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

EXECUTIVE SUMMARY → MAY 2022

Mental Health Reform
Promoting Improved Mental Health Services

HSE Seirbhís Sláinte Níos Fearr á Forbairt | Building a Better Health Service

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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 that the findings and recommendations of this study will be reflected in the development of these much needed services and supports.

"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 who 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 led Community/Voluntary Agency talks about the failure of Irish policy to support individuals with a dual diagnosis).

EXECUTIVE SUMMARY

1. INTRODUCTION

The definition of Dual Diagnosis for the purposes of this study refers to individuals who present to any service seeking support who are co-presenting with mental health difficulties as well as Substance and/or Alcohol Use Disorders (SUD/AUD). They may also be experiencing Homelessness or Housing Insecurity (HHI) as a result.

The care of this population in Ireland is provided by a number of Statutory (HSE/ Department of Health [DOH]) and non-statutory organisations in the Community/Voluntary Sector (CVS). They provide front line services to individuals with a Dual Diagnosis as well as policy oversight and advocacy.

This qualitative research study aims to explore the concept of Dual Recovery as understood by twelve stakeholders who operate in the fields of mental health, addiction and homelessness in Ireland.

2. BACKGROUND TO THE STUDY

Mental health difficulties do not occur in a vacuum and are influenced by a number of socioeconomic and other factors over a person's life and SUD/AUD is increasingly viewed as a long-term, chronic condition impacting on the life course of the individual.

Both issues show a high degree of co-occurrence, with long term SUD/AUD linked to mental health difficulty, and mental health difficulty linked to higher levels of substance use over a long period of time. There is a growing acknowledgement that there is a need for an integrated approach to treatment for individuals with a Dual Diagnosis. Historically, Irish policy on SUD/AUD and on mental health has left the care of these individuals in a vacuum – unable to access mental health services because of addiction and vice versa.

There is also a high degree of correlation between Homelessness or Housing Insecurity (HHI) and Dual Diagnosis and these issues are, in many instances, inextricably linked. While one issue may influence the onset of another (i.e. homelessness leading to mental health difficulty) it is clear that once in motion, there is a non-linear relationship between mental health difficultly, SUD/AUD and HHI. People experiencing HHI often have poorer mental and physical health and a higher rate of prevalence of SUD/AUD than the general population.

Irish policy on Mental Health, SUD/AUD and Housing

Following a long period of deinstitutionalisation, the care of people with mental health difficulty was to be met by care in the community. Delays in implementing early recommendations for community based services meant that actual policy did not emerge until much later. The first comprehensive mental health policy 'A Vision for Change' in 2006 sought to establish a number of Community Mental Health Care Teams (CMHTs) for adults and Child and Adolescent Mental Health Services (CAMHS) for young people. This policy actively excluded the care of individuals with a Dual Diagnosis, stating that the care of people with SUD/AUD lay outside of the mental health care system.

Many of the objectives of that policy were not met due to a number of factors including an economic recession and the rate of policy implementation was slow, inconsistent and missed a number of targets.

More recent policy, *Sharing the Vision*, prioritises mental health difficulty as a major societal issue and has at its core a trauma informed, recovery framework based on a human rights approach.

Policy on SUD initially evolved from a criminal justice approach, based on an abstinence model with a strong emphasis on the illegality of substance use. A harm-reduction approach emerged in the 1990s but was closely tied in with reduction in criminal activity and so SUD remained predominantly within the criminal justice system. A strong community response to SUD led to the establishment of a number of community and voluntary organisations, with policy following at a later point in time.

In spite of the fact that problem alcohol use is a considerable public health issue in Ireland, linked to morbidity, poor health and suicide, AUD was not included in strategies on harmful substance use until 2009.

Most recent Irish policy on SUD/AUD (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. The emphasis is on a continuum of care model which is less about treatment and more about social care – family supports, housing, educational and healthcare supports. It also employs a human rights approach and has a focus on enabling people with SUD/AUD to live meaningful lives.

Housing policy in Ireland has been problematic for a number of years and the numbers in homelessness has increased year-on-year.

Housing is not yet a basic human right in Irish law but recent moves towards recognising that secure housing is an important social determinant of health has led to the creation of a Housing First strategy contained within the last two national housing policies. This Housing First model is aimed at providing housing to people with complex needs, such as individuals with a Dual Diagnosis, and providing wrap-around supports to enable them to engage fully in society.

Ireland, in ratifying the UN Convention on the Rights of Persons with Disabilities (UNCRPD), is committed to meeting its obligations under this Convention including the right to adequate housing and social inclusion. Recent Irish policy, specifically aimed at housing strategy for people with disabilities, is committed to the creation of integrated care pathways and is based on an inclusion health model. Mental health difficulty can also be known as psychosocial disability and therefore, the rights of the UNCRPD are extended to people with mental health difficulty.

Recovery Philosophies

Recovery, both in mental health difficulty and in SUD/AUD, has moved towards a greater emphasis on the individual as they operate in their society. It is defined as a process whereby a person can regain a meaningful sense of community belonging and a positive sense of identity.

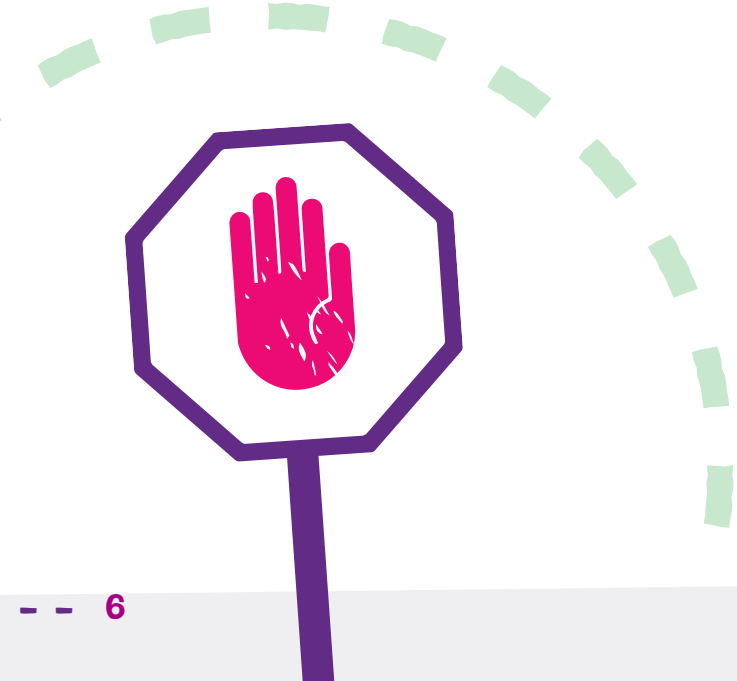
This understanding is evident in recent Irish mental health and SUD/AUD policy, which places recovery goals within a human rights framework. It reflects a shift towards recognising the need for equity of people living with psychosocial disabilities and underpins that change occurs as part of a connection to community and is characterised by partnership, equality and choice.

As such, it sits within the framework of Recovery Capital, which refers to the totality of resources necessary to initiate and maintain recovery, including social, physical, human and cultural capital. Recovery in this sense has implications for the wider physical and lived community with higher levels of recovery capital predicting sustained recovery.

Perspectives on Recovery

Recovery in mental health difficulty is seen both as a process and an outcome and in SUD/AUD as a multidimensional process. Recovery for individuals with a Dual Diagnosis suggest that it is about being able to participate in the community and to have access to holistic individualised treatment all of which lead to personal ownership of one's own life.

From a stakeholder perspective there are a number of long-standing, historical, political, professional, structural and practical barriers which impede Dual Recovery. Care systems in Ireland for individuals with a Dual Diagnosis operate in three separate treatment systems – mental health services, primary care services and addiction services (including community/ voluntary organisations). As a result, they often each have their own, often polarising philosophies and approaches to recovery, leading to barriers which include poor communication, lack of professional commitments, trust issues, confidentiality concerns and resource availability. These barriers act as impediments to effective interagency work, seen as crucial to attaining Dual Recovery. Individuals with lived experience of Dual Diagnosis feel disregarded in their own recovery planning.



> "..BARRIERS act as impediments to effective interagency work, seen as crucial to attaining dual recovery.."

Models of Care

Models of Care for individuals with a Dual Diagnosis can occur as either a sequential or parallel process. In sequential (serial) models, individuals receive intensive SUD/AUD treatment first with less intensive mental health treatment at a later stage. While this can be useful it does not acknowledge the interactive nature of Dual Diagnosis and individuals may find themselves excluded from treatment for one disorder for a number of reasons. Parallel approaches involve simultaneous treatment of both disorders but is beset with difficulties due to divergent philosophies and a lack of collaboration between treatment services.

The ideal then is an integrated model of care. This is defined as a combination of treatments from both mental health and SUD/AUD treatment providers. All supports would be delivered in the same treatment programme and ideally by the same provider, with both issues being viewed as primary thereby reducing the need for philosophical cohesion. Such approaches however require increased demands on care teams as well as the need for cross-training.

The most appropriate approach is one based on client need, regardless of the framework employed. A common process is to employ a four quadrant framework where the severity of the difficulty (either in mental health or in SUD/AUD) determines the level of care needed.

Such models of care often do not exist in health and social care systems which tend to be in existence to support only one need. Recent Irish policy recognises the significant overlap between the two conditions but historic structuring of separate mental health and addiction services has impeded support for individuals with a Dual Diagnosis. In some instances, even referral into a service is problematic and in many instances, people were excluded from accessing mental health services because of addiction issues. This point was reinforced in the initial development of a model of care based on Vision for Change mental health policy.

Considerations for a Dual Recovery approach

In accepting that recovery is a personal and social process that goes beyond symptom reduction, the individual is the central actor and decision maker in their own recovery journey, with day-to-day life the area for central change. Recovery is facilitated by a number of factors and can also be impeded by a number of barriers. Such barriers include lack of individualised support, complex and often uncoordinated care systems and a lack of continuation of care.

Social Issues Around Dual Diagnosis

Amongst those barriers are homelessness and housing insecurity (HHI), social exclusion and stigma. Individuals with a Dual Diagnosis are more likely to experience chronic HHI than the general population and are also over-represented in the Irish criminal justice system. HHI 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 the general population.

Social exclusion, a driving force in health inequity, is often an outcome of both mental health difficulty and/or SUD/AUD which can result in fractured family relationships and social networks which are often permanent.

Stigma, as a social process, is characterised by adverse social judgement of either a person or group leading to exclusion, rejection, blame or devaluation. Stigma and discrimination against

people with SUD/AUD or mental health difficulty is widespread. For individuals with a Dual Diagnosis, this stigma can be more prevalent with higher levels of structural discrimination in health care settings, leading to a poorer quality of care.

Overcoming Integration Barriers

A rapid realist review of evidence based approaches for the care of individuals with a Dual Diagnosis in Ireland indicated that a four-level framework would be required to provide a structure for service integration. Key to this is the development of a common shared language which would allow for comprehensive dialogue and this, along with training programmes, could result in competencies that are understood and accepted by everyone involved, with the input of the lived experience of individuals with a Dual Diagnosis as a key point of knowledge.

Another barrier to integration was identified in that funding infrastructure in Ireland serves to maintain two separate streams, further underlining the division of mental health and addiction services.

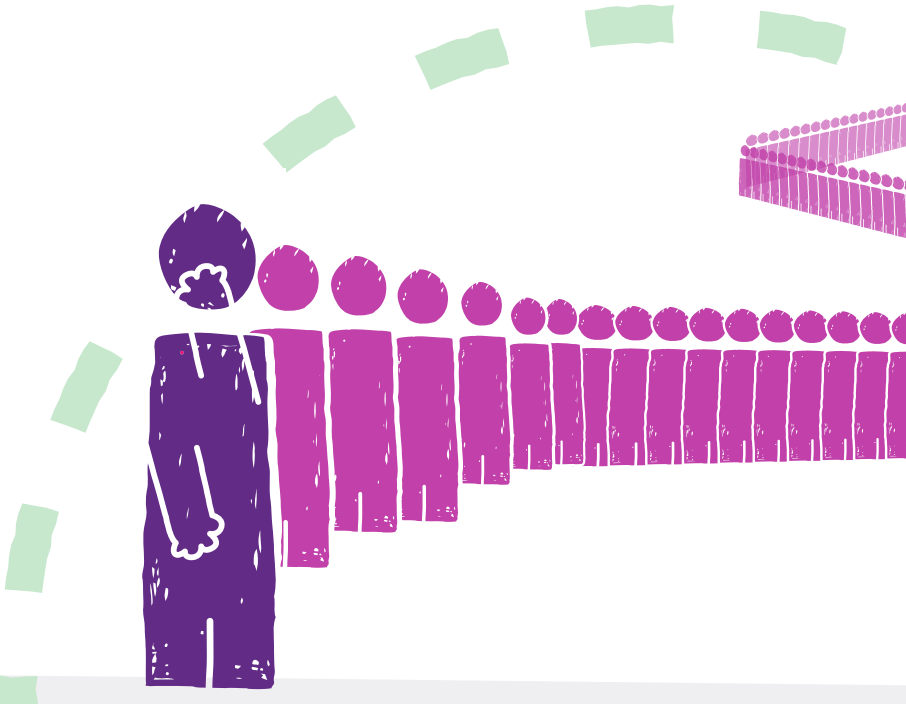
The Impact of COVID-19

While Ireland succeeded in taking care of the physical health of individuals with complex needs during the pandemic, nonetheless the mental health impact of the restrictions was, as in many other countries, left largely unattended.

Towards Dual Recovery

In spite of the fact that individuals with a Dual Diagnosis experience a wide range of negative outcomes, there is significant lack of care for this population in Europe, with just 1.2% of services targeted specifically at Dual Diagnosis. Ireland currently operates just six services that engage in local integration efforts between mental health and SUD/AUD services. Ireland is committed, under the new mental health plan, to develop a model of integrated service provision for the care of this cohort by 2024.

> .. Ireland currently operates **JUST SIX SERVICES** that engage in local integration efforts between mental health and SUD/AUD services ..



3. METHODOLOGY

As an organisation which advocates for mental health in the voluntary sector in Ireland, Mental Health Reform (MHR) provides a unified voice in campaigning for reform of mental health services. Many of its 77 members are engaged in supporting individuals with mental health difficulty, SUD/AUD and HHI. The organisation organised an online roundtable discussion on the issues of Dual Diagnosis, and specifically Dual Recovery (16.11.2021) attended by 29 members. This qualitative study sought to provide further exploration of the issues raised at this discussion.

Study Aims and Objectives

This research study is a qualitative analysis of the concept of Dual Recovery, its meaning as well as barriers to Dual Recovery for individuals with a Dual Diagnosis as understood by service providers and advocates in the field of mental health difficulty, SUD/AUD, homelessness and Dual Diagnosis.

Specifically, the research had the following aims:

RESEARCH AIMS

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.

Research Design

The study used a qualitative approach, allowing participants to explore their own views and understanding, personally and organisationally, of the meaning of Dual Recovery and what is needed to achieve that aim. Interviews were conducted using a semi-structured, open ended interview schedule.

Purposive sampling was used to ensure that data collection represented a broad input from organisations involved in the direct or indirect care of individuals with a Dual Diagnosis. Specifically, the research aimed to include organisations that were already providing a level of cross-sector care either which were mental health-led, SUD/AUD-led or HHI-led but also provided support in all three areas of difficulty.

Participants were recruited by email initially following the online discussion and asked if they, or someone within their organisation, would be interested in taking part in the study. A total of twelve participants were initially contacted, given a participant information leaflet and consent form, and a period of one week to decide on participation. Of that twelve, seven agreed to participate and a further five participants were recruited as a result of their recommendations. Twelve interviews were conducted in total – the majority (n=9) were directly engaged in support to people with mental health difficulty, SUD/AUD and housing, but also provided cross care. The remaining three participants supported individuals with a Dual Diagnosis at policy or advocacy level.

Data Collection

Interviews were conducted by two independent researchers between 26.11.2021 and 10.12.2021, and the majority of the interviews were online (Zoom). Interviews lasted an average of 36:00 minutes.

Data Analysis and Anonymisation

Interviews were transcribed verbatim and any potentially identifying information was removed. Each participant was assigned a pseudonym for inclusion in the report and are referred to as representatives of their organisations in broad terms.

Interviews were analysed using NVivo and used the Framework Method, allowing for organisation of data into categories jointly developed by the researchers. In identifying commonalities and differences in the data, the researchers were able to draw descriptive explanations clustered around themes, enabling a lucid, synthesised and valid interpretation of the data.

Data Protection

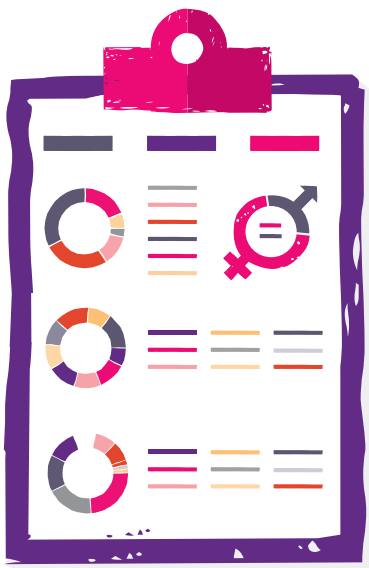
Separate recording devices were used to record the interviews, data was fully anonymised and transcripts were securely held using an alpha-numeric code. All computers and recording devices were double-encrypted and stored securely. All GDPR guidelines were adhered to and only the immediate members of the research team had access to the study materials.

Challenges with the Study

The decision to recruit participants already providing cross care meant that those engaged in the provision of care for one exclusive cohort (i.e. those with mental health difficulty without SUD/AUD) did not participate.

The study aimed to interview between 9 and 12 participants across a range of services. Qualitative research is not aimed at making generalisations to a larger population but is concerned with induction and is emergent in nature. There is no ideal sample size and data is deemed to be complete where no new data emerges. This concept of data saturation is widely accepted as a methodological principle in qualitative research.

> .. the study aimed to interview between 9–12 participants across a range of services ..



4. KEY FINDINGS

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 subsequently led to the creation of a number of barriers to the provision of care for this cohort including issues with collaboration, training and access to planned and continued care. Participants also pinpointed a number of social barriers including HHI, social exclusion and stigma. They discussed the impact of COVID-19 restrictions on the care for individuals with a Dual Diagnosis. Their discourse also explored the proposed new model of care for individuals with a Dual Diagnosis. These findings are summarised below.

SUMMARY

Divergent Philosophies as Barriers to Dual Recovery

These findings focus on the barriers to care created by divergent recovery philosophies which in turn have created systemic barriers to Dual Recovery.

* ***Recovery Philosophies***
  On a micro level, recovery is widely accepted as holistic. On a macro level, recovery is poorly understood and there is difficulty translating policy into action.
* ***Models of Care***
  Models of care are experienced as linear, inflexible and unintegrated

Social Barriers to Dual Recovery

* Social barriers to Dual Recovery focussed on homelessness, social isolation and multi-stigmatisation

Dual Recovery in a Pandemic

* An emphasis on public (physical) health measures to the detriment of care for people with psychosocial issues

Towards a new Model of Care

* Broadly welcomed, but essential that the lived experiences of individuals with a Dual Diagnosis is key to its development, implementation and continuous monitoring and is adequately funded.

Systemic Barriers to Dual Recovery

* ***Poor Interagency Collaboration***
  Interagency collaboration was found to be challenging, with an over-reliance on a medical model and specific difficulty with psychiatric/mental health services
* ***Lack of Training***
  An absence of cross-education training in Dual Diagnosis for services generally as well as for GPs and personnel in social care was found to create a lack of understanding on the issues
* ***Problematic Care Pathways***
  Discourse on care pathways arose as participants found wide variations in access to support, which was often dependent on location. Families, in particular, found it difficult to access care and there was evidence of a lack of early intervention as well as limited GP/mental health input
* ***Lack of Continuity of Care***
  Participants felt that there was little continuity of care and that short term responses were inadequate, with discharge from hospital A&E especially problematic
* ***Limited Care Planning Involvement***
  Participants also felt that there was a need to engage individuals with a Dual Diagnosis in their own care planning

5. DISCUSSION

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

Until recently Irish policy on mental health difficulty, SUD/AUD and HHI has developed as separate strategies resulting in the effective exclusion of individuals with a Dual Diagnosis from access to care. Following deinstitutionalisation, mental health policy has been slow in responding to the needs of people with mental health difficulty. It has also served to explicitly exclude individuals with a Dual Diagnosis, placing the responsibility of care for individuals with a Dual Diagnosis outside of the mental health system.

This duality of policy has had a number of effects on the provision of care to individuals with a Dual Diagnosis, resulting in the creation of divergent recovery philosophies and models of care.

Participants in this study felt that while recovery as a holistic process was widely understood at a micro level, on a macro level there was poor understanding of this approach and that there was considerable difficulty translating policy into action.

The evidence of non-linear relationships between mental health difficulty, SUD/AUD and HHI is central to the experience of individuals with a Dual Diagnosis, yet until recently Irish policy has consistently failed to address this. Participants discussed the impacts of this one accessing care, citing their experiences of existing access to care as linear, inflexible and unintegrated.

This lack of cohesive understanding has resulted in the creation of a number of systemic barriers to Dual Recovery. Participants in this study referred to the challenging nature of interagency collaboration, an over reliance on a medical model and specific difficulty in interacting with psychiatric and mental health services.

Furthermore, an absence of cross-education training on Dual Diagnosis was evident, creating a lack of understanding of the issue. Care pathways were experienced as hugely varied and often dependent on location, with families in particular finding it difficult to access care.

When care was available, it often came in the form of short term responses which were inadequate, especially following hospital discharge from A&E, with little evidence of individual engagement in care planning.

.. lack of cohesive under-standing has resulted in the creation of a number of systemic barriers to dual recovery ..

The systemic barriers discussed have in turn created a number of social barriers to Dual Recovery, positioning individuals with a Dual Diagnosis at the extreme end of social exclusion who are stigmatised at societal level and also within healthcare settings. Participants discussed the extreme isolation of individuals with a Dual Diagnosis who were often homeless and experience stigma on personal and institutional levels.

While there was evidence of greater levels of interagency collaboration at the outset of the COVID-19 pandemic, this appears not to have been maintained. Equally, the focus on the physical health threat of the virus has meant that the psychological impact of the pandemic has been largely left unattended.

The proposed new Model of Care for individuals with a Dual Diagnosis has the potential to address many of the issues raised by service providers in this study. However, the participants expressed concern that any new approach should be grounded in the input of those with lived experience of Dual Diagnosis and is underpinned by a human rights based approach which receives adequate and consistent funding.

6. CONCLUSION AND RECOMMENDATIONS

In spite of a recent movement towards recovery and health-led holistic strategies, there are a number of barriers to care for individuals with a Dual Diagnosis and it is imperative that mental health services reflect this reality. The recommendations are informed by those working directly with individuals with a Dual Diagnosis and puts forward the following four over-arching recommendations, some of which are measured against the recommendations within the 2022-2024 *Sharing the Vision* (STV) Implementation Plan:

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, Outcome 2(d): STV Implementation Plan] which specifically relates to individuals with Dual Diagnosis.

Recommendations are:

1.1 Embed the expertise of individuals with lived experience of Dual Diagnosis 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 and the prevalence of Dual Diagnosis needs to be established. The existing reporting systems in mental health and addiction could be modified to this end.

1.3 A National Protocol for Dual Diagnosis should be developed to ensure two-way collaboration between mental health and addiction services across all sectors.

1.4 A dedicated Dual Diagnosis Practitioner post should be funded in each of the relevant Community and Voluntary Sector (CVS) organisations.

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, including training in human rights, respect for the person's will and preferences as well as supporting recovery.

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. 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 Implementation Plan] 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.

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.

3.6 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

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

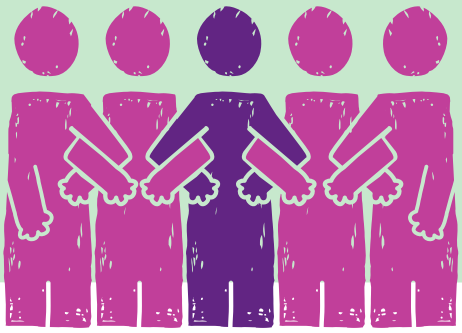
4.1 Continued commitment to expanding the Housing First model with social inclusion, tenancy sustainment and recovery supports.

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.

> **..those with Dual Diagnosis must be considered in housing and social inclusion strategies..**



ACKNOWLEDGMENTS

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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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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.

DUAL RECOVERY

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