals with a dual diagnosis, where healthcare was geared towards physical/public health to the detriment of individuals with mental health difficulties. Finally, their discourse explored a proposed new model of care for individuals with a dual diagnosis, which offers cautious hope.

4.1 Divergent Philosophies

4.1a Divergent Recovery Philosophies

Holistic Approaches to Recovery

In discussing the meaning of recovery, all (n=12) of the participants referred to recovery in different ways yet with a similar recurring theme – that recovery is seen as an individual journey underpinned by a person-centred holistic approach which should involve a continuum of care. Also key to this understanding is the need for an acceptance that both mental health difficulty and SUD/AUD recovery is a process that can be subject to set-backs.

> ***‘That people would have a place in their community … and would have meaningful activities that they are engaged with. [And for people with severe mental health difficulty] that they are engaging with their mental health team … and not becoming unwell.’***
> (Eva, Mental Health led NGO)
>
> ***‘First of all, it is supporting people to manage whatever diagnosis or symptoms they have to live a quality of life … it’s providing supports to do that.’***
> (Annemarie, Housing led NGO).
>
> There was also talk of the need to develop greater levels of understanding that both mental health difficulty and SUD/AUD recovery which is not characterised by a forward linear progression. ***‘[For young people especially] it’s to have key people who understand the journey and the nature of lapse and relapse on the recovery journey … and significant intervention from services to be able to identify step down services in the community that can support them on that journey.’*** (Matthew, Statutory Agency)

Recovery as a Poorly Understood Concept

Only three of the participants felt that this holistic approach to recovery was widely understood and accepted. The majority (n=9) felt that the concept of recovery was poorly understood and linked back to a medical model of recovery, which was enmeshed in early approaches around abstinence models and criminal justice approaches.

> ***'I don't think there's a common understanding of recovery. I don't think there's a common understanding of addiction. I don't think there's a common understanding of mental health I definitely don't think there's a common understanding of dual diagnosis.'***
> (Caroline, Statutory Agency).
>
> ***'[In earlier strategy] it wasn't the word recovery … rehabilitation was the word that was used. It is quite polarised still. It was much more polarised in the past.'***
> (Colm, SUD/AUD led Community/Voluntary Agency).

Recovery in Practice

The absence of consensus on recovery philosophies led a number of participants to pinpoint issues around translating policy into action.

> ***'Vision for Change was a disaster. It was*** **[a manual on]** ***how not to have dual diagnosis services. It was a mandate for showing the door to drug users for fifteen years. Pathways were just completely shut. There's a hundred and eighty degree turn with Sharing the Vision, with mandates for dual diagnosis. That's not enough because in Ireland we're very good at making policies but we're not so good at implementing them. Party budget, partly mind-set. '***
> (Colm, SUD/AUD led Community/Voluntary Agency).
>
> ***'Everyone is working in their own little silos. I think that there has been a shift in it*** **[a holistic concept of recovery]** ***but we're actually very far away from getting it implemented in services.'***
> (Maria, SUD/AUD led NGO).
>
> ***'At one level, it is a concept that is accepted, or at least it's there… it's about practice and putting it into practice. What does recovery look like in practice?'***
> (Laura, Mental Health led NGO).

4.1b Divergent Models of Care

The participants in this study who are directly engaged in service provision (n=9) are all engaged in some level of integrated or cross-care. Initially established as services to provide support to either people experiencing difficulties with mental health or with SUD/AUD or with homelessness, their services have evolved into integrating the needs of individuals who present with any or all of these issues. Their discourse is a reflection of the models of care that they have developed in response to perceived need.

> ***'We recognised*** **[some years ago]** ***the need for mental health … and we're seeing increased need for that. The biggest challenge for us is the whole dual diagnosis bit and linking in*** **[with hospitals, homeless services]*****. So, we've built our mental health team … quite a bit ourselves***

> ***from fundraising. And that kind of multi-dimensional collaboration approach … at least you're trying to address whatever the needs are.'*** (Barbara, SUD/AUD led NGO).
>
> Eva, who advocates for individuals with a dual diagnosis, felt that the ideal model of care would be within the primary care centre which would house both a CMHT and an addiction service, with ***'a real integration between the two … as well as an assertive outreach element.'*** (Eva, Mental Health led NGO).
>
> Barbara and Eva also discussed the need for outreach to be a part of that collaboration. Barbara explained that members of their Assertive Outreach Team (AOT) have all completed training in mental health. ***'People that are on the street … often there are very complex cases out on the street, and they're service resistant, for various reasons and women in particular. So, I think there has to be an element of mental health underpinning*** **[it all]** ***whether it's in reach, outreach, fixed base services.'*** (Barbara, SUD/AUD led NGO).

Inflexibility in Models of Care

Some of the participants (n=3) are engaged in dual diagnosis from a policy or advocacy level, and can see the issues that arise with linear or inflexible models of care:

> ***'For the clients who are linked in with community mental health teams … it's very disjointed. They can be quite poor at attending appointments in differing locations ... it often doesn't work very well with them. And on the other hand, there can be a very unrealistic attitude about SUD*** **[if someone is presenting at A&E following an overdose]** ***"He just needs to stop using" and … as a result of that clients have not really had their mental health presentation taken seriously.'*** (Eva, Mental Health led NGO)
>
> Laura, who was involved in policy on the previous and new mental health strategy maintains that in the first mental health policy the separation of SUD/AUD and mental health was a ***'bone of contention … but there was a view …held by people who had sway. And that was unhelpful. That kind of rigidity in Vision for Change was very unhelpful.'*** (Laura, Mental Health led NGO).
>
> Caroline is involved in the development of a new Model of Care for individuals with a dual diagnosis and says that the new mental health policy, Sharing the Vision, has allowed for a greater degree of freedom, ***'thus enabling the provision of resources to people at all levels of dual diagnosis presenting for support… [including people with SUD and/or AUD]'.*** (Caroline, Statutory Agency)

4.2 Systemic Barriers to Dual Recovery

4.2a Interagency Collaboration

A number of issues arose in discussion around interagency collaboration with the majority (n=10) of the participants. In some instances, (n=5) they felt it was needed but absent and felt this was a result of policy. For others collaboration was working (n=4), but very slow and communication was difficult, and for five (n=5) of the participants there was also discourse around a failure of engagement by psychiatric services. Only two of the twelve participants felt that interagency collaboration was working well.

> Martina, who works with people experiencing HHI, says that while they do a lot of multidisciplinary and interagency work, it can be challenging. ***'We don't always see eye to eye. But we have case conferences and try to put a plan in place to make sure that everybody is on the same page working with that individual. But nine times out of ten it's us calling the case conference and leading it and setting the agenda and making sure we have goals to make sure that people do what they have said they will.'*** (Martina, Housing led NGO).

Creating Collaboration

> Caroline talks of the problems of trying to create a culture of collaboration and cooperation at a statutory level. ***'The health system is set up as a health system. It is diagnostic led and* [because of that] *there is an automatic divide – this structural division that's actually in place because of the nature of the organisation. It has to be that nature because it's a health service. We're trying to build a collaborative movement amongst all of the healthcare professionals who are going to work together to cross those barriers.'*** (Caroline, Statutory Agency).
>
> Equally Annemarie, who is engaged in supports for people experiencing HHI also talks of a disconnect. ***'For some of the shorter stay services, where clients might be coming in directly from the street or emergency accommodation and we're trying to get them referred into the homeless mental health teams … but the feedback from that is generally really difficult because the addiction services won't recognise mental health. And if someone is active in their addiction, mental health won't engage with that person. And it depends on what your local area is and what services are in your area.'*** (Annemarie, Housing led NGO).

Issues with Psychiatric/Community Mental Health Services

Prior to engagement with a service, a level of information is needed in order for a service to make decisions about care planning and there are issues around sharing of information:

> ***'Getting that information does not come easily or quickly. It slows down the process of getting the person into us. I cannot get information from mental health services.'*** **In discussing one client with quite complex needs who wanted to attend for residential detox, Amy explained that they *'eventually got a report from the consultant psychiatrist, who wanted another review – that all took one year.'*** (Amy, SUD/AUD led NGO).
>
> ***'There seems to be huge issues accessing psychiatry – obviously there's a huge issue trying to access CMH services.'* (**Maria, SUD/AUD led NGO).
>
> ***'I found it very difficult at the start with the psychiatric services … there can be expectations that are not communicated or explored. We have a new case management approach that is linked in with a psychiatrist … [but] a lot of the time they don't have time to sit down and do a three way with us [and] they will not do the referral.'*** (Orla, SUD/AUD led Community/Voluntary Agency).

> And while Matthew points to improved working relationships with CAMHS, he feels strongly that more work needs to be done. ***'Sometimes when people are referred to a* [mental health service] *just because substance use is identified* [it's important] *not to be so quick to progress them on and to discharge them. It's better to create the opportunities where we can work together.'*** (Matthew, Statutory Agency).

4.2b Training

Of the twelve participants, the majority (n=10) talked of the need for a range of training initiatives for services involved in supporting people with dual diagnosis. While the majority of participants said that a properly funded dual diagnosis service (located in a single building) would be the ideal, in the absence of that there was a need for greater understanding of the interaction between mental health difficulty and SUD/AUD and ultimately homelessness.

For people working in predominantly SUD/AUD services, which is based largely on trauma informed care, the emphasis is on learning about mental health difficulty.

> ***'Mental health teams need to be trained in addiction and addiction teams need to be trained in mental health – there has to be an understanding there. You don't have to know how to fix it, but you have to know who to go to get help. You have to have an understanding about how that affects the person and what they do.'*** (Amy, SUD/AUD led NGO).

The need for wide-ranging training

However, that training gap exists outside of services too, with a number of participants feeling that there is a need for a practical education piece in medical and social care courses.

> ***'There still seems to be a gap in training – right across lots of different professionals from nurses to psychiatrists – not just a kind of 'let's pile on more stuff' but really a practice gap, an application. A fair proportion of GPs don't have a lot of confidence or practical experience in … how to approach people with mental health difficulties … so it's either refer on or prescription.'*** (Laura, Mental Health led NGO).
>
> However, sometimes prescribing of medication by GPs can be an issue if an individual is in recovery, as Annemarie explains. ***'Codeine is very addictive and generally clients would be advised not to take* [it] *but often GPs will prescribe it and that can be a bit of a challenge.'*** She explains that while there are good relationships with some GPs who become very involved in care planning, generally in the community there is not much engagement and ***'they can prescribe a variety of medications to clients* [which would be] *a risk to their recovery. They can only go on what the client is telling them as well … they may not have the full information.'*** (Annemarie, Housing led NGO).
>
> The gap in training is not confined to traditional medical roles but can also exist in social care courses. ***'I think there needs to be more emphasis in colleges around mental health and addiction for people doing social care … we take in a lot of Spanish support workers and their***

> ***level of education around mental health and addiction would be a lot higher* [than in Ireland].'** (Philip, Housing led NGO).
>
> Colm, who works in the academic field, pointed out that training opens up an opportunity for changes in perception: ***'We offered* [medical students] *a module where we'd bring them to clinics, get them to sit down and let the service users tell their story and it actually has a big impact. They do volunteer work. They change. It changes how they think.'*** (Colm, SUD/AUD led Community/Voluntary Agency).

4.2c Care Pathways

Active Substance Use Care Pathways

Care pathways depend on the type of service that individuals are seeking and differ for each organisation, which is widely acknowledged as unclear for individuals with a dual diagnosis, as the participants explain.

> ***'From a dual diagnosis perspective there isn't a pathway – it's all the luck of the game. At the moment you'd be very lucky to get referred anywhere and there would have to be a few lies told I'm sure to get into any service.'*** (Orla, SUD/AUD led Community/Voluntary Agency).
>
> ***'There's no common assessment that I'm aware of that is being done.'*** (Maria, SUD/AUD led NGO).
>
> This is particularly the case with mental health difficulty history, as Amy pointed out. She cited the case where, for example, acceptance to a detox unit works on self-referrals but is dependent on the level of substance use. If a person is on MMT or prescribed BZD (benzodiazepine) at a certain dose, they are accepted. If not, they are referred to community addiction services where GPs liaise to reduce dosages. ***'The addiction piece is nearly easier – clients themselves can give us a lot of that. They know when they started* [substance use]. *They don't often know much about their mental health history.'***
>
> She continues that individuals with a dual diagnosis may have found themselves in hospital at some stage, unclear of the reason for admission and discharged a few hours later on new medication. ***'Quite often that first piece* [mental health history] *does not come easily or quickly.'*** (Amy, SUD/AUD led NGO).
>
> Barbara also talked of lack of residential capacity ***'In crisis services, there's no referral – it's walk in. We don't have enough beds but there's not funding for any extra ones at the moment.'*** (Barbara, SUD/AUD led NGO).
>
> Annemarie is involved in provision of services primarily to people experiencing HHI and talks of the need to have services under one roof: ***'At the moment, if somebody has addiction, you go there…if they have mental health, you go elsewhere … there needs to be an open door culture within services.'*** (Annemarie, Housing led NGO).

Family Access to Care Pathways

There was also discussion on the difficulties that families face in trying to source help and support for their family member with a dual diagnosis. Maria talked of the struggle that families face in advocating for their loved one.

‘There’s been cases where **[their]** ***son or daughter could have been in A&E after self-harming 3 or 4 times over a two-week period. There hasn’t been an emergency intervention and they need inpatient care at this point. They feel dismissed and the family feel dismissed because they are screaming out for help but also sometimes the person themselves is saying “if you release me, I am going to go and kill myself” and they have still been released.’*** She explains that in some instances those sons and daughters go on to succeed in their planned suicide. (Maria, SUD/AUD led NGO).

The Need for Early Intervention

Both Maria and Orla talked of the need for early intervention. ***‘Early intervention is the key and that just doesn’t happen … you can see that from the way the wait lists for kids are – about a year and a half or two years in some areas.’*** (Maria, SUD/AUD led NGO).

‘Substance use may be in existence for a month to three years **[but is often not picked up until]** ***their behaviour, their school attendance … or they’re getting in trouble and have a*** **JLO [Juvenile Liaison Officer]** ***through the community … or they’re indebted … or if they are absconding. In some instances, they have pre-existing contact with CAMHS and once substance use is picked up … it’s closed to that service.’*** (Orla, SUD/AUD led Community/Voluntary Agency).

The struggle to support a loved one with dual diagnosis can lead to development of a family member’s own substance use or mental health difficulty. As Orla explains: ***‘We have noticed that a lot of people in the family would develop dual diagnosis*** **[themselves]** ***… they would now be struggling and going on prescribed medication, maybe over medicating and drinking and developing mental health issues – it consumes a lot of people.’*** (Orla, SUD/AUD led Community/Voluntary Agency).

GP Involvement in Care Pathways

There was evidence of little addiction support from GPs and CMHTs, a sentiment echoed in many participants’ discourse.

‘It’s rare that we get GP referrals. I think sometimes GPs – they’re under a bit of a time constraint. And people have to wait – if it’s your first time being referred in through your GP, waits of up to 9 months are really not unusual. And by the time they reach the CMHT they seem to be much more in crisis – things have deteriorated for them a lot.’ (Eva, Mental Health led NGO).

The Establishment of Mental Health Services by SUD/AUD Providers

Long waiting lists and set criteria for counselling (for example substance free) means that many clients are seeking help but excluded from doing so. In response, some of the homeless and addiction services who participated in the study have set up their own mental health/counselling services, as Amy explains:

> ***'A lot of the external counselling services wouldn't work with our client cohort because they are in active addiction.'*** (Amy, SUD/AUD led NGO).
>
> ***'We have a drop in service … a counsellor would come in on a set day and time not to see anybody in particular – but would sit in the service and if anybody feels that they want to meet the counsellor they can. If somebody wants to engage, they can.'*** (Philip, Housing led NGO).

4.2d Continuity of Care

There is evidence of consensus on the meaning of recovery as holistic and dynamic (at both policy and service provider level), requiring a high level of wrap-around supports and therefore a need for continuation of care. This continuity of care is seen as perhaps one of the biggest barriers to maintaining recovery for individuals with a dual diagnosis.

> ***'Addiction services can be quite good for somebody who doesn't have mental ill-health, but the mental health piece is harder and they need more support … they need it on a longer basis than you can give them and they need it in their community.'*** (Amy, SUD/AUD led NGO).
>
> ***'People with addiction issues normally end up in* [statutory addiction service] *but only the addiction is being looked at and that's it and then they're back out again and there's no link up when they are leaving other than AA meetings.'*** (Maria, SUD/AUD led NGO).
>
> One organisation that provides residential detox and rehabilitation explains that often people think a set number of weeks is going to be sufficient, but it is not. ***'They need aftercare – you have people who have worked very hard to get themselves into detox and then they might be going back into emergency accommodation, which is not ideal. There are a few drug-free hostels now but ultimately what you'd like to do is for people to really recover in the whole sense of their lives.*** '(Barbara, SUD/AUD led NGO)
>
> Eva explains that ongoing support needs can vary. ***'For a lot of clients, it will be social isolation … as they are coming to the end of case closure. We try and link them in with peer supports, working within the community. That's very social.'*** (Eva, Mental Health led NGO).
>
> ***'People need that layer of … flexible trampoline support. Jobs… relationships, being able to maintain a tenancy. They don't necessarily need support all the time, but they need it to be there when they do need it. That kind of support is a huge challenge for systems to provide.'*** (Laura, Mental Health led NGO).

Following Hospital Admission

There was considerable discussion (n=7) around the **issue of individuals with a dual diagnosis presenting to A&E in crisis having self-harmed or attempted suicide.** ***'People are going in, they are after self-harming, they will fix them up physically, but they could be released a couple of hours later … and get an appointment for three months down the road. That baffles me.'*** (Maria, SUD/AUD led NGO).

Maria explains that often people will be brought in time and time again by Gardai *'**and it's a revolving door thing – "oh we don't do that here type of attitude" – well maybe you don't and that's ok but we need to be able to signpost who does do this.''*** (Maria, SUD/AUD led NGO).

Lack of knowledge also arises in hospital presentations to A&E: ***'A&E is not the appropriate place for somebody to go to unless they have specially trained staff – I think it's difficult enough if you have a mental health issue* [but] *if you throw in addiction you're screwed.'*** (Maria, SUD/AUD led NGO).

4.2e Care Planning

Co-produced care planning is a cornerstone of the approach to the care for majority of the participants who provide services on a day-to-day basis. (n=7). However, it is evident that there are variations in attitude to this leading to it being seen more as an espoused foundation of care than an active basis of care.

***'People with dual diagnosis need to be heard … they need one person to case manage them … so that somebody could work on some aspect of what they were presenting with, so we didn't differentiate if they have a mental health or substance** use problem.'* (Orla, SUD/AUD led Community/Voluntary Agency).

'I think sometimes we fall into the trap of saying what recovery should be for a client rather than the client themselves making the call on what they would like the recovery to be.' (Philip, Housing led NGO).

***'Care plans are collaborative – we're trying to empower independence and for people to start working on taking control of these elements in their own life.'* (**Annemarie, Housing led NGO).

However, as Laura pointed out, there is wide variation in attitudes to co-production.

'Services vary – you can have a fantastic experience with some [mental health] services and then people have a very poor experience – it's almost like that 1960s psychiatry – it's very rigid, it's not affirming, it's not empathetic. The potential of co-production isn't acknowledged.' (Laura, Mental Health led NGO)

Caroline and Colm discussed the proposed new Model of Care in relation to co-production. ***'The Model of Care will be agreed with co-production in it. The whole person centeredness of it is very important. Services are important but clients are more important.'*** (Colm, SUD/AUD led Community/Voluntary Agency).

Caroline relates that the two Community Healthcare Organisations (CHO) pilot sites have been identified for initial roll-out of the new Model of Care using a PPI (Public Patient Involvement) approach involving people with lived experience of dual diagnosis.

'The new Model of Care will be at first draft stages in the first quarter of 2022, and already two pilot sites have been identified. Key to the success of this new model is the engagement of people with lived experiences in the evaluation of the pilots, using a PPI approach.' (Caroline, Statutory Agency).

4.3 Social Barriers to Dual Recovery

4.3a Homelessness and Housing Insecurity

Stable housing was viewed as a critical element of recovery for individuals with a dual diagnosis, and emphasised the interconnectedness of mental health difficulty, SUD/AUD and homelessness.

'It's kind of a vicious circle because of mental health and then they're finding themselves homeless because of mental ill-health and homeless because of addiction ... the three are interlinked.' (Barbara, SUD/AUD led NGO).

'If somebody is in homeless services, they can't access community mental health services, because they're homeless. And with no disrespect to the homeless mental health teams, it can sometimes be difficult to get the client assessed.' (Philip, Housing led NGO).

'It's the cornerstone of it really – if you don't have the basics you know, food and shelter – it's really difficult to feel like you're in a place where you can have recovery. **[But]** ***housing needs to be stable.... because private renters it's really precarious.'*** (Eva, Mental Health led NGO).

Maria welcomes the acceptance of the need for a Housing First approach: ***'There was no mention of Housing First a number of years ago … and now you hear … informed commentators talk about Housing First. And that's a big shift. Progress is slow, but at least it's happening … you don't have to jump over those ten bars and then you might get a house … if you're worthy enough.'*** (Maria, SUD/AUD led NGO).

4.3b Social Isolation/Exclusion

This need for a sense of community was echoed in discourse around social isolation experienced by many of the service users who are supported by the participants.

'I think the word community is important because it is **[dual diagnosis]** ***very socioeconomically driven.'*** (Colm, SUD/AUD led Community/Voluntary Agency).

'Original building programmes supported people to stay in their communities which is hugely important in terms of the supports that are there informally and that builds up. Some communities are much more fragmented – we have to look at ways of trying to build communities … and put in so much that it allows people the opportunity to participate collectively.' (Matthew, Statutory Agency).

> ***'In many instances people in recovery need to learn how to socially interact with people and to have communication skills.'*** (Orla, SUD/AUD led Community/Voluntary Agency).
>
> The absence of these skills can lead to recovery regression as explained by Annemarie and Philip.
>
> ***'Often when they are moving into their own home the isolation, loneliness, kicks in and they might have a relapse with their addiction, and their mental health deteriorates.'*** (Annemarie, Housing led NGO)
>
> ***'People are extremely isolated – they wouldn't have the mainstream ongoing supports around addiction or mental health that people in a service would have. One of them said to me recently that they felt like a ghost.'*** (Philip, Housing led NGO).

4.3c Stigma

While stigma, as a social process, is undergoing some change for people with mental health difficulty it is still poorly understood, as is SUD/AUD. However, stigma goes beyond a social process and is also evident in the attitudes of medical staff.

> Laura talked about attitudes to mental health difficulty following a period of deinstitutionalisation in Ireland. ***'There was a recognition that there was an awful lot of stigma related to mental illness, as it was at the time. And that people … would need all sorts of help and support*** **[when they left an institution].** ***There's an awful lot of people sharing their experiences … and that's fine if it's anxiety, depression, OCD*** **[Obsessive Compulsive Disorder]** ***… but certainly far fewer people are coming out in terms of schizophrenia, psychosis, the rougher end of bipolar disorder.'*** (Laura, Mental Health led NGO).
>
> ***'The evidence around stigma is … about exposure … the stories you hear and your own personal experiences. We have experience of things like anxiety or depression … much less direct experience of psychosis … so the stigma is kind of skewed … and with addiction issues as well, you still have a lot of stigma … probably more stigma now for drug and substance abuse issues than a lot of mental health issues.'*** (Laura, Mental Health led NGO).
>
> ***'There's so much stigma … particularly with addiction. I mean if you're still in addiction it's your fault in some way? A lot of our clients can be multi-stigmatised – maybe a prisoner of addiction, mental health. I think it has somewhat reduced but there's still a lot of stigmas around severe and enduring mental illness. There's still that fear there from people.'*** (Maria, SUD/AUD led NGO).
>
> ***'I think there's a lack of education … people working within hospitals … and we need to get mental health 24/7 services – there's no access to beds sometimes – there's all that stuff you have for physical health that's just not there for mental health.'*** (Maria, SUD/AUD led NGO).
>
> Maria talked of dismissive attitudes in A&E: ***'It's hard for people to reach out – so when you do to be met with that*** **it [disregard for suicidal ideation/attempted suicide]** ***it just enforces what the***

person is already feeling about themselves – that they don't really matter.' (Maria, SUD/AUD led NGO).

'There was this **[dual diagnosed]** ***client recently who is extremely chaotic and self-harms … and a doctor in the hospital told her … that she was taking up a lot of time and that she was either going to do it or not. That has impacted her hugely.'*** (Orla, SUD/AUD led Community/Voluntary Agency).

'Addiction and this interchange between crime and social issues, stigma, health and medicine is nuanced. and there's work being done on stigma. There has to be a change in mind-set.' (Colm, SUD/AUD led Community/Voluntary Agency).

4.4 Dual Recovery in a Pandemic

The pandemic has had widespread effects on availability of, and access to, care with a lack of focus on the need to attend to other social and health issues. Colm had worked during the HIV pandemic, when the public health approach was on harm reduction. ***'So not necessarily to benefit the individual directly but to improve public population health. You can see even now in COVID there is a difference in emphasis between public health and individual care. They're completely bought into COVID, and they think that's the only real issue that matters. That's a very bad mistake. COVID has shown up the weaknesses in society.'*** (Colm, SUD/AUD led Community/Voluntary Agency).

This was echoed by Barbara, who felt that in many instances lack of detox/stabilisation beds meant that opportunities were missed: ***'There were only three agencies that kept their detox and rehab open, albeit on a reduced capacity... One or two women that were motivated and ready to go – but it never happened because of COVID, so we've lost them.'*** (Barbara, SUD/AUD led NGO).

'I think [after COVID] we're not going to find anybody that doesn't have a mental health issue, underpinned by addiction, homelessness. COVID has had a huge impact on everybody … but it is exacerbated for the people that we support – it's now ratcheted up to something completely different.' (Barbara, SUD/AUD led NGO).

A number of participants talked about the fact that the pandemic restrictions, which required high levels of cocooning, have perhaps led to the development of a greater understanding of the need for social inclusion**. *'I think COVID has highlighted [the fact that] when you take away people's scaffolding, which is what they have in recovery, they're left with themselves. There are a lot of people in different levels of recovery that haven't got to the point where they have dealt with their own underlying issues. They have put in so many things to keep them busy from themselves.'*** (Orla, SUD/AUD led Community/Voluntary Agency).

4.5 Towards a new Model of Care

In discussing the development of a new Model of Care for people with dual diagnosis, there was hope that it would enable very real progress, and an acknowledgement that this could only be achieved by creation of a more straightforward system of care that had at its heart the input of individuals with a dual diagnosis.

> ***'We have a very strong recovery ethos … we are developing a model of care, but the pillars we are building it on are recovery and engagement, training, capacity building and with people with lived experiences voices being at the table – we are using a full PPI approach to everything we do. We are trying to develop between HSE's mental health and engagement team, the Recovery Academy of Ireland and the social inclusion network – we're heading dual recovery.'***
> (Caroline, Statutory Agency).
>
> ***'I think it's very encouraging that at HSE policy level they're very clear that we need to build as many bridges and pathways and make them as straightforward as possible. And I think a lot of the barriers that occur … is a decision that is seen as almost like it has some statutory basis … but it's just a decision they made. It could be changed … a lot of the barriers and the frustrating thing about them is it's just the local decision making. It can be presented in a very authoritative way and people think "Oh, we're not going to be able to change that".'***
> (Laura, Mental Health led NGO)

4.6 Summary of Findings

Divergent Philosophies as Barriers to Dual Recovery

- **Recovery Philosophies**
    - Participant/Micro View
        - Widely accepted as holistic
    - Macro view
        - Poorly understood
        - Difficulty translating policy into action
- **Models of Care**
    - Experienced as linear, unintegrated
    - Inflexible

Systemic Barriers to Dual Recovery

- **Interagency Collaboration**
    - Challenging
    - Over-reliance on medical model
    - Difficulty with psychiatric/mental health services

- **Training**
    - Lack of cross-education in mental health difficulty/SUD/AUD
    - Absence of training for GPs, Social Care courses

- **Care Pathways**
    - Wide variation
    - Dependent on location
    - Family issues accessing care
    - Early intervention lacking
    - Limited GP/Mental Health input

- **Continuity of Care**
    - Not dynamic
    - Short-term responses inadequate
    - Discharge from A&E problematic

- **Care Planning**
    - Co-production levels poor

Social Barriers to Dual Recovery

- **Homelessness and Housing Insecurity**
    - Stable housing essential
    - Social inclusion supports needed

- **Social Isolation/Exclusion**
    - Community involvement essential

- **Stigma**
    - Limited shift in attitudes, especially for severe mental health difficulty and SUD/AUD
    - Experience of multi-stigmatisation for individuals with a dual diagnosis

Dual Recovery in a Pandemic

- Emphasis on public health measures to the detriment of care for people with psychosocial issues

Towards a new Model of Care

- Broadly welcomed
- Needs input from individuals with a dual diagnosis

5.0

DISCUSSION

5.0 DISCUSSION

This chapter outlines the key findings from the research and places them in the context of national and international literature in the field of dual diagnosis and dual recovery. In doing so, it generates an understanding of the barriers that exist in the provision of services for individuals with a dual diagnosis in Ireland.

5.1 The Effects of the Duality of Irish Policy on Individuals with a Dual Diagnosis

Irish policy in the areas of mental health difficulty, SUD/AUD and HHI has, up until recently, been developed as separate strategies, which has resulted in the effective exclusion of individuals with a dual diagnosis from access to care.

Following a long period of deinstitutionalisation, mental health policy has been slow in responding to the needs of individuals with mental health difficulty. Plans for the development of psychiatric services within the community (DOH 1984) were not acted on until 2006 (A Vision for Change HSE 2006). At this time a combination of factors (as discussed in Section 2.3) led to this policy failing in that it was inconsistent, lacked proper funding and direction (Johnson 2014; Kelly 2015; MHR 2015).

That policy also had the effect of excluding individuals with a dual diagnosis in that it explicitly placed the responsibility for care of individuals with a dual diagnosis outside of the mental health system (HSE 2006). This is in spite of the fact that there is a clear correlation between mental health difficulty and SUD/AUD (Iro and O'Connor 2009; Kamali et al. 2000; Lyne et al. 2010). Early policy on substance use served to position SUD/PSUD within the criminal justice system (Butler 2017; EMCDDA 2016; O'Gorman 1998) with health-led approach coming much later (DOH 2017).

Central to the experiences of individuals with either mental health difficulty or SUD/AUD is a history of homelessness or housing insecurity (Whitehead and Dahlgreen 1991; WHO 2013), and there is a clear non-linear relationship between mental health difficulty, SUD/AUD and HHI (Murphy, Mitchell and McDaid 2017). Secure housing is seen as central to the stability of individuals with a dual diagnosis (Padgett et al 2006) yet Irish housing policy has consistently failed to address HHI (Hearne 2020; Social Justice Ireland 2020).

While more recent Irish policy on mental health difficulty (Sharing the Vision, DOH 2020), as well as on SUD/AUD (Reducing Harm, Supporting Recovery DOH 2017) and HHI (Housing for All, DHLGH 2021) share commonalities in that all employ recovery focussed models, and can be seen to address the issue from a human rights perspective, the duality of policy up to this point has led to the creation of divergent philosophies on recovery and models of care, which have created a number of systemic barriers to the attainment of recovery for individuals with a dual diagnosis. These barriers include poor interagency collaboration, lack of training, unclear care pathways for individuals with a dual diagnosis as well as a lack continued care where the individual has little or no involvement in their care planning.

The following section allows for an exploration of the outcome of that historic duality and places the experiences of the participants as they negotiate care provision for individuals with a dual diagnosis on a day-to-day basis within international and Irish literature on the subject

5.2 Divergent Recovery Philosophies and Models of Care as Barriers to Dual Recovery

The majority of participants in this study are involved in the provision services for individuals with a dual diagnosis, providing a range of services within their organisational structures. As a result, they display a comprehensive understanding of the interplay between mental health difficulty, SUD/AUD and HHI in line with research findings (Iro and Connor 2009; Kamali et al. 2000; Laudet and White 2010; Lyne et al. 2010; Murphy, Mithcell and McDaid 2017).

This level of comprehension of the needs of individuals with a dual diagnosis to achieve and maintain recovery are in line with the framework of recovery capital, which refers to the totality of resources needed to initiate and maintain recovery (Best and Laudet 2010; Cloud and Granfield 2008; Laudet and White 2010; Minkowitz 2007; UN 2006; Watson et al. 2004).

There is concern expressed by the participants with a macro-view of dual recovery (i.e. those engaged in policy and/or advocacy) that these concepts are poorly understood in a wider sense. Even with the publication of new policy on both mental health difficulty and SUD/AUD (Department of Health 2017; HSE 2020) there is acknowledged difficulty translating policy into action.

Views on what recovery is differs between service providers and those presenting for support, often resulting in individuals with a dual diagnosis feeling that they have no role to play in their recovery journey (Brekke et al. 2018; Costello et al. 2020; Deegan and Drake 2015; De Ruysscher et al. 2017; Garbare 2015; Roberts and Bell 2013). This finding is echoed in the discourse of the participants, who expressed the opinion that, while critical to successful dual recovery, co-production is in many instances discouraged.

Equally, the experiences of the participants regarding models of care are in line with other findings in that that they are experienced as linear, inflexible and unintegrated, disallowing for supported transition for individuals with a dual diagnosis towards dual recovery (Garbare 2015; Mueser et al. 2003; Thylstrup and Johansen 2009).

5.3 Systemic Barriers to Dual Recovery

These philosophical differences, created by policy duality coupled with funding disparities (O'Gorman et al. 2016) has led to individuals with a dual diagnosis finding themselves excluded from accessing services and as a result receiving no treatment at all (Department of Health 2016; Proudfoot and MacGabhann 2019), and has served to create a number of structural barriers to care.

5.3a Poor Interagency Collaboration

While there is clear consensus on the need for integration between addiction and mental health services, social care systems are only equipped to deal with one issue at a given time, often leading to service rejection (Davidson and White 2007; Department of Health 2017; Turning Point 2016).

The participants in this study have found interagency collaboration challenging, citing experiences of no, poor or slow communication with and a failure of engagement by psychiatric and statutory mental health services of particular concern. Coordination between mental health and SUD/AUD services in other countries has similarly been experienced as lacking due to fragmentation of services, poor networking and poor information exchange (Baldacchino et al. 2011; Bjorkquist and Hansen 2018).

5.3b Lack of Training

The need for a shared language was evident in the findings of this study when participants were discussing training. The majority of participants who were engaged in the provision of SUD/AUD led services or HHI led services had received training in mental health or were using a system of trauma informed care. The majority felt that the ideal would be a properly funded dual diagnosis service located in a single building but in the absence of that, there was a greater need for more understanding of the interaction between mental health difficulty, SUD/AUD and HHI.

This finding is also reflected in recent Irish research that indicates a lack of a realistic approach to training in that it needs to involve training and cross training of service providers in both mental health and SUD/AUD on a number of different levels. It is only in this way can a common language, dialogue and competence around dual diagnosis emerge to enable integrated treatment (Minyard et al. 2019).

Of particular concern to the participants in the study is that gaps in training exist across the medical and social care divide and was not just limited to those providing SUD/AUD or HHI services. It was suggested that training had to have a practical application, especially for GPs whom, the participants felt in many instances, had little experience of mental health difficulty and addiction.

5.3c Unclear Care Pathways

Lack of clarity on care pathways is reflected in research on models of care which have tended to be serial or parallel, both of which have consequences for access to support (Darke et al. 2009; DeVido and Weiss 2012; Garbare 2015; Mueser et al. 2003; Woody 1996).

The participants talked of a wide variety of care pathways. For those working directly with clients in the field of SUD/AUD and HHI, access to support can range from self-referral (but may be subject to specific criteria) as well as a result of crisis (admission to A&E). There was evidence that access to care was dependent on location, with those experiencing HHI particularly at risk and unable to access CMHTs which, as a service, is accessed according to specific locations.

The lack of addiction support from GPs meant that individuals with a dual diagnosis were often referred on to CMHTs, but the waiting list for adult referral was cited as nine months, by which time they were often in crisis and presenting to A&E.

The majority of the participants felt that there was little or no early intervention for either mental health difficulty and/or SUD/AUD and with waiting lists for CMHTs of up to 18 months that this situation was untenable.

5.2d Absence of Continuity of Care

As both mental health difficulty and SUD/AUD are increasingly being viewed as life long, chronic conditions (Grigson 2018; Laudet and White 2010; Zgierska et al. 2021), there is a clear need for continuity of care which correlates to commitment to treatment, greater service satisfaction and community engagement (McCallum et al. 2015).

The findings of this study suggest that participants felt that the lack of continuity of care presented perhaps the greatest barrier to dual recovery. There was a need for systems to be more dynamic in responding to the individual needs of individuals with a dual diagnosis, allowing for wrap around supports at each point on their recovery journey. Comprehensive supports are needed to enable people to live meaningful lives (Mayock, Butler and Hoey 2018).

Short term responses to SUD/AUD in particular were considered to be an issue, with many entering statutory services where addiction issues are addressed but not accompanying health difficulty. They discussed the need for wider levels of continuing care incorporated in the concept of recovery capital, which they felt, was largely absent leading to social isolation for individuals with a dual diagnosis.

These findings contravene current Irish policy on SUD/AUD which states care should be provided as a continuum, with the emphasis less on treatment and more on social care (family supports, housing, educational, criminal justice and healthcare supports) (Department of Health 2017). This attainment of personal goals is also a cornerstone of new Irish mental health policy (HSE 2020) but in the views of the participants, there is little evidence of this continuum of care in practice.

5.3e Limited Involvement in Care Planning

The majority of participants felt that co-production in care planning was crucial to the achievement of personal goals and in enabling people to live lives that are meaningful to them. They note that care plans need to be interactive and flexible and that they serve the individual best when they empower independence.

This is in line with previous findings in research that suggest that recovery has a number of meanings to people, is multi-dimensional and is not static (Costello et al. 2020; McCabe et al. 2018; Stott and Priest 2018). Essential to this finding is that the individual should be the central decision maker in their own recovery journey (Brekke et al. 2018).

This is only achieved by incorporating the lived experience of individuals with a dual diagnosis and their families in each level of the system which aims to support them (Minyard et al. 2019).

5.4 Social Barriers to Dual Recovery

The systemic barriers to recovery, as a result of policy inconsistency and duality, has led to the creation of a number of social issues for people with a dual diagnosis, resulting in the positioning of individuals with a dual diagnosis at the extreme end of social exclusion (Clinton et al. 1998; Schafer 2007; van Bergen et al. 2019; Vrooman and Hoff 2013). This has led to the stigmatisation of individuals with a dual diagnosis, which is not only experienced at a personal level, but exists as discrimination in healthcare settings (Evans-Lacko and Thornicroft 2010; Thornicroft et al. 2016).

Recovery is a social process that extends beyond symptom reduction in both mental health difficulty and SUD/AUD with recognition of the role that personal and social factors play and where day-to-day living is central to the area for change (Brekke et al. 2018).

5.4a Homelessness and Housing Insecurity

Inappropriate, insecure or unstable housing is seen as a major obstacle to achieving dual recovery (Brekke 2017; Skogens, von Grieff and Topor 2017). Stable housing was viewed as a critical element of recovery for all of the participants in this study. They described stable housing as the cornerstone of recovery and as a means for individuals with a dual diagnosis to recover in the whole sense of their lives.

The participants welcomed the adaptation of the ‘Housing First’ model in Irish policy but noted that supports were needed beyond the provision of a place to live. There was also considerable discussion on the need to build not just houses but communities that allow for people in recovery to attain a sense of belonging and connection, which is central to Ireland’s commitment to Article 19 of the UNCRPD (UN 2006).

Individuals with a dual diagnosis are more likely to experience long term homelessness than the general population (Tsemberis, Gulcur and Nakae 2004). As a result, maintaining housing also requires high levels of supports as people strive to develop a sense of belonging.

5.4b Social Exclusion

Social exclusion is best understood as a lack of full participation in society (van Bergen et al. 2019) and both mental health difficulty and addiction in their own right are considered a form of social exclusion. Disruption (often permanent) in family networks of those in active addiction is common (Copello et al. 2010; Duggan 2012; Orford et al. 2010; Rossow and Hague 2004). For people with mental health difficulty, great emphasis is placed on social connections, though their social networks are smaller than the general population and they experience higher levels of social exclusion, often leading to an exacerbation of their mental health difficulty (Clinton et al. 1998; Goldsmith et al. 2008; Wang et al. 2017; White et al. 2000).

The need for a sense of belonging or community was discussed by all of the participants as being central for maintaining recovery. This could only be achieved by continuing to support people past initial recovery gains, so that they could build up their own social skills to allow them to participate fully in society.

5.4c Stigma

As a social process characterised by adverse social judgement, stigma and active discrimination against people with mental health difficulty and/or SUD/AUD is common and can have a negative impact on people’s lives (Weiss, Ramakrishna and Somma 2006).

There was considerable discourse amongst the participants on this issue. While some found recent developments in discussions on mental health difficulty around depression and anxiety helpful, echoing previous findings that social contact/discourse can improve attitudes and knowledge (Thornicroft et al. 2016) there remained continued stigma for those with more severe and enduring mental health difficulty.

For individuals with SUD/AUD participants felt that there was limited or no change in stigmatisation, with dismissive attitudes in A&E of particular concern, echoing studies that stigmatisation exists also in healthcare settings (Weiss, Ramakrishna and Somma 2006).

While there is limited research on the experiences of stigma for individuals with a dual diagnosis, there is evidence that they experience greater levels of structural discrimination in healthcare and their quality of care is less than those with a single diagnosis of mental health difficulty or SUD/AUD (Evans-Lecko and Thornicroft 2010). Certainly, this was borne out by the findings in this study. Individuals with a dual diagnosis are, as one participant stated, multi-stigmatised as a result of the combination of their mental health difficulty, SUD/AUD and homelessness.

5.5 Dual Recovery and the COVID-19 Pandemic

While there was evidence of greater levels of interagency collaboration at the outset of the COVID-19 pandemic (O'Carroll, Duffin and Collins 2020) it was not clear from the discussion of the participants that this had been maintained.

The focus on physical health, to the detriment of mental health, has been well documented (Torales et al. 2020; Xiang et al. 2020) and there is evidence of increased mental health difficulty and lapses in substance use during the pandemic for those with dual diagnosis who also experience HHI (MQI 2020). The requirement for self-isolation is seen as a primary driver for these changes.

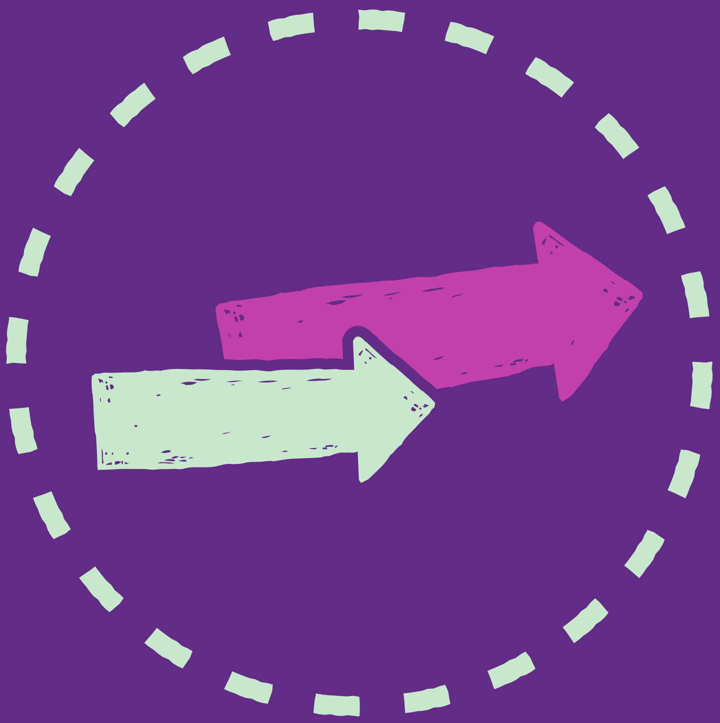
The widespread effects of the pandemic on access to care was of concern to the participants in this study. In particular, reductions in bed numbers for those wishing to access detox or stabilisation services was seen as a lost opportunity.

5.6 Towards a new Model of Care

Models of care for individuals with a dual diagnosis are the exception rather than the rule, with evidence of a very low number of services developed for this cohort (Baldacchino et al. 2011). Even as separate experiences, SUD/AUD and mental health difficulty create high levels of demand across individuals, families, services and society as a whole, leading to a range of negative outcomes (MacGabhann et al. 2004; Thylstrup and Johansen 2009).

Traditionally, models of care have been experienced as sequential or parallel giving rise to a number of issues around access to treatment, care pathways and continuity of care (Darke et al. 2009; De Vido and Weiss 2012; Garbare 2015; Mueser et al. 2003). It is evident in the discourse of the participants in this study that any model of care to be developed should be both flexible and integrative and based on common approaches to recovery and ongoing support, with the lived experience of the individual as key. This is in finding with other studies (Garbare 2015; Thylstrup and Johansen 2009).

The development of a new model of care for dual diagnosis within the HSE, as recommended under 'Sharing the Vision', was largely welcomed by the participants. The approach is to firstly lay the foundation for improved interagency communication and has at its core a PPI approach which involves those with lived experience of dual diagnosis. This model centres on a strong recovery ethos with engagement, training and capacity building as cornerstones, and three pilot sites have been identified for trial in early 2022. One of the overarching outputs of the implementation plan for 'Sharing the Vision' is to have a network of Dual Diagnosis Teams in place across the country by the end of 2024, with enhanced collaboration between mental health and addiction services staff (HSE 2022). Concern has been expressed however about the need for sufficient funding levels to achieve this as well as an historic continued failure of translation of policy into action.



6.0

CONCLUSIONS & RECOMMENDATIONS

6.0 CONCLUSION AND RECOMMENDATIONS

In spite of a movement towards recovery and health-led holistic strategies that have at their core a human rights framework, prior policy coupled with lack of implementation and inadequate funding to date in Ireland has served to create barriers to care for individuals with a dual diagnosis. Studies suggest that the prevalence of dual diagnosis may be the norm rather than the exception. It is imperative that our mental health services reflect this reality.

The findings of this study are in line with research which indicates that individuals with a dual diagnosis have found themselves largely rejected by services as a result of their combined mental health difficulty and SUD/AUD presentation. This, often combined with HHI, has left them at the extreme end of social exclusion and experiencing multi-stigmatisation. Long waiting lists for access to mental health services, coupled with poor understanding of the interaction between mental-ill health and SUD/AUD has led to a number of organisations developing their own dual diagnosis service. It is these organisations that have participated in this research study, and they have a clear understanding of what is needed to support such individuals going forward, as well as a comprehensive working knowledge of the barriers to the achievement of dual recovery.

The recommendations contained herein are informed by those working directly with individuals with dual diagnosis and in some cases their family, friends, carers and supporters. It is a strong recommendation to involve experts by experience in any and all policy development on the treatment of dual diagnosis. The UNCRPD requires that people with psychosocial disabilities be consulted and included in the development stages of policies, laws and procedures.

This study puts forward the following four overarching recommendations, some of which are measured against the recommendations within the 2022-2024 Implementation Plan for Sharing the Vision (STV):

1. Implement a fit-for-purpose Model of Care urgently

A Model of Care is under development at the time of writing. Sharing the Vision, the national mental health policy, commits to a tiered model of dual diagnosis service provision being developed and available [Recommendation 57 and Outcome 2(d) STV Implementation Plan] which specifically relates to individuals with dual diagnosis.

Recommendations are:

1.1 While the findings of this study suggest that individuals with lived experience of dual diagnosis will be involved in evaluation and monitoring of pilot sites for the new Model of Care, that this approach should be embedded into the entire Model of Care process, from implementation to continuous monitoring and evaluation.

1.2 A fit-for-purpose Model of Care requires accurate data. Therefore, it is recommended that the prevalence of dual diagnosis is identified. It is necessary to establish the true incidence of dual diagnosis in Ireland and this could be achieved by introducing monitoring mechanisms to identify dual diagnosis when individuals are accessing support. The existing reporting systems in mental health and addiction could be modified to this end.

1.3 Clear pathways are required to allow for improved understanding and communication between mental health care teams and SUD/AUD led and HHI led organisations. A National Protocol for Dual Diagnosis should be developed to ensure two-way collaboration between mental health and addiction services across all sectors. If such a protocol is not already being considered in the Model of Care, this study recommends its inclusion and development. As stated above, experts with lived experience should be included in these processes.

1.4 A dedicated Dual Diagnosis Practitioner post should be funded in each of the relevant Community and Voluntary Sector (CVS) organisations. Such a Practitioner would act as a liaison practitioner who is trained to work with mental health and addiction, supporting the CVS and establishing and maintaining strong relationships with mental health services.

1.5 The introduction and implementation of a ‘No Wrong Door’ principle.

1.6 An emphasis on trauma-informed training and care for all levels of staff and practitioners linked with individuals with dual diagnosis. Training in human rights, respect for the person’s will and preferences as well as supporting recovery are also important elements required for the successful roll-out of a fit-for-purpose Model of Care.

2. Develop and run an awareness raising campaign on dual diagnosis and dual recovery

A campaign aimed at raising awareness of dual diagnosis is needed across all sectors of mental health provision and addiction services for those providing services, accessing services as well as policy-makers. Education, training and a commitment to helping people overcome stigma will be essential to a successful Model of Care. The proposed National Stigma Reduction Programme [Recommendation 7, STV] should incorporate addressing stigma towards individuals with a dual diagnosis. As part of this awareness raising campaign, it is recommended that there is specific training for the following:

2.1 Mandatory practical training for GPs, Social Care, A&E medical staff in mental health difficulties and addiction.

2.2 Mandatory training for community mental health teams on addiction and dual recovery.

2.3 Mandatory training for SUD/AUD led organisations on mental health difficulties and dual recovery.

2.4 Training should be informed by experts with lived experience, including those accessing services as well as their family, friends, carers and supporters.

2.5 As highlighted in the above recommendation, training must be trauma-informed, person-centred, human rights compliant and respect the person’s will and preferences.

3. Provide Ring-Fenced Funding to Support Dual Diagnosis Treatments in Existing Services

A new, improved Model of Care will require adequate funding to ensure that individuals with a dual diagnosis can access the treatment that they need in the existing mental health and/or addiction services. Funding should be ring-fenced in the health budget specifically for the treatment of individuals with a dual diagnosis. This treatment must be embedded into existing services; such is the potential prevalence of dual diagnosis.

3.1 Implementation plans must be fully costed.

3.2 Any pilot schemes should be costed and evaluated with input from persons accessing the services. Funding to allow for improvements to the Model of Care must be provided for and actioned following operation of projects/services.

3.3 Appointment of specifically trained dual diagnosis professionals in hospital A&Es available 24/7.
3.4 Designated beds for inpatient treatment following crisis intervention for individuals with dual diagnosis.
3.5 Appointment of dual diagnosis professionals to CMHTs, CAMHS, SUD/AUD led and HHI led agencies.
3.5.1 This would complement the above recommendation that the CVS would have dedicated Dual Diagnosis Practitioners on their teams. Cross-agency collaboration and integration will require funding and will be essential to providing holistic treatments.

4. Improve Access to Housing and Social Inclusion

The National Housing Strategy for Disabled People was launched at the end of 2021 and its implementation plans are being developed during 2022. It is recognised that people with psychosocial disabilities have rights under the UNCRPD. Therefore, those with dual diagnosis must be considered in housing and social inclusion strategies. The recommendations stemming from the findings in this paper call for

4.1 Continued commitment to expanding the Housing First model with social inclusion, tenancy sustainment and recovery supports.

As demonstrated in this paper, those experiencing homelessness and housing insecurity must also be considered and therefore, it is a recommendation that;

4.2 Funding for Homeless Mental Health Teams is increased to strengthen their reach and outcomes across the country.
4.3 The above training recommendations in trauma-informed care, human rights compliance, person-centred care are also relevant to this recommendation. An awareness of the prevalence of dual diagnosis in housing, homeless, mental health and addiction services will be vital to sufficient housing supports being provided to individuals with a dual diagnosis.

7.0

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7.0 REFERENCES

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APPENDIX

APPENDIX

Mental Health Reform
Promoting Improved Mental Health Services

PARTICIPANT INFORMATION LEAFLET FOR SERVICE PROVIDERS

STUDY WORKING TITLE: Dual Recovery – A Needs Analysis: A qualitative exploration of the meaning of dual recovery and the barriers to achieving that goal

We are currently conducting a qualitative research study and would like your assistance.

This study is a qualitative needs analysis which aims to review current services in mental health, addiction and housing with a view to pinpointing gaps in services required for dual recovery. The research will focus on the experiences of key stakeholder/informants across a range of service providers to allow for a full exploration of the issues. There is a substantial prevalence of co-presenting mental health difficulty and Substance Use Disorder (SUD) and an overly narrow focus on these issues in isolation has led to greater challenges in gaining and maintaining recovery for this cohort. Stable housing is seen as an important component for recovery both in mental health and SUD.

Why am I being asked to take part?

As a person in an organisation who has been supporting individuals to access services, we are asking you for your experiences of accessing supports for your service users in the areas of mental health, SUD and housing.

Specifically, the research aims to document and analyse the experiences of key stakeholders in order to explore issues around dual diagnosis and dual recovery. The research aims are as follows:

- An exploration of the existing pathways for service user requests for support – either in mental health, SUD and/or housing to identify what is required going forward
- An examination of current response times to service requests and how this impacts service users
- An assessment of service user engagement in care planning and the ways in which service users can be best involved
- An identification of tools or methods for current diagnostic criteria, with a view to generating a comprehensive understanding of how mental health difficulty and SUD is currently diagnosed

By participating in this research, you will be helping us to get a clearer picture of the problems that service users and organisations might face and what they feel may be needed going forward to achieve dual recovery.

Who will we be talking to?

We are asking a number of organisations (NGOs/Voluntary/Community/Statutory) with mental health difficulty, SUD and/or homelessness service users to talk to us in the form of an audio recorded interview.

What do you need me to do?

We would greatly appreciate your assistance with this research by agreeing to an interview.

How will the interviews be conducted?

The interviews will take on average 40 minutes and will be conducted at a place and time chosen by you. You may choose to be interviewed in person at a specific location, by phone or online using Zoom, Teams or Google Meet.

What information about me will be included in this study?

While your opinions will be included as part of the study, you will not be identified in any way when the report is being written. We will take care to ensure that any identifying information is removed.

What happens to my personal data?

Personal data will be processed only as necessary and with as few people involved as possible. Only anonymised transcripts will be held – recording data will be destroyed following transcription. All data will be stored with Mental Health Reform by the Data Protection Officer for a period of 7 years, after which it will be destroyed. Your information will be held in a separate document using an alpha-numeric code which ensures that you are not identified.

You have the right to view transcripts, change or delete any information you have given to the researcher, as well as the right to correct any errors.

Who is organising the study?

This study is being funded by Mental Health Reform and is being undertaken by an independent research team.

Is there any payment for taking part?

There is no payment for participation. We will travel to you to conduct the interview if that is your wish.

What happens next?

We have attached a consent form with this email so that you can take time to decide on whether or not to participate. We will contact you within one week to arrange a date, time and place for the interview. If you do decide to participate, please sign the attached consent form and return it to the email address below.

Kathyan Kelly, Researcher.

Mental Health Reform
Promoting Improved Mental Health Services

SERVICE PROVIDER CONSENT FORM

As you know, we are currently conducting a needs analysis. We are asking a number of people in organisations supporting people with mental health difficulty, SUD and/or homelessness to tell us about their experiences around the issue of dual diagnosis/recovery.

In particular, we want to know how services currently operate and what difficulties, if any, you encounter in accessing support for individuals with a dual diagnosis in both initiating and maintaining recovery.

We also want to know generally what you think should be done going forward to help with these issues.

We are asking for you to participate in this study, however participation is your decision entirely.

If you do consent, this participation will take the form of a 40-minute interview which will be audio recorded. We will ask you some general questions about your organisation, as well as questions about service pathways, timely delivery of services as well as service user involvement in treatment plans.

Your responses will be anonymous. You will not be named in any report. Your participation is voluntary. You can withdraw from participation at any time before, during or after your interview is completed.

Privacy

Your responses will be anonymous. No information from which you could be directly or indirectly identified will be published. Data will be stored securely on a double encrypted computer and only the research team will have access to your transcripts. No names, contact or other personal details will be assigned to your responses. Data storage will meet the requirements of the Data Protection Acts 1988 - 2018 and the 2018 General Data Protection Regulation (GDPR). All data will be stored for a period of 7 years and then destroyed.

Your input will be included into an overall research study, which will be made publicly available, but again anonymously.

Consent to participate:

Please tick as appropriate:

I have read and understand the information leaflet for the above study. The information has been fully explained to me and I have been able to have any questions answered.	
I understand that this study is entirely voluntary, and if I decide I do not want to take part, I can stop at any time without giving a reason. I understand that deciding to withdraw or not participate will not affect my future support.	
I understand that I will not be paid for taking part in this study.	
I know how to contact the researcher if needed.	
I agree to participate having been fully informed of the risks and benefits set out in the information leaflet.	
I understand that my data will be protected, and that I will not be identified and that my information will only be shared in the form of a report.	
I understand that there are no direct benefits to me from participating in this study.	
I understand that I can stop at any time without giving a reason and refuse to answer any questions I do not like.	
I consent to audio-recording of the interview.	

Name: **Date:**

Researcher Name and Date:

If you have any questions, please do not hesitate to contact the Research Team,

Kathyan Kelly or Riadhna Holahan

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This study would not have been possible without the support of all of the participants who are working in the fields of mental health difficulty, substance use disorder, alcohol use disorder and homelessness. They have given freely of their time and engaged in the research process with enthusiasm and honesty.

Their accounts of working, either directly or indirectly, in supporting individuals with a dual diagnosis are key to the development of an understanding of what is needed to attain a comprehensive approach to the achievement of dual recovery.

Mental Health Reform would like to sincerely thank the authors, Kathyan Kelly and Riadhna Holahan who brought a wealth of knowledge and experience in undertaking this study on behalf of Mental Health Reform.

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Kathyan has a background in health, mental health and communication spanning over 35 years. She has worked on a number of projects as an independent research consultant which have a specific focus on social inclusion.

She works extensively with marginalised populations and her research has explored issues for those with mental health difficulty, substance/alcohol use disorder, intellectual disability as well as people experiencing homelessness and children in at-risk families.

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MSc Mental Health, BA Social Care,
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Riadhna has worked in many capacities across homeless and addiction services for over a decade. Now, as a Psychotherapist and Lecturer, she has particular interest in attachment, trauma, addiction, recovery and mental health service provision.

Riadhna has vast experience working with adolescents and adults experiencing mental ill health and/ or problematic substance use and related issues as well as with their families.

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