

The role of mental health service (psychiatrists) and primary care services (GPs) in their treatment of dual diagnosis. A comparative study.

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ABSTRACT

OBJECTIVE: This research study set out to compare two treatment services Primary Care Services (GPs) and Mental Health Services (Psychiatrists) in their treatment of patients with dual diagnosis in an Irish population. DESIGN: A postal questionnaire with five sections Section 1: General Questions on demographics (Q.1 – 3a). Section 2: Policy / Service Provision (Q.4 – 8b). Section 3: Co-ordination of care (Q.9 -15). Section 4: Policy / Assessment (Q16 – 16a). Section 5: The management of Dual Diagnosis. SUBJECTS AND SETTING: Two hundred ($n=200$) Dublin GPs and two hundred ($n=200$) Psychiatrists RESULTS: 85% of Psychiatrists compared to only 50% of the GPs stated that their definition for dual diagnosis was the same or similar to the one that had been given to them at the beginning of the study and in addition it was found that 27.7% more patients with drug and alcohol problems are likely to be treated by Psychiatrists than GPs. Thus in practice GPs are less likely than Psychiatrists to have a treatment model for dual diagnosis. It was also found that In comparison to Psychiatrists, GPs treat patients with dual diagnosis as having two separate conditions, Cohen's $d = 0.627$. CONCLUSION: Addiction services are reluctant to accept individuals with a dual diagnosis because of their lack of mental health training. The stark findings in this study show a lack of policies and structures that need to be implemented if service providers are to start treating patients with a dual diagnosis. Lack of structures for treating dual diagnosis can account for the high percentage of readmissions for patients with dual diagnosis. From the evidence provided it is apparent that Primary care services and mental health services continue to function as two separate services.

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CHAPTER 1: INTRODUCTION & LITERATURE REVIEW

1.0 INTRODUCTION

Mental illness and addiction frequently occur together but have traditionally been treated separately, often in isolation and with an unsuccessful history (MacGabhann et al 2004). Complex interactions between the two can have serious consequences for the health and well being of the individual patient. Successful treatment of either substance disorders or mental illness is extremely challenging if treated separately. Both disorders are chronic, relapsing, stigmatising and potentially disabling. Mental health and substance misuse problems generally require the use of long-term management approaches by the relevant treatment services and when appropriate in general practice. The term dual diagnosis and co-morbidity are interchangeably used. There is at present considerable debate surrounding the appropriateness of these terms to describe what is commonly a heterogeneous group of individuals with complex needs and a varied range of problems.

Clinicians have long been confronted with a number of perplexing problems in their attempts to treat dual diagnosis patients who present with long and complex mental illnesses. The majority of problems in treating these patients have been attributed to inappropriate assessment tools and poor co-ordination of care among the various treating professionals (Teeson & Proudfoot 2004).

Dual diagnosis is a relatively new phenomenon with service providers only in the last two decades accepting its existence as a condition requiring treatment. With this in mind it is worth mentioning that there is little research or development in relation to dual diagnosis specifically in Ireland. It is also a fact that the term dual diagnosis only appeared for the first time in “A Vision for Change 2006”. This was the first government published document to recognise the term Dual diagnosis. “Mental Health and Addiction Services and the

Management of Dual Diagnosis in Ireland” a research study into the prevalence of dual diagnosis in Ireland by (MacGabhann et al 2004) provided the basis for this research study in their recommendations that further research was needed in relation to the role of GPs and primary care in the management of dual diagnosis.

This research study set out to compare two treatment services Primary Care Services (GPs) and Mental Health Services (Psychiatrists) in their treatment of patients with dual diagnosis in an Irish population. The structure of the literature used for this study firstly addresses the psychiatric services incorporating the forensic mental health service and judicial system both in Ireland and abroad in relation to the prevalence of dual diagnosis in mental health settings. It shows how the Irish social policy with regard to its increasing drug culture has impacted on mental health services in relation to the treatment of dual diagnosis. Primary care services are addressed in relation to the prevalence and treatment of dual diagnosis both from an Irish and international perspective. The final part of the literature review addresses current treatment models in relation to dual diagnosis.

1.1 Definitions & Terminology

Mental illness is defined in the Mental Health Act 2001 as “a state of mind of a person which affects the person’s thinking, perceiving, emotion or judgement and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment in his or her own interest”.

Substance misuse can be defined when alcohol, or other drugs, are abused and cause significant emotional, social and mental health problems. Individuals who have a substance abuse disorder have a strong desire to use substances they have difficulty controlling and will very often experience problems associated with their usage. Substance misuse typically

encapsulates substance abuse and substance dependence and is defined under a substance use disorder in the Diagnostic and Statistical Manual of Mental Disorders {DSM-iv-tr} (American Psychiatric Association, 2003). Substance misuse diagnosis arises from the continued use of substances in situations that are hazardous or that result in significant mental problems {DSM-iv-tr}. Moderate substance misuse can affect the brain's neurochemistry and result in the patient presenting with psychiatric symptoms, it can also exacerbate or mask psychiatric symptoms, (Hall, Lynskey, & Teeson, 2000).

The World Health Organisation (WHO 1994) defined dual diagnosis/co-morbidity as having a substance misuse co-existing with a psychiatric disorder. For this research study it was decided to use the term dual diagnosis rather than the term co-morbidity.

CHAPTER 2: LITERATURE REVIEW

2.0 Chapter Introduction

The purpose of this literature review is to provide the context for this report, particularly in terms of highlighting the need to know about dual diagnosis. The literature contains much discussion about what dual diagnosis is, and introduces considerable debate on the use of the terminology relating to the subject. It also introduces the history of Irish social policy in relation to the development of treatment protocols for patients who have a dual diagnosis. The next section will address the prevalence of dual diagnosis in the mental health services.

2.1 Mental Health Services (Psychiatrists)

2.1.1 Prevalence of Dual Diagnosis.

One of the most comprehensive studies to date which was conducted in the United States of America USA, the Epidemiologic Catchment Area study (ECAS) estimated that over half of all adults suffering from mental illnesses are also affected by substance use disorders. The same study found that the rate of lifetime substance use disorder in the general population was 17 percent, compared with 48 percent for persons with schizophrenia and 56 percent for persons with bipolar disorder, (Reiger et al. 1990). Further studies in the USA by Kessler et al. (1994) found that 27 percent of the people who had been diagnosed with a psychiatric disorder also abused substances. Research based evidence by Bourtros et al. (1998) also showed a rapid increase in the number of admissions to the Connecticut State Hospital as drug related. They found that for patients with a first time admission with a diagnosis of psychosis, prevalence rates for substance misuse was 20-30%.

An Australian study on the prevalence of dual diagnosis in the community estimated that its co-occurrence was somewhere between 30 percent and 80 percent, (New South Wales (NSW) Health Authority, 2000). These persons often have difficulty accessing appropriate

services for their dual diagnosis due to barriers in both mental health and substance abuse. Research studies have shown that the number of people with a psychotic disorder who misuse alcohol and illicit substances is higher than those with a psychotic disorder who do not use alcohol or illicit substances (Fowler et al. 1998; Regier et al. 1990; Schneier & Siris 1987). Research also indicates a worsening of mental health symptoms in individuals with psychotic disorders who misuse substances, including an increase in the psychiatric admission rates (Martinez-Aravelo et al. 1994) depressive symptoms and suicidal ideation (Strakowski et al. 1994; Krausz et al. 1996) and increased positive symptoms of psychosis (Rolfe et al. 1999) such as suspicion and grandiose delusions (Strakowski et al. 1994).

U.K. prevalence figures are relatively scarce. The only recent large scale study in the U.K. is the OPCS National Psychiatric Morbidity Survey which showed 2 percent of the “household” population in the U.K. were rated as drug dependent and were 8 times more likely to have a psychiatric illness compared to the general population, (Farrell et al, 1998). The survey also found that there had been an increased usage of GP services by drug dependent individuals. Another survey conducted of a population of dual diagnosed patients in the inner London hospitals by (Menezes et al. 1996) found that 36 percent of admissions had polysubstance misuse. Patients with substance misuse problems had twice as many admissions in the previous 2 years as those who were drug and alcohol free. Prevalence figures for dual diagnosed patients are usually based on hospital populations, which by nature are only a representative sample. Inpatient treatment is usually as a last resort for individuals warranting immediate treatment and therefore is representative of only the acutely ill population. It is also likely that a number of individuals would not present for inpatient treatment as they would be treated by the GPs (Menezes et al. 1996).

Condren et al. (2001) found similar prevalence rates in an Irish study on illicit substance and alcohol misuse in outpatients with Schizophrenia. Their findings showed that there was a prevalence rate of 45 percent for illicit substances and 33 percent for alcohol. Findings by Kamali et al. (2000) showed that 39 percent of inpatients with a diagnosis of schizophrenia had a history of substance misuse. The main substances involved were alcohol, cannabis or a combination of both (MacGabhann et al. 2004). Several studies have addressed the link between dual diagnosis and violent behaviour. The following sections will look at dual diagnosis within this setting.

2.1.2 Violence and Dual Diagnosis.

Studies by Bartles et al. 1991; Cuffel,1994; Eronen et al. 1996; Swanson et al. 1990 Tardiff et al. 1997 (cited in MacGabhann et al. p.28) stated that “the association between violent behaviour and dual diagnosis is greater than that between violent behaviour and mental illness alone. Swanson et al. (1990) reporting results from the ECAS, discovered a one year prevalence rate for violence in people with schizophrenia who also misused substances of (30.33%) that was four times greater than that in people with schizophrenia alone” (8.36%) which was, in turn, four times greater than that in people with no psychiatric disorder and substance misuse alone (2.05%). “The Detection and treatment of Substance Abuse in Offenders with Major Mental Illness” was an intervention study researched by Ritchie, G. et al. (2002). The results of this study showed that alcohol and drug misuse increase the likelihood of violent behaviour and have a deleterious effect on the mental health of people with major mental illness. Furthermore, the combination of substance misuse and mental illness is known to increase the incidence of aggressive behaviour (Ritchie, G. et al. 2002). Scott et al. (1998) “showed that the overall levels of violence in a community care group were considered low but found that patients with a dual diagnosis were over six times more likely to report hostile and violent behaviour” (MacGabhann et al, p.28).

2.1.3 Forensic Mental Health Services and Dual Diagnosis.

The National Forensic Services of Ireland looked at the prevalence rate of dual diagnosis in a needs assessment study conducted by Dr. H. Kennedy Consultant Forensic Psychiatrist on all admissions to the Central Mental Hospital, Dublin between 1997 -1999. It revealed that 450 patients had been admitted to the hospital during this period.

- Out of the 450 a census group of 89 patients was used in the study.
- There were 82 male patients representing 92% and there were 7 females representing 8% for this census group, the mean age was 40.5 years.
- The findings showed that there was dual diagnosis for Alcohol of 52%, for Intravenous Drug Addiction 11% and for all Other Drugs 58%.
- On a further breakdown of these figures the total number of admissions for 1997 was 140 patients of whom 6% had substance abuse and dependence related issues.
- For 1998 the total number of patients admitted was 149 of whom 11% had substance abuse and dependence related issues.
- In 1999 there were 196 patients admitted of whom 9% had substance abuse and dependence related issues.

In a recent unpublished review that the author conducted of all admissions to the Central Mental Hospital, Dublin, for 2005 it was found that 65 of the 77 (84 %) patients who had been admitted had co morbidity for drug and alcohol problems of varying degrees. The findings showed that there was co morbidity for Drugs only of 23%, for Alcohol only of 10% and for Drugs and Alcohol of 50%. It can be seen from the above breakdown of yearly figures that there is an increase in the number of patients admitted for 2005 with substance misuse problems and a mental illness.

Research into drugs and alcohol misuse by Thomson et al. (1997) at the State Hospital Carstairs, Scotland, showed that alcohol and drug misuse prior to admission to the special medium and high secure psychiatric services in Scotland was high. They also found that the problem was worsening. The research indicated that 55% of the patient group met the criteria for dual diagnosis.

2.1.4 Dual Diagnosis in the Judicial System.

Evidence based research also indicates that there is an increase in the number of committals by the judicial system of people with a dual diagnosis. In a recent report submitted to the Minister for Health in January 2006 by the expert group on Mental Health Policy in Ireland “A Vision for Change” it showed that there are up to 12,000 committals made yearly to the 14 prisons in Ireland. Of these it stated that 2.6% of all sentenced prisoners suffered from a severe mental illness. This figure went up to 7.6% among the remand prisoners. The report stated that 70% of these were addicted to alcohol and drugs. It also stated “these figures were far above those prevailing in the general public” (Department of Health 2006). Recommendations included in this document were for the establishment of a clinical nurse specialist in addictions to be assigned to the relevant centres. In relation to service provision there is currently a clinical nurse specialist employed in the forensic mental health services at the central mental hospital in Dublin.

This research is further supported by Duffy et al.’s (2006) study which investigated the Psychiatric morbidity in the male sentenced Irish prisons population. Their findings suggested that “the prevalence of drugs and alcohol problems was high among fixed and life-sentences prisoners. Dual diagnosis was common with 2.4% prevalence of psychosis for fixed sentenced prisoners and 7.1% for lifers.” They found that these findings were similar to an international “meta analysis”. They also found that “72.9% of prisoners reported a history

of harmful use or dependency on either alcohol or drugs on committal to prison”. There findings also revealed that “there was a high prevalence of substance problems among psychotic prisoners which did not differ significantly from non-psychotic prisoners”. They felt that this lack of significant difference only emphasised “the difficulties concerning diagnosis and natural history in those with psychotic illness who use intoxicants. In this study, all those with a lifetime diagnosis of a mental illness were known to the community mental health services, as were 23% of all fixed sentence prisoners. The perception that “forensic” patients are qualitatively different from other patients in the community mental health services e.g. due to their dual diagnosis, is not borne out by this data” (Duffy et al. 2006).

Further evidence to support the prevalence of dual diagnosis in forensic mental health comes from a study by Wright et al. 2006 which addressed the psychiatric morbidity among women prisoners newly committed and amongst remand and sentenced women in the Irish prison system. The findings from this study showed that “5.4% of the committals and 5.4% of the cross-sectional sample had a psychotic illness within the previous six months. 8.5% of the committals and 16.3% of the women in the cross-sectional sample had a major depressive disorder in the last six months. 8.6% of committals and 15.2% in the cross-sectional sample had an anxiety disorder in the past six months. 65.6% of the women interviewed at committal and 65.2% of the cross-sectional sample had a substance misuse problem in the last six months (94 newly committed prisoners representing 9% of committals per year and a cross-sectional sample of 92 women representing 90% of women already in custody were used for in this study).

2.1.5 U.S.A. Based Research

There is further evidence to support the progressively growing prison population with a dual diagnosis. A study by Torrey (1995) of American jails claimed that “jails and prisons were replacing public mental hospitals as the primary purveyors of public psychiatric services for individuals with serious mental illness in the United States”. He also reported that in the San Diego county jail “14% of males and 25% of female inmates were on psychiatric medication”. Torrey (1995) also claimed that “the majority of seriously mentally ill individuals who end up in jail have been charged with relatively minor offences which included alcohol and drug related offences”. Teplin (1990) conducted an epidemiological study of mental illness in the largest American jail, Cook County jail in Chicago. Her findings showed that “9% of male urban jail detainees had a severe mental disorder (schizophrenia or major affective disorder) at sometime during their lifetime, 6% had a current episode and that these figures were two to three times higher than the general population rates” (Teplin 1990). The figures found for females were startlingly higher with over 80% of the sample meeting the criteria for one or more lifetime episodes of severe mental illness according to the DSM-111-R. “Substance abuse or dependence was extremely prevalent affecting 70% of the sample overall and 60% within six months of the study interview” (Teplin 1990). It was found that the drugs that were predominantly misused were heroin and cocaine.

2.1.6 U.K. Based Research

Evidence from a U.K. study of a group of community care patients with a dual diagnosis in an inner city catchment area in south London Scott et al. (1998) found that “dual diagnosed patients were five times more likely than patients with psychosis only to report a lifetime history of criminal offending. Greater severity of offending, such as assault and increased rates of imprisonment were also found in this group” (MacGabhann et al, p.28). The study

showed that the overall levels of violence in the group were considered low but found that patients with a dual diagnosis were over six times more likely to report hostile and violent behaviour. This was supported by (Wright et al 2002) who found a higher rate of offending behaviour in patients with a dual diagnosis.

The drug culture in Ireland is a relatively new phenomenon. Social policy has been developing strategies in dealing with this phenomenon since the mid 1960s. According to MacGabhann et al. (2004 p13) “Dual diagnosis is not clearly understood or formally recognised in policy, nor often, in mainstream addiction and mental health services themselves. Whereas many aspects of dual diagnosis were formally overlooked, there is now an initial picture of how these are being addressed in addiction and mental health services. They are fragmented, with a mixture of service models applied, seemingly to align with an overall service model rather than with the complex needs of people with dual diagnosis”. The following section shows how historically social policy has developed in Ireland in relation to the treatment of dual diagnosis.

2.2 Social Policy in Irish Mental Health and Addiction Services

2.2.1 Historical Evidence.

Historically treatment for substance abuse was reliant on psychiatric inpatient hospitalisation. Previous documentation recommended the move away from hospitalisation to care in the community under the primary care services GPs (Department of Health, 1984). The document “Planning for the Future” (Department of Health, 1984), “outlined how admission rates for alcohol-related problems were increasing, mainly as a result of the psychiatric hospital being seen as a treatment centre for such problems as well as a result of public pressure on people to seek hospital admission in the unrealistic belief that a stay in hospital would cure them” (Irish college of Psychiatrists 2005). By the mid 1970’s half of

all male admissions to psychiatric hospitals were for alcoholism (Butler 2002). Butler goes on to state that this was due mainly to the fact that alcoholism was widely accepted by almost everybody in Ireland, including the World Health Organisation (WHO), as a disease and should be treated as such. Butler found that during the period 1973-1988 Ireland was faced with the emergence of a new public health perspective on alcoholism. It was also a period which saw conflict between the disease model and the public health perspective. In 1980 the WHO recommended that Ireland adopt policies to reduce alcohol consumption levels. He stated that this was met with some difficulties as Ireland had a cultural tolerance towards alcohol and Irish people had a strong belief in the disease concept arguing that it was a culture which liked the disease concept and the public health perspective and was regarded as generally unpalatable. According to Butler the 1960's is universally associated with increase in drug use and this was attributed to the youth culture of the time for example the free spirited hippies. The working party on drug misuse 1968-1971 was the first official committee set up to address the drug problems seen to be emerging in Ireland. It was based within the Department of Health; this committee believed that a supply reduction system was more important than a treatment system. Up until now little to no research evidence had been available as difficulties have been encountered in obtaining evidence.

2.2.2 Research Evidence

There was little statistical evidence to support the claim that Ireland was facing an increase in drug use apart from the observations made by the Gardai (Butler, 2002). According to Butler Gardai claimed that there was an increase in the number of pharmacy robberies in the greater Dublin area a claim that was supported by the Crime figures involving known drug users which increased from 350 cases in 1969 to 940 in 1997. The drugs commonly used at the time were Cannabis and Lysergic Acid Diethylamide (LSD). Heroin and synthetic opiates were not being used at this time. A Strategic Taskforce set up during this time

recommended that an advisory body on drugs should be established to monitor the changing drug scene and that an education programme geared towards young people be implemented with the aim of prevention similar to that of the National Council on Alcoholism. This proposal was met with criticism especially from the Catholic Church, which questioned its integrity. Despite all the concerns with whether to educate or not to educate school goes on the effects of drug use the committee on drug education noticed that little by way of education was being carried out in the schools, (Butler 2002). Butler also noted that there was also little by way of effective treatments made available as the following section indicates there was no Irish drug policy in relation to treatment.

2.2.3 Traditional Treatment Services

Despite the need for treatment and rehabilitation services for drug users to be implemented, similar to those in existence for alcoholics (in accordance with the Alcohol Policy) no Irish Drug Policy was available. Inpatient treatment centres were set up in the wrong locations, most were in psychiatric hospitals or they were placed in centres that had been originally set up for the treatment of alcoholics in units like St Dymphna's (this was a unit attached to St. Brendan's Psychiatric hospital). This proved not to benefit either the alcoholic or the illicit drug user. A belief also began to emerge that illicit drug users had no psychiatric problems and therefore treating them in psychiatric hospitals was inappropriate. In 1972 Usher's Island opened as an out-patient facility for young addicts. The first voluntary body set up offering treatment facilities for illicit drug users was the Coolemine Therapeutic services in 1973. In 1977 the only Health Board inpatient treatment centre for drug users was Jervis St Hospital. The overall view held on addicts was that these young people constituted a more deviant and behaviourally difficult group than alcoholics, (Butler, S. 2002).

2.2.4 Drug Changing Patterns

There was a radical change in the drug scene in the Dublin area in the period 1980-1985 with the increased availability of Heroin being used intravenously by young people who came from the disadvantaged inner-city and the peripheral working-class areas around Dublin. Despite increasing numbers of illicit drug users the Department of Health had still failed to acknowledge the arrival of Heroin onto the streets of Dublin nor had it any contingency plans in place to implement. Political disharmony within the various government bodies and a lack of full understanding of the implications of Heroin use were the excuses used by the policy makers. The Special Government Task Force on Drug Abuse was set up in 1983 with the agenda to sort out the emerging drug scene in Dublin, (Butler, S. 2002).

The period 1986-1996 saw the relocation of the National Drug Treatment Centre Board from Jervis St. Hospital to Pearse Street and renamed Trinity Court. In 1999 the government's strategy to prevent drug misuse recommended a move away from centralised drug treatment centres and was to include GP's in the Methadone treatment programmes for addicts. It also saw the beginning of the needle exchange programme for addicts who remained on Heroin. It was during this period that Irish society began to accept that it had a drugs problem and that new approaches and disciplines needed to be looked for. Throughout this decade the Department of Health remained the dominant body determining policy making, (Butler, 2002). Ireland was not alone the UK were also having difficulties which can be seen from the next section.

2.2.5 U.K. Mental Health and Addiction Services

Over in the United Kingdom (U.K.) there was concern about the increase in drug misuse which was also emerging there. The Task Force to Review Services for the Drug Users (U.K. Department of Health, 1996) were recommending that all drug users needed to have access

to primary care through normal registration with a GP and that GPs were well positioned to identify and offer advice to drug users in relation to specialist services. The GP is recognised as the first port of call for patients and should be providing shared care for individuals with substance abuse and mental illness (U.K. Department of Health, 1996). The following sections will address dual diagnosis in the primary care services.

2.3 Primary Care Services (GPs)

2.3.1 Prevalence of Dual Diagnosis.

The coexistence of substance use and mental health problems creates a problem for specialist services and primary care services alike. Dual diagnosis appears to be common, and interactions between the two conditions perpetuate a high degree of suffering. It is widely accepted that GPs encounter a large number of patients with dual diagnosis but the majority of them struggle to provide adequate care for these patients as they simply do not have enough time, knowledge or experience. It can be argued that the knowledge base regarding the management of patients with dual diagnosis in the primary health services may be considered sparse at best.

MacGabhann et al.'s (2004 study) "Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland" found that the addiction services and the mental health services both worked in parallel with regard to the treatment of dual diagnosis. In other words problems were treated separately, the addiction services treated the addiction and then referred the patient to the mental health services and the mental health services treated the mental health problems and then referred the patient to the addiction services for treatment for their addictions. However neither service treated both together. The treatment services available to patients in Ireland individually appeared to exclude patients with a dual

diagnosis. Further support for these findings can be seen in the following section which uses similar studies found in the U.K.

2.3.2 U.K. Research Findings and Treatment Recommendations.

When Ritchie et al. (2002) investigated substance misuse and mental illness in offenders at the State Hospital Carstairs, Scotland, they found that by using questionnaires such as the Drug Abuse Screening Test DAST-20 and the Alcohol Dependence Scale ADS substantially increased their findings in support of prevalence rates of alcohol and drug misuse in patients with a mental illness. These results reinforced the need for an active screening and treatment strategy in patients with dual diagnosis. The intervention programme that they used as part of their study was also successful in raising knowledge of alcohol and drugs and their harmful effects (Ritchie, G. et al. 2002).

These findings are supported in the U.K. by (Strathdee et al. 2002) in their epidemiological needs assessment and design of a training and service response model. In this they found that the treatment of people with a dual diagnosis was generally less successful when treated independently by both services. The study assessed the rates of dual diagnosis in five treatment settings, primary care, addiction services, mental health services, forensic psychiatry and community care services. The findings of this study showed that it was possible to develop a brief screening and assessment procedure for dual diagnosis that could be used routinely in brief assessments by GPs and in general by staff from a wide range of backgrounds. The main research instrument selected for the brief assessments was the Mini International Neuropsychiatric Interview “MINI” (Sheehan et al. 1998). This screen took around 7-10 minutes to complete. It could later be followed by a more comprehensive assessment for those who screened positive for at least one substance misuse and one mental health problem.

Strathdee et al. (2002) found that the recruitment of specialist services to the study was extremely encouraging although the response from GP practices was less so, with only six practices agreeing to take part in this south London borough of Bromley study. What developed from this study was that part of the recommendations stated that people with mild mental health problems and substance misuse should be treated by the primary care services. In comparison people with a severe mental illness and substance misuse, who are more likely to need the joint working of both mental health and substance misuse services, it recommends their treatment should be led by the mental health teams and be in line with current models of care. In all of the services studied by Strathdee et al. (2002) they found that patients with a dual diagnosis had more complex problems, greater criminal involvement, more behavioural problems and a poorer quality of life than their equivalents with no dual diagnosis problems.

Further evidence to show GPs reluctance in the treatment of dual diagnosis is found in a paper delivered by Professor Louis Appleby 2002, to members of the British government. On the issue of dual diagnosis Prof. Appleby said that “dual diagnosis was probably the main problem faced by mental health clinicians as the problem usually spanned two services - mental health and addictions and this could result in people falling between services”. When elaborating on this agenda he also stated that 30% of all patients with mental health problems went to visit their GPs but the level of training for GPs on mental health was poor. When asked, some GPs did say that they would be willing to treat people with a dual diagnosis but also stated that the funding available was inappropriate. Similar findings that were found in Australian studies such as that by (McCabe & Holmwood 2002) are shown in the following section.

2.3.3 Australian Research Findings and Treatment Recommendations.

General practitioners are amongst the most accessible health care professionals in Australia. They see 85% of Australians at least once a year (McCabe & Holmwood 2002). The provision of brief interventions in general practice settings allows the GPs to manage the majority of patients with dual diagnosis reducing the need to refer them to psychiatric treatment services for example inpatient psychiatric hospitals. It is claimed that successful management of dual diagnosis will lead to a reduction in the use of substances and a minimisation of the effect of mental health issues and will significantly enhance the patient's quality of life (Kavanagh 2000). Despite considerable literature regarding dual diagnosis, there is limited information regarding the nature of specific effective approaches for the treatment of patients with dual diagnosis in general practice (Evans et al. 2000). Research has shown that dual diagnosis tends to respond poorly to traditional substance treatment programmes. It has been found that a comprehensive approach to management that addresses both the substance misuse and the mental health problem lead to significant improvements in the overall functioning of patients with dual diagnosis (Friedman et al. 1999). The successful outcome of any treatment process is dependent on the speed of illness/disease detection. The next section addresses the need for adequate assessment tools in assessing patients for dual diagnosis within a primary care services with the view to providing treatment.

2.3.4 Treatment Identified as Needed.

Further evidence to support these findings can be found in a study on dual diagnosis: "GPs the important but missing link in the system" (The PARC Co-morbidity Report 2002). The aim of this study was to identify and implement an effective role for the GP in the early detection and treatment of patients with dual diagnosis. Previous research had found that because of the complexity of dual diagnosis using a simple assessment tool would be clinically inappropriate. Recommendations from the study included the provision of

educational and training opportunities for GPs, the development of a shared cared model of treatment for patients with a dual diagnosis and general primary care services should adapt a multidisciplinary team approach to the treatment of patients with dual diagnosis (Central Division of General Practice 2002).

“The management of people with a co-existing mental health and substance use disorder guidelines” was developed in Australia by the New South Wales Health Department to address the unmet needs of people with a dual diagnosis. Included in its aims are “to improve the health care and health outcomes for people with dual diagnosis. To increase the knowledge, skills and the ability of all primary care providers to enable better identification, assessment, prevention and management for people with coexisting mental health and substance use disorders and to improve education and training for specialist and primary care providers.” (NSW Health Department, 2000 p3-4). Part of its brief was also to introduce screening and comprehensive assessments to identify individuals with a dual diagnosis. These included the identification of high risk groups and individuals with particular attention being directed at people with a family history of mental illness, substance misuse or both disorders. Evidence suggests that it is feasible to prevent the onset of both psychiatric and substance use disorders if early intervention and prevention strategies are implemented during childhood and adolescence (Teesson & Proudfoot 2004).

Engagement is seen as the first step towards developing a trusting relationship and is seen as one of the crucial factors in early interventions. It is also the area that most clinicians feel is the most difficult to achieve with people with a dual diagnosis. Assessment tools that aid the formulation of an early diagnosis need to be used both to address mental health and substance misuse problems. These include the Alcohol Use Disorder Identification Test known as the AUDIT and the General Health Questionnaire or the Mini Mental Health

Questionnaire (NSW health Department 2000). Prevention is a theme of both the NSW National Mental Health Plan (2003-2008) and the NSW National Drug Strategy (2004-2009). GPs are situated in the best position to provide these assessments. As already mentioned they are amongst the most accessible health care professionals in Australia “they see 85% of Australians at least once a year” (McCabe and Holmwood 2002). Early interventions are needed where patients present with a dual diagnosis. It is widely accepted that these are among the most difficult group of people to provide treatment for due mainly to their lack of engagement and motivation. The following section looks at how early interventions have been shown to make a difference in the treatment of patients with a dual diagnosis.

2.3.5 Early Interventions Recommended as a Treatment

The World Health Organisation “WHO” (1996) emphasised the need to implement strategies at primary care level to identify early, people consuming harmful amounts of alcohol. This report also outlines “the potential of primary care GPs for detecting and treating problem drinkers as the service has a high contact rate with large populations of people and provides continuing care ” (Faculty of Substance Misuse 2005). Several studies have shown the improved efficacy of treating substance misuse and mental health in primary care through the use of screening tools, brief interventions and monitoring. The Strategic Taskforce on Alcohol, Second Report (2004) outlines the need for early intervention in detecting alcohol abuse. It also made reference to the successful pilot study of ten GP practices that participated in screening, detection and brief interventions of individuals who presented with alcohol problems. The report also highlighted the importance of incorporating all GP practices into the screening of all patients for alcohol problems. This would be supported with training in relation to detoxification and the availability of an on-site addiction

counsellor. It has been envisaged that GPs would apply similar screening tools to assess patients who present with drug related problems, mental health related problems or both.

The WHO (2003) published the Alcohol, Smoking and Substance Involvement Screening Test ASSIST guidelines for use in primary care GP practices. It is a brief screening questionnaire to find out about people's usage of psychoactive and illicit substances. The WHO also reported that GPs have the opportunity to screen a broad range of people for general lifestyle issues as part of their health care service. It also stated that “ in developed countries up to 85% of people see their GP at least once a year” (WHO 2003) and patients with problems related to drug taking or mental illness are likely to present to their GPs more often.

2.4 Treatment Models

2.4.1 Historical Evidence

Historically, three types of treatment models have been identified in the literature; serial, parallel and integrated. Serial treatment model involved treating two conditions independently for example in a patient with dual diagnosis either the mental illness (depression) or the substance misuse (alcohol) would be treated first then the other one would be treated. Difficulties have been found with this approach as it was based on the assumption that one condition was more needy than the other when in fact, both mental illness and substance abuse are most likely to coexist in the same patient. Problems encountered with this treatment approach included exclusion and with this came relapse.

Professionals following the parallel model of treatment focus on treating both conditions simultaneously but by two different treatment agencies. Problems occur with approach when the patient finds it difficult to remain motivated enough to attend two different centres for

treatment. There can also be a conflict of interest when a patient attends two different services for simultaneous treatment.

The integrated model uses the same service provider to treat both conditions simultaneously. Research has shown that integrated model has produced the best treatment outcomes in comparison to the other two models.

2.4.2 International Evidence.

Internationally mental health and substance abuse professionals have recognised the increased need for an appropriate treatment model for individuals with dual diagnosis. As mentioned already the addictive and mental health treatment models emphasised separate philosophies and treatment approaches that contradicted each other and were therefore difficult to adapt to the needs of patients with dual diagnosis. What appears to be emerging as one of the best ways forward in the treatment approach to dual diagnosis is the integrated treatment model (MacGabhann et al. 2004). “In this shared-care model, mental health and substance misuse clinicians work together with a dual diagnosed client through combined clinics” (MacGabhann et al. 2004 p42-43). The integrated model so far is one of the most effective treatment models and the model of choice in the U.S.A. (MacGabhann et al. 2004).

2.4.3 Irish Evidence

Traditionally in Ireland the serial/sequential model has been the model used to treat mental illness and substance abuse, with both services providing the necessary treatments for their own service. Exclusion from treatment services can often be the result of the serial model, where individuals are being told that they were not eligible for treatment in one service until their other problem had been taken care of. Treatment recommendations resulting from the study “Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland” MacGabhann et al. 2004 recommended that “training and education should be

improved at all levels and that the introduction of a clinical nurse specialist in addiction, preferably a psychiatric nurse was desirable”. Also included in the study was the belief by the National Advisory Committee on Drugs NACD “that guidelines for managing dual diagnosis in Ireland should be developed by a specialist committee representative of stakeholders including the NACD, substance misuse psychiatry, general psychiatry, the Mental Health Commission, the Irish Psychiatric Association and the Irish College of Psychiatrists and others” (MacGabhann et al. 2004 p9).

Methadone has long been a treatment approach to managing patients with substance misuse problems. Traditionally methadone was dispensed through approved centres only in Dublin but with the spread of heroin nationally the need for GPs and Pharmacists prescribing or dispensing methadone has increased. The following statement highlights the current problems being experienced by GPs in relation to methadone treatment programmes.

In a recent editorial in the Irish medical times (2006) Dr. N. O’ Cleirigh a Dublin GP stated “that it is probably fear of the unknown that is keeping GPs from prescribing Methadone” the majority of methadone prescribing GPs are in the Dublin area. It was also revealed that some areas such as the midlands have no methadone clinics. Dr. O’ Clerigh also said that “the lack of local clinics meant that GPs and pharmacists prescribing or dispensing methadone in some areas were not getting the necessary support from the Health Services Executive HSE. The methadone treatment programme needed to have more GPs involved in prescribing methadone”. In the annual report of the Irish College of General Practitioners ICGP it stated that an audit of the programme was planned but was waiting funding from the HSE. In the report it also stated that the ICGP was planning to provide a distance learning programme for GPs who were willing to participate in the programme (ICGP 2005).

There are several issues around the treatment provision for patients with dual diagnosis. the following section describes the rationale the researcher had for this study.

2.5 Rationale for this study.

The relationship between mental health and substance abuse is complex. People with dual diagnosis experience a range of conditions that vary in severity and often change over time causing increased difficulties in determining a positive diagnosis. Treatment plans are hampered as a result of this. Hypothesis (1) is a one tailed hypothesis which states that: In practice GPs are less likely to have a treatment model for dual diagnosis than psychiatrists.

The subject of dual diagnosis in relation to the treatment and practice of Primary Care Services (GPs) and Mental Health Services (Psychiatrists) was the topic chosen for this research study. In it dual diagnosis refers to the coexistence of both a mental illness and substance abuse. For this study Hypotheses (2) is a one tailed hypothesis which states that: Dual diagnosis is defined differently by GPs and Psychiatrists.

People with a dual diagnosis are considered to have a poorer prognosis than those with a single mental diagnosis, are more socially isolated and experience more financial and legal difficulties. They present with more physical health complaints, have higher rates of relapse and have more hospitalisations, placing a huge financial burden on health service providers (McDermott & Pyett, 1993). Hypothesis (3) is a one tailed hypothesis which states that: patients with dual diagnosis are treated as two separate conditions by GPs and Psychiatrists.

Substance abuse is a common concurrent condition among the mentally ill, and substance abuse is a common reason for relapse into mental illness. The needs of people with dual diagnosis have historically been served in a fragmented manner across the globe. The service these people receive in addiction and mental health settings is often less than optimal, a situation that contributes significantly to poor client outcomes and leads to overuse of resources in the mental health services and the criminal justice system.

The rationale for this study was to address the issues surrounding the treatment of dual diagnosis in a comparison study between Primary Care Services and Mental Health Services. MacGabhann et al (2004 p79 & p13) stated that “general practitioners have a role in the care of dually diagnosed clients. They act as a referral source to addiction or mental health services, or they treat clients with a dual diagnosis themselves” and that “the role of GPs and primary care in the management of dual diagnosis” required further research. This research study looked at the primary care services “GPs” and mental health services “Psychiatrists” in their treatment of individuals with a dual diagnosis.

It is the belief of the researcher that this study “a comparison between GPs and Psychiatrists in their treatment of dual diagnosis” has not been researched before from an Irish perspective.

2.6 Hypotheses

1. In practice GPs are less likely to have a treatment model for Dual Diagnosis than Psychiatrists. This is a one tailed hypothesis. The null hypothesis is rejected
2. Dual Diagnosis is defined differently by GPs and Psychiatrists. This is a one tailed hypothesis. The null hypothesis is rejected
3. In comparison to psychiatrists GPs treat Patients with dual diagnosis as having two separate conditions. This is a one tailed hypothesis. The null hypothesis is rejected.

CHAPTER 3: METHODOLOGY

3.0 Chapter Introduction

The purpose of this research study was to compare the role of Primary Care Services (GPs) with that of Mental Health Services (Psychiatrists) in their treatment of dual diagnosis. MacGabhann, et al (2004) had been commissioned by the National Advisory Committee on Drugs (NACD) to conduct a research study on Mental Health and Addiction Services and their Management of Dual Diagnosis in Ireland, incorporating the working definition of dual diagnosis “the co-existence of both mental health and substance misuse problems for an individual” the definition emerged from the first phase of the study.

3.1 Materials

The material used was a questionnaire containing 33 questions divided into 5 parts. (Appendix B).

- Section 1: General Questions on demographics (Q.1 – 3a).
- Section 2: Policy / Service Provision (Q.4 – 8b).
- Section 3: Co-ordination of care (Q.9 -15).
- Section 4: Policy / Assessment (Q16 – 16a).
- Section 5: The management of Dual Diagnosis (Q17 – 33).

The questionnaire had a validity co-efficient of 0.29 for reliability. The questionnaire also contained a qualitative component.

3.2 The Sample

Two hundred Dublin GPs and two hundred Psychiatrists were sent questionnaires for the purpose of this study. GPs were randomly selected from the GP register in the Dublin area which was sub-divided into geographical areas determined by postal addresses. Psychiatrists

from the Dublin area whose practices focused on adult psychiatric services were selected. The same number of GPs and Psychiatrists were used to allow for a representative sample. To control for random and constant error the selection of GPs from each area was through randomly selecting every fourth name from the register per geographical area. A consensus sample of psychiatrists was used selecting everyone from the list. Difference in the method of selecting was due to number of psychiatrists being less than the number of GPs. The raw data was kept to check against any random and constant error occurring.

3.3 Procedure

A questionnaire containing instructions to complete all sections was posted to two hundred Psychiatrists and two hundred GPs in the Dublin city and county area. (**Appendix A**).

A cover letter accompanied the questionnaire, it included a briefing on my background, an outline of the research being conducted, the working definition used by MacGabhann et al, a time restriction on returning the completed questionnaire and a pre-paid stamped addressed envelope to my work address. In keeping with the guidelines of the Psychological Society of Ireland all participants were informed as to their anonymity and their right to withdraw from the study at any time.

3.3.1 Returns

One hundred and twenty five questionnaires were returned. Twenty were not used because they were not completed properly and four were returned with a note stating that the GPs were no longer in clinical practice.

3.4 Data analysis

- Data was analysed using SPSS for windows, version 12.0
- A value of minus one was given to missing data in the analysis.

- In the Likert scale items were given a low score of 1=strongly agree to a high score of 5=strongly disagree. The scoring was used to distinguish between the strongly agree to strongly disagree answers.
- Analysis was carried out on all data but only significant results were reported on for this study.
- Content analysis using recurring themes was included for this study for the qualitative questions.

CHAPTER 4: RESULTS

4.1 Demographic Information

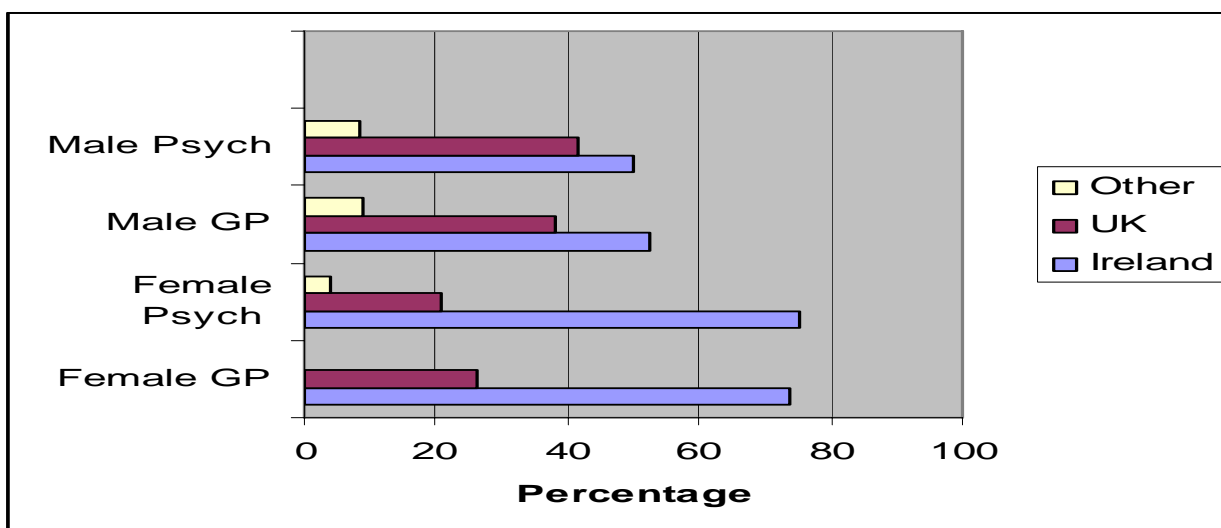
4.1.1 Response rates and demographics of respondents.

One hundred and twenty five questionnaires were returned (response rate 31.25%). Of these forty represented GPs $n=40$ and sixty one represented Psychiatrists $n=61$. Twenty four were returned for the Primary Care Services with letters stating that the GP was not practicing or was deceased. Demographics in relation to gender and country of undergraduate and graduate training can be seen in **Table 1**. Column 3 “*other*” refers to the smaller collective number of countries of medical training. It can be seen from the **Table 1** that there are more female than male GPs who undertook their training in Ireland. In contrast to the Psychiatrists, which shows males were twice as likely to have trained in Ireland. In **Figure 1** it can be seen that there were almost equal female GPs and female Psychiatrists who trained in Ireland compared to all other medical doctors represented below. It can also be seen in **Figure 1** that there were no Female GPs trained outside of Ireland and the UK.

Table 1: Demographics for Questions 1a and 2a.

	Ireland	UK	Other
Female GP	73.7%	26.3%	0%
Female Psych	75%	20.8%	4.2%
Male GP	52.4%	38.1%	9.1%
Male Psych	50%	41.7%	8.3%

Figure 1: Demographics for Question 1a and 2.



4.1.2 Response rates to service provision for substance misuse problems.

Question 3a of the study asked respondents to state which substance their services treated. Total number of GPs $n=40$ compared to Psychiatrists $n=55$ answered this question a value of minus one was given for missing data, 6 Psychiatrists failed to answer. It can be seen from table 2 that GPs are more likely than Psychiatrists to provide a treatment service for patients with alcohol related problems (52.5% of GPs compared with 23.6% of Psychiatrists). For Drugs alone slightly more Psychiatrists 3.6% than GPs 2.5% stated that they provide treatment for drugs only. It can be seen from **Table 2** that where Drugs and Alcohol problems are presented together only 45% of GPs provide a treatment service compared to 72.7% of Psychiatrists. From the information in **Table 2** findings show that 27.7% more individuals with drug and alcohol problems are likely to be treated by the Psychiatrists than GPs

Table 2: Percentages of GPs and Psychiatrists who treated alcohol only, drugs only and alcohol and drugs together.

	Alcohol	Drugs	A&D	Total
GPs	$n=21$	$n=1$	$n=18$	$n=40$
	52.5%	2.5%	45.0%	100.0%
Psychiatrists	$n=13$	$n=2$	$n=40$	$n=55$
	23.6%	3.6%	72.7%	100.0%

4.1.3 Response rates to the different substances treated.

In a further breakdown of substances treated by GPs and Psychiatrists it can be seen from **Figure 2** that alcohol is treated almost equally by both services. There is only a marginal difference of 1.8% between the two services for their dealings with patients with heroin abuse this was most likely due to individuals with heroin abuse attending

- (1) Harm reduction centres for needle exchanges such as the Merchant Quay Project.
- (2) Methadone dispensing centres such as Trinity Court Drug Treatment Centre.
- (3) Methadone Dispensing Pharmacies.

However with regard to all other drugs **Figure 2** clearly demonstrates that Psychiatrists have significantly more dealings with patients who had abused drugs other than alcohol or heroin in comparison to the GPs.

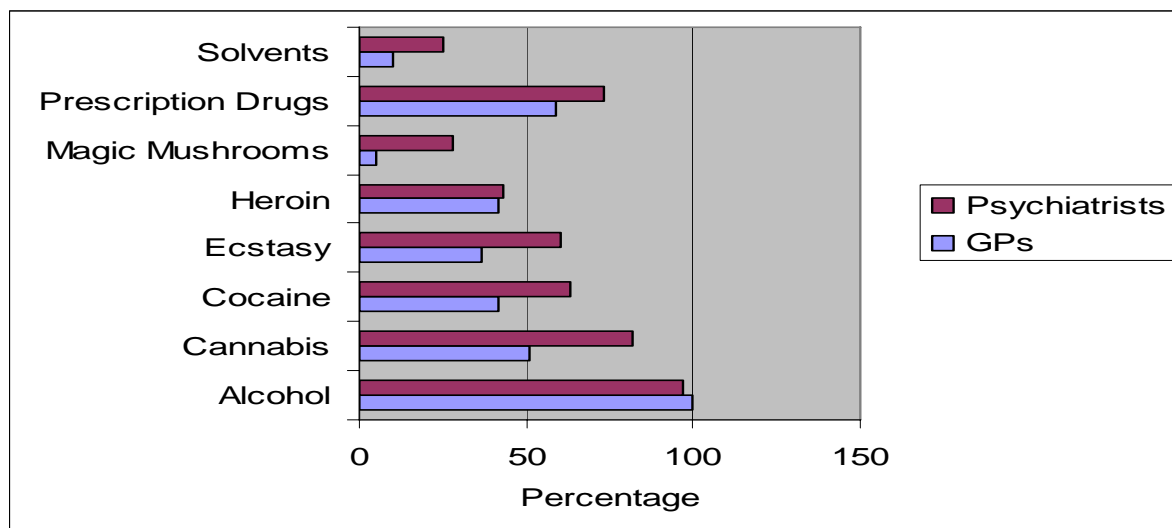


Figure 2: Percentage of drug categories treated by GPs and Psychiatrists.

4.2 Policy, Service and Provision.

4.2.1 Policy.

Where the respondents were asked if there were “some people with dual diagnosis who would not be treated in your service?” Over 50% from both services stated that they did not treat dual diagnosis in their service (77.5% of GPs and 54% Psychiatrists). In question 4a the respondents were asked to elaborate on their policies, the following statements were found to be the most recurring. 15% of GPs referred patients to appropriate service if drugs were involved, 10% stated that patients with dual diagnosis were difficult to treat, 12.5% would not treat them due to high level of aggression accompanying addiction and 10% stated severity of mental health issues would be an issue. 13% of Psychiatrists stated that the individual should be detoxified in hospital and referred to addiction services, 10% stated they should be treated in appropriate dual diagnosis therapeutic programmes that provided an education programme and 8% stated that they were concerned about aggression issues.

It can be seen in **Figure 3** that 44% of respondents stated that they have a specific policy on dual diagnosis. Of these, 14.6% in GPs and 29.8% of Psychiatrists indicated that they have a policy. Percentages were calculated from the total number of responses from primary care services and mental health care services.

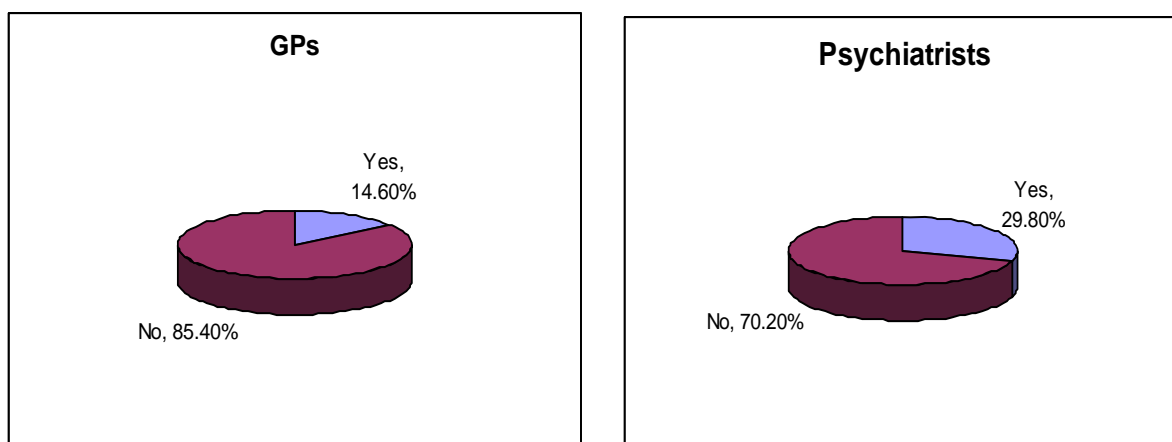


Figure 3: Percentage of GPs and Psychiatrists who answered yes or no to the question, “Do you have a policy that specifically addresses dual diagnosis?”

4.2.2 Structure.

It can be seen from **Figure 4** that over 46% of all respondents stated that they had structures in place that specifically address dual diagnosis.

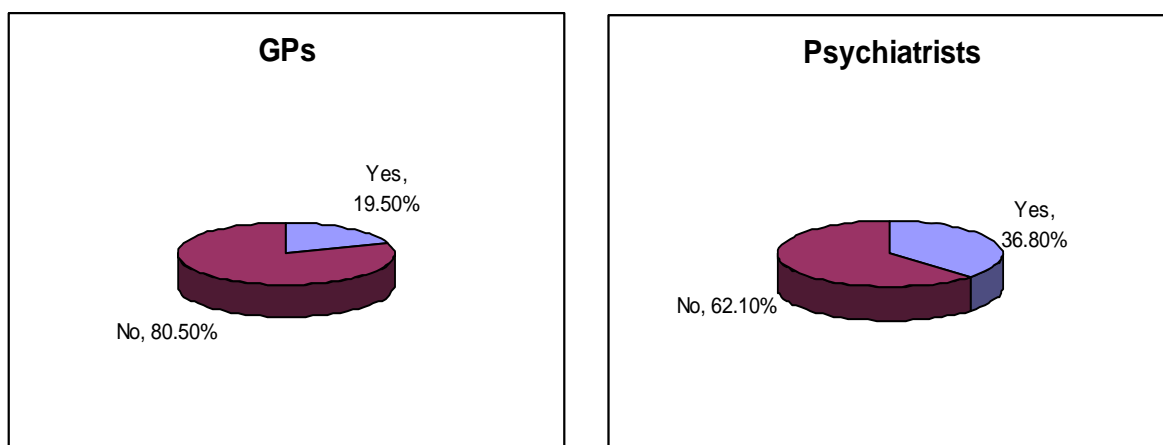


Figure 4: Percentage of GPs and Psychiatrists who answered yes or no to the question “do you have structures in place which specifically address dual diagnosis?”.

Figure 5 shows that of the respondents who stated that they have structures in place, that 69.9% of both GPs and Psychiatrists indicated that those structures were formal, 79.7% indicated that they were informal and 50.3% indicated that their structures were both formal and informal. When asked to elaborate on their structures 10% of GPs described structures that concerned referring patients onto the appropriate addiction service while 5% described sending patients for counselling psychology and psychotherapy and 5% described referring patients for 1:1 counselling. Once again only a small amount of Psychiatrists 9.8% described structures such as those in place in St. Patrick’s hospital Dublin for the treatment of dual diagnosis. 3.3% described referring patients to the Clinical Nurse Specialist/Counsellor and emphasized the role of the multidisciplinary team in providing a treatment plan for patients with dual diagnosis. 6.5% described using clear lines for referring patients on to the appropriate treatment services. Of note it was found that the structures for dealing with patients with dual diagnosis in either service included the referral of patients to addiction counsellors though only a minority of respondents answered this section.

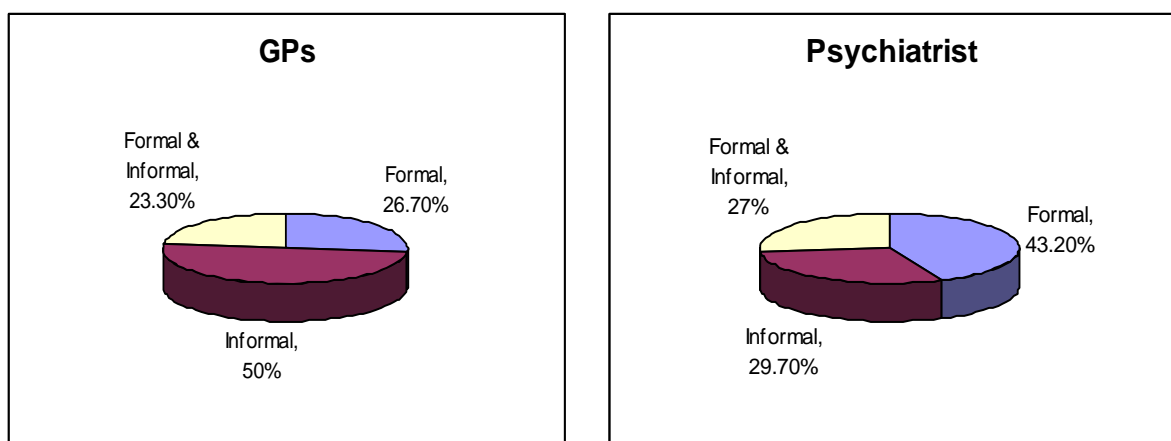


Figure 5: percentages of GPs and Psychiatrists structures that are formal, informal or formal & informal.

It can be seen from **Figure 5 & Figure 6** that 35.1% of Psychiatrists are more likely than GPs to formally record the number of people with dual diagnosis that attended their service. Of the GPs who responded only 2.4% didn’t know if their service formally recorded the

number of people with dual diagnosis compared to 11.7% of Psychiatrists who didn't know if their service formally recorded the number of people with dual diagnosis.

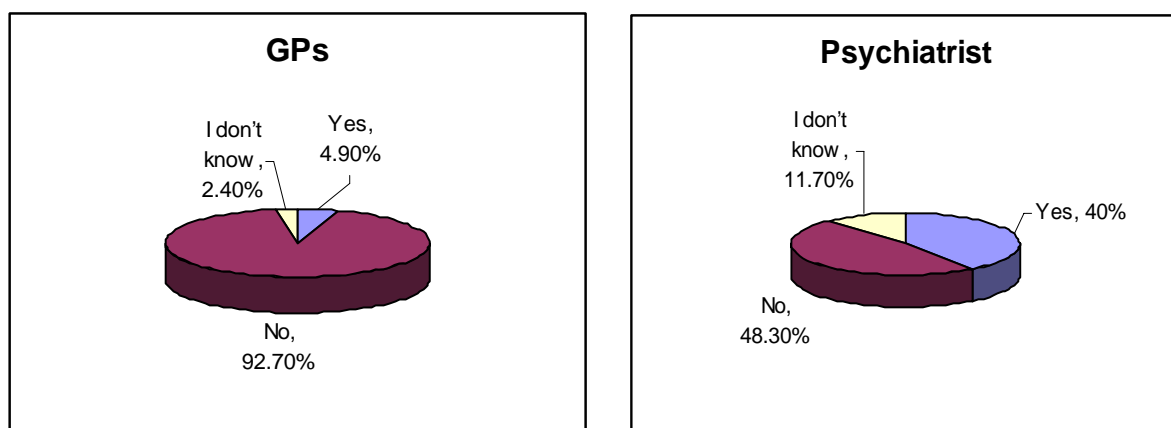


Figure 6: Percentage of GPs and Psychiatrists who formally record the number of people with dual diagnosis.

4.3 Co-ordination of care.

It can be seen from **Table 3** that 41.5% of GPs would refer patients to appropriate services and receive back compared to 37.9% of Psychiatrist. When asked to elaborate both GPs and Psychiatrists described making an initial assessment and then referring to the appropriate addiction services and once the patient had commenced treatment they would accept them back. It can be seen from the results in **Table 8** that 37.9% of the respondents excluded patients with a dual diagnosis from treatment in their service. The exclusion of patients with a dual diagnosis was more frequent in GPs services 34.1% compared to Psychiatrists 13.8%.

Table 3: Frequencies and percentages of GPs and Psychiatrists who indicated how care was coordinated when a patient with dual diagnosis enters either service.

Service	Referred to other service	Protocols combined treatment	Other	Total
GPs	<i>n</i> =14 34.1%	<i>n</i> =17 41.5%	<i>n</i> =10 24.4%	<i>n</i> =41 100.0%
Psychiatrists	<i>n</i> =8 13.8%	<i>n</i> =22 37.9%	<i>n</i> =28 48.3%	<i>n</i> =58 100.0%
Totals	<i>n</i> =22 22.2%	<i>n</i> =39 39.4%	<i>n</i> =38 38.4%	<i>n</i> =99 100.0%

In the question what formal communication links do you have with (mental health services for GPs and vice versa for Psychiatrists) 55% of GPs responded having none compared to 37.3% of Psychiatrists. It can also be seen in **Table 4** that Psychiatrists were 6% more likely than GPs to engage in joint casement management for their patients. This is in keeping with the multidisciplinary team approach to patient management found in most hospitals. When respondents were asked to describe what other types of formal communication links they used 36% of Psychiatrist described using a discharge letter Compared to 20% of GPs and 29.5% of Psychiatrists described telephone calls as good communication links compared to 17.5% of GPs.

Table 4: Frequencies and percentages of GPs and Psychiatrists indicating formal communication links in either service.

	GP	Psychiatrists
None	55%	37.3%
Liaison Worker	7.5%	10.2%
Joint Assess	2.5%	1.7%
Joint Case Mgmt	2.5%	8.5%
Combined Clinic	2.5%	1.7%
S. L. Agreements*	2.5%	3.4%

* Service level agreements

4.4 Policy / Assessment.

Each service was asked if they assessed patients for dual diagnosis on entering their service. 80.3% of Psychiatrists stated they always assessed for dual diagnosis compared to only 30% of GPs. 11.5% of Psychiatrists compared to 52.5% of GPs sometimes assess patients for dual diagnosis on entering their service. When asked how they assessed for dual diagnosis Psychiatrists as seen in **Figure 7** have significantly higher percentages than GPs across all sections of assessment rating scales except for the “informally” section which shows 45.9% of GPs compared to 22.8% of Psychiatrists assessed for dual diagnosis informally. There was no elaboration or explanation on what “informally” assessing entailed by GPs.

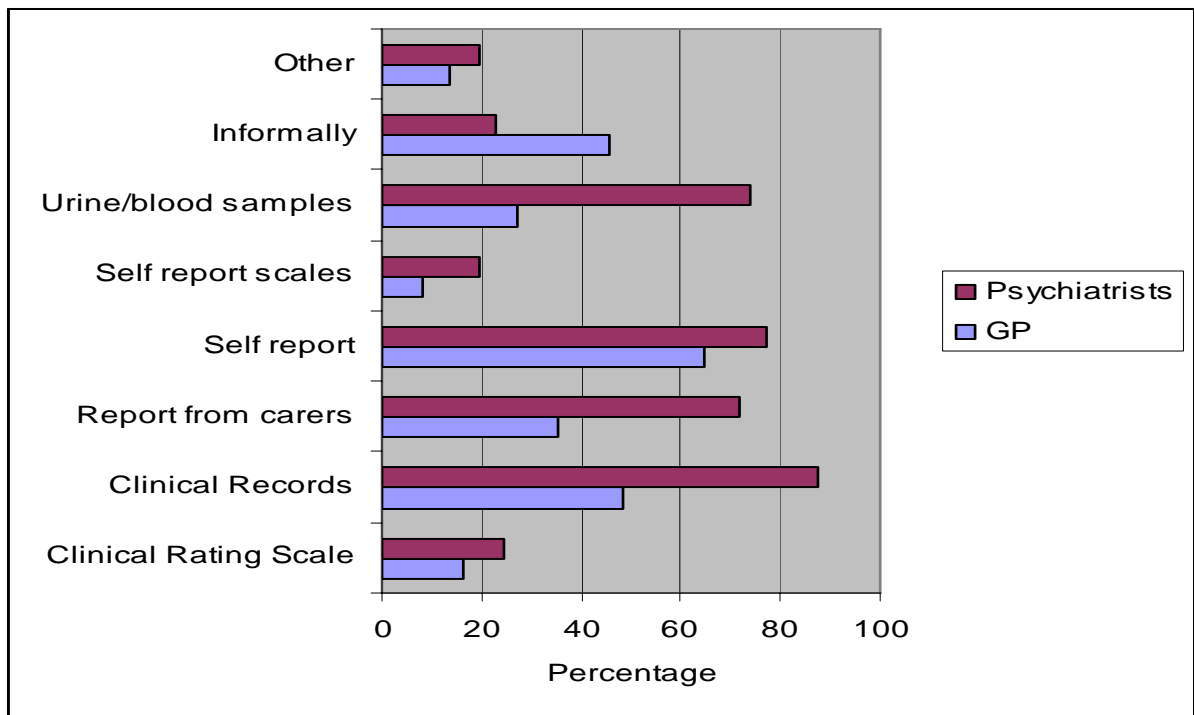


Figure 7: Percentages of GPs and Psychiatrists indicating how patients are assessed for dual diagnosis in either service.

4.5 The Management of Dual Diagnosis.

It can be seen from **Table 5** that 57.5% of GPs agreed/strongly agreed with the statement that patients with dual diagnosis should be treated by mental health services compared with 78.8% of Psychiatrists with an indecisive 32.5% of GPs neither agreeing nor disagreeing with this statement compared to just 11.5% of Psychiatrists.

Table 5: Frequencies and Percentage of ratings of the statement “People with dual diagnosis should be treated by mental health services”.

	GPs	Psychiatrists
Strongly Agree	<i>n</i> =8 20%	<i>n</i> =20 32.8%
Agree	<i>n</i> =15 37.5%	<i>n</i> =28 46%
Neither agree nor disagree	<i>n</i> =13 32.5%	<i>n</i> =7 11.5%
Disagree	<i>n</i> =4 10%	<i>n</i> =4 6.5%
Strongly disagree	<i>n</i> =0 0	<i>n</i> =2 3.3%

Table 6 demonstrates that 27.5% of GPs compared to 67.2% of Psychiatrists believe that their staff are adequately trained to assess dual diagnosis whilst 30% of GPs believe the opposite to be true, compared with 8.2% of Psychiatrists.

Table 6: Frequencies and Percentage of ratings of the statement “Clinical staff in my service are adequately trained to assess dual diagnosis”.

	GPs	Psychiatrists
Strongly Agree	<i>n</i> =5 12.5%	<i>n</i> =8 13.1%
Agree	<i>n</i> =6 15%	<i>n</i> =33 54.1%
Neither agree nor disagree	<i>n</i> =17 42.5%	<i>n</i> =15 24.6%
Disagree	<i>n</i> =7 17.5%	<i>n</i> =5 8.2%
Strongly disagree	<i>n</i> =5 12.5%	<i>n</i> =0 0

Of note **Table 7** shows that both GPs and Psychiatrists support the notion of a fully integrated specialized service as being the best way to effectively help people with dual diagnosis (GPs 70% and Psychiatrists 85.2%)

Table 7: Frequencies and Percentage of ratings of the statement “A fully integrated specialized service is the best way to effectively help people with a dual diagnosis”.

	GPs	Psychiatrists
Strongly Agree	<i>n</i> =15 37.5%	<i>n</i> =34 55.7%
Agree	<i>n</i> =13 32.5%	<i>n</i> =18 29.5%
Neither agree nor disagree	<i>n</i> =9 22.5%	<i>n</i> =5 8.2%
Disagree	<i>n</i> =3 7.5%	<i>n</i> =3 4.9%
Strongly disagree	<i>n</i> =0 0	<i>n</i> =1 1.6%

Independent t Test looking at the difference between GPs and Psychiatrists on their Management of Dual Diagnosis Scale (MacGabhann, L. et al 2004)

	N	Mean	Std Deviation	Std Error Mean
GPs	41	37.54	4.935	.771
Psychiatrists	60	34.73	3.974	.513

Cohen's d = 0.627

Patients with dual diagnosis/co-morbidity are treated as 2 different conditions by GPs and Psychiatrists. For Cohen's d there is a moderate to large level of significance. The null hypothesis is not accepted.

4.6 Qualitative Analysis

4.6.1 Content analysis for Q31 for GPs and Psychiatrists who provided a definition of dual diagnosis.

Participants were asked to adopt for this questionnaire the definition of dual diagnosis as the "Co-existence of both Mental Health and Substance Misuse Problems for an individual" When asked what until now has been your working definition of dual diagnosis 50% of GPs compared to 85% of Psychiatrists replied that they had the same definition as the one given to them for this study. 7.5% of GPs stated that they had never thought about it. 25% of GPs failed to make a statement compared to 9.8% of Psychiatrists. It can be seen in **Figure 8** that dual diagnosis is defined differently by GPs and Psychiatrists therefore it is possible to reject the null hypothesis.

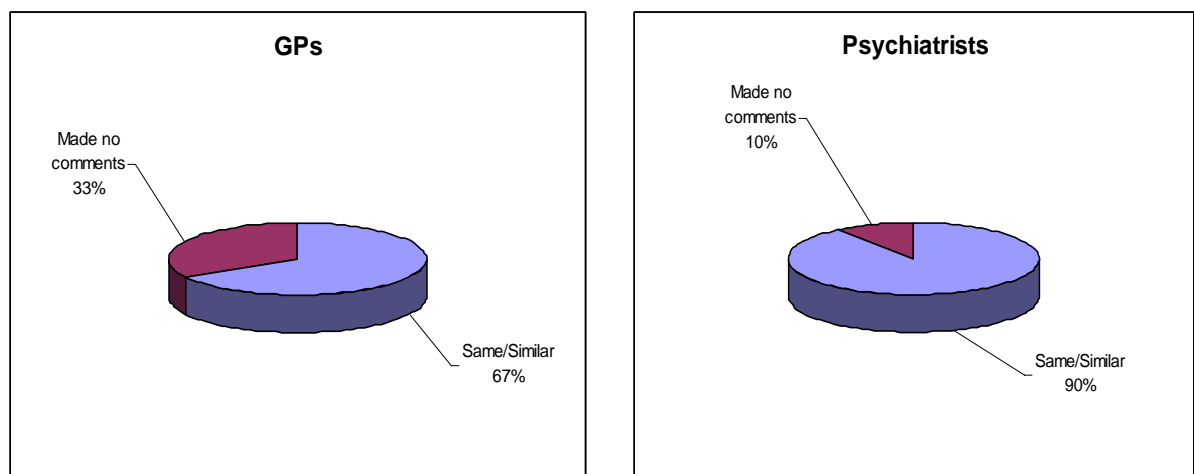


Figure 8: Percentage of GPs and Psychiatrists who had a definition of dual diagnosis.

Of the remaining GPs the following definitions had be given in response to this question.

- Problem with this definition is it fails to take into account the hen and the egg situation.
- Nothing formalized.
- Didn't have one for this diagnosis thought it meant two psychiatric disorders.
- Dual diagnosis has been a recognized entity in GP practice in my experience I have never seen the term mentioned in any correspondence from Mental Health or Addiction services.
- Haven't though about it first deals with the problem in context of problem.
- I now understand the definition now I have a label for if.

Of the remaining Psychiatrists the following definitions had been given in response to this question.

- Both a substance misuse disorder and an affective component, one being equally as important in causing/preventing the other.
- Psychiatric illness (psychosis) secondary to psychoactive substance misuse.
- Dual diagnosis in a psychiatric institution is an often finding and in my understanding it's not bad to make two or more diagnosis on a patient because psychiatry is not like internal medicine or surgery.

4.6.2 Content analysis Q32, GPs and Psychiatrists who wrote about the difficulties they experienced in dealing with individuals with dual diagnosis.

Where the respondents were asked the question "in your opinion what are the difficulties involved with service provision for people with dual diagnosis?" 87% of Psychiatrists and 80% of GPs reported various difficulties. The following are some of the recurring themes that emerged from this question in relation to difficulties experienced by GPs.

Table 8: Difficulties GPs encountered with dual diagnosis patients.

Patient Difficulties
Aggressive and threatening behaviour. Poor compliance. Chaotic lives with little interest in change.

Table 9: Difficult issues GPs dealt with

GPs issues
Specialised services unwilling to accept responsibility for homeless and adolescent patients. Refusal of psychiatric services to accept patients with addictions other than alcohol. Time consuming in GP setting. Poor patient motivation. Fear of drug users.

Table 10: Service difficulties encountered by GPs

Service dissatisfaction
Inadequate access to psychiatric support within addictions services. No communication service between GPs and Psychiatrists. Non integration of mental health services and addiction services. Prejudices and lack of dual treatment facilities.

The following are some of the recurring themes that emerged from this question in relation to difficulties experienced by Psychiatrists.

Table 11: Difficulties Psychiatrists encountered with dual diagnosis patients.

Patient Difficulties
Poor compliance. Issues around relapse. Under recognition of dual diagnosis.

Table 12: Difficult issues Psychiatrists dealt with.

Psychiatrist issues
Lack of motivation. No long term follow up. A lot of problems associated with homelessness. Financial difficulties. High unemployment rate.

Table 13: Service difficulties encountered by Psychiatrists.

Services dissatisfaction
No decent alcohol service. Inadequate training for patients. Lack of communication between addiction services and mental health. No single services to address both.

It can be seen from the above tables the difficulties reported by both the GPs and the Psychiatrists show that there is a lack of commutation between the two services. They both made reference to no single service available to treat patients with dual diagnosis despite both accepting that these groups of people are difficult to treat within each of their own services.

4.6.3 Content analysis Q33, where GPs and Psychiatrists were asked to provided feedback in the way of a comment on this research study.

The final question in this research study asked the participants to provide comments that they thought would be helpful to the researcher. Less than 50% of the respondents provided a response to this question. 22.5% of GPs compared to 38% of Psychiatrists availed of this opportunity the following are some of these comments. The comments were all positive and encouraging (see **Appendix C**).

By looking at the comments one can see two very different services working independently of each other in their provision of treatment for patients with a dual diagnosis. Despite this there is a general theme from the psychiatrists in their comments that an integrated service to treat both mental health and substance abuse would be the way forward in treating patients with dual diagnosis.

CHAPTER 5: Discussion

For this study four hundred questionnaires were posted out to two hundred GPs and two hundred Psychiatrists in the Dublin area. One hundred and twenty five questionnaires were returned, of these twenty four were returned from GPs with letters stating that the GPs were either not practicing or had deceased. The response rate used in this study was 31.25%. Research has indicated that achieving acceptable response rates from health care providers for postal questionnaires is an on going challenge. (Paul, C.L., Tzelepis, F., Walsh, R.A. 2005) found that using a “moderately sized monetary incentive was able to achieve a significant increase in response rates for retail pharmacists thereby reducing potential bias in the sample”. The researcher for this study offered no incentive to the targeted sample population therefore it can be argued that the response rate of 31.25% for health care professionals can be considered a positive representative sample.

MacGabhann, L. et al. (2004) adopted the definition of dual diagnosis as the “Co-existence of both Mental Health and Substance Misuse problems for an individual” in their research study. In this study the researcher used the same definition of dual diagnosis. Similar results were found in this study in relation to inconsistencies reported for the treatment of patients with dual diagnosis received from GPs and Psychiatrists. For example, 54% of psychiatrists who responded indicated that they treat dual diagnosis but of these only 36.8% stated that they had structures in place to treat dual diagnosis (see **Figure 4**). In comparison GPs were found to have a greater discrepancy in relation to the findings, for example, 77.5% of GPs who responded stated that they treat dual diagnosis but of these only 19.5% stated that they had structures in place to treat dual diagnosis. This discrepancy is a clear indication that there remains a lack of clarity around the concept of dual diagnosis which adds support to the findings of (MacGabhann, et al. 2004). Lack of structures for treating dual diagnosis can account for the high percentage of readmissions for patients with dual diagnosis. Evidence to

support this can be found in “A Population of Dual Diagnoses Patients in the Inner London Hospital” survey by Menezes et al. (1996) which reported that patients with substance misuse problems had twice as many admissions in the previous two years as those who were drug and alcohol free. It can be argued that insufficient structures result in more hospitalisations for this group of patients. The research hypotheses (1) which stated that in practice GPs are less likely to have a treatment model for dual diagnosis than Psychiatrists was supported by this study.

With reference to the definition of dual diagnosis given to the participants in their letters (see **appendix A**) outlining the rationale for this study, the final section of the questionnaire provided the participants with an opportunity to express/elaborate on what up until now had been their working definition of dual diagnosis. It can be seen in **Figure 8** that 85% of psychiatrists compared to only 50% of the GPs who responded, stated that they used the same or similar definition. Thus supporting the research hypotheses (2) which stated that: Dual diagnosis is defined differently by GPs and Psychiatrists. Of note of the remaining respondents who provided their working definition of dual diagnosis one GP replied that he/she had never seen the term mentioned in any correspondence from the Mental Health or Addiction Services. Another GP replied that he/she understood the definition but now had a label for it. Of the psychiatrists who replied to this question one stated that dual diagnosis was where two psychiatric conditions presented simultaneously. This supports the findings in the “Vision for Change” document (2006) on a service commissioned by The South Western Area Health Board which showed that 68% of GPs indicated that they had no specific training in mental health, while the remaining 32% had training which consisted of between three and nine months clinical placement during their hospital rotation. This is supported by the findings of this study also. **Table 6** demonstrates that 27.5% of GPs compared to 67.2% of Psychiatrists believe that their staff are adequately trained to assess

dual diagnosis whilst 30% of GPs believe the opposite to be true, compared with 8.2% of Psychiatrists.

In contrast Angold, et al. (2000) described dual diagnosis as the co-occurrence of two different mental conditions which were both complex and difficult to treat. However in support of MacGabhann et al. (2004) other researchers such as (Hall, Lynskey, & Teeson, 2000) have disputed this argument claiming that moderate substance misuse can affect the brain's neurochemistry by either the patient's presentation with a psychiatric disorder or it can exacerbate an already existing psychiatric disorder. With disputes such as these it is understandable to see how 33% of GPs were unable to provide a definition for dual diagnosis despite having one supplied to them. MacGabhann, et al. found similar issues around the Mental Health and Addiction Services understanding of what complexities were included in defining what dual diagnosis was. This study found that not only were there differences in the definition of dual diagnosis given by both GPs and Psychiatrists but there were also stark differences in the way that they defined their structures and policies around this issue

Within all establishments policies are developed to provide safe and effective guidelines to persons concerned in each particular works department. Structures are put in place to ensure the most effective delivery of a service to the individual while adhering to these policies. **Figure 3** shows the respondents who were asked if their service had a treatment policy on dual diagnosis, a total of 44.4% all respondents replied that they had a specific policy in operation. Of these significantly more Psychiatrists stated that they had a treatment policy 29.8% compared with 14.6% of GPs. The discrepancy which this study found between these responses could indicate that there were misconceptions in what is termed dual diagnosis. It could also indicate that policies in relation to dual diagnosis within some of the services had not been put into practice. What is interesting is the high percentage of respondents (85.4%

of GPs and 70.2% of Psychiatrists) who indicated they did not have a specific policy which addressed dual diagnosis. These findings are similar to what (MacGabhann, L. et al. 2004) found.

With regard to what structures they have in place to specifically address dual diagnosis participants who responded “yes to question 6” were asked to elaborate on these structures within their practices. A marginal difference was found with 8.2% of psychiatrists compared to 10% of GPs who described structures that included referring patients on to the appropriate addiction services for treatment. 2.5% of GPs indicated that they referred patients for 1:1 counselling while 2% of GPs described sending patients for counselling psychology and psychotherapy. 16.4% of Psychiatrists described structures in place in St. Patrick’s Hospital for the treatment of dual diagnosis and 9.8% of Psychiatrists described referring patients to a Clinical Nurse Specialist/counsellor. When asked to outline the nature of said structures 43.2% of Psychiatrists compared to 26.7% of GPs reported that they had formal structures in place in their service, with 29.7% of GPs compared to 50% of Psychiatrists reporting that they have informal structures in place, with a total of 50.3% reporting that they were both formal and informal (**Figure 5**). It would appear from these findings that GPs regard their practices as having informal treatment structures which would be in keeping with their community based position while in comparison psychiatrists structures are hospital based and as such would treat individuals in a more formal setting. The most recently published government documentation “A Vision for Change 2006” shows that the prevalence of dual diagnosis within the criminal justice system is increasing. The stark findings in this study show a lack of policies and structures that need to be implemented if service providers are to start treating individuals with a dual diagnosis. GPs recommendations in this document are for the implementation of clinical nurse specialists in addictions or similar into community practices. Unfortunately it is concerning to think that two years following the MacGabhann

el al study the acceptance of dual diagnosis as a working model is no further on. Of note this study also has demonstrated that the need for the acceptance of a working model has grown as this study has found an unprecedented increase in the use of illicit drugs.

Alcohol has long been accepted by almost everybody in Ireland, including the World Health Organisation (WHO), as a disease and should be treated as such (Butler 2002). To date it continues to be the most misused substance in this country. In this study 100% of GPs and 96.7% of Psychiatrists indicated that they treat patients with alcohol problems (**Figure 2**). The figures are lower when GPs and Psychiatrists were asked if their services treated people with alcohol only, drugs only or both. 52.5% of GPs compared to 23.6% of Psychiatrists indicated they only treated individuals with alcohol misuse. In the same question Psychiatrists were 37.7% more likely than GPs to treat individuals who misuse both alcohol and drugs (**Table 2**). These findings support those of a recent unpublished review by this researcher of all admissions to the Central Mental Hospital Dublin for 2005 which is an increase on the findings by Kennedy (1997-1999). However, it can be argued from these findings that psychiatrists encounter more patients who have not been treated for substance misuse problems in primary care settings. These research findings are in keeping with those of Fowler et al. (1998); Regier et al. (1990); Schneier & Siris (1987) who have shown that the number of people with a psychotic disorder who misuse alcohol and illicit substances is higher than those with a psychotic disorder who do not use alcohol or illicit substances. Menezes et al. (1996) found that patients with substance abuse problems had twice as many admissions to psychiatric hospitals compared to those who had no substance abuse problems. It can also be seen from **Figure 2** that Psychiatrists compared to GPs have significantly more dealings with patients who have abused all the categories of substances listed for this study. Therefore the research hypothesis (3) which stated that: In comparison to Psychiatrists, GPs

treat patients with dual diagnosis as having two separate conditions, is supported by a moderate to large level of significance for Cohen's $d = 0.627$.

The most efficient treatment approach to patients with dual diagnosis is the integrated model (MacGabhann et al). Co-ordination of care can be planned and followed up through a single treatment service provider. Of note **Table 7** shows that both GPs and Psychiatrists support the notion of a fully integrated specialized service as being the best way to effectively help patients with a dual diagnosis (GPs 70% and Psychiatrists 85.2%). However when GPs and Psychiatrists were asked to elaborate on how they co-ordinated a treatment programme for patients with dual diagnosis 3.6% more GPs compared to Psychiatrists indicated that they would refer patients to the appropriate addiction services for substance misuse treatment first (**Table 3**). When asked to elaborate further both GPs and Psychiatrists indicated that they would do an initial assessment prior to referring the patient to the addiction service. Both indicated that they would receive the patient back once treatment had been established. An interesting contradiction came to light when 57.5% of GPs agreed with the statement that patients with dual diagnosis should be treated by mental health services compared with 78.8% of Psychiatrists (**Table 5**). This dispenses with the notion of an integrated service and is more supportive of a serial treatment model. However an Australian study on the prevalence of dual diagnosis estimated that this group of patients often had difficulty accessing appropriate mental health and substance misuse services (NSW Health Authority, 2000). This researcher's findings also indicate that patients with a dual diagnosis are often excluded from the appropriate treatment service. This is particularly evident in this study where 34.1% of GPs compared to 13.8% of Psychiatrists excluded patients with a dual diagnosis from treatment in their service. In assessing the reasons why this would be the case this study asked respondents "What are the difficulties involved with service provision for people with dual diagnosis?" (Q 32).

Both GPs and Psychiatrists included fear of patients who may be violent due to their drug use as part of their answer to this question. Others felt that lack of motivation on the part of the patient enhanced the problem. Historically here in Ireland violence in relation to drug misuse was reported by the Gardai who in 1997 reported an increase from 350 cases in 1969 to 940 in 1997 in the greater Dublin area (Butler 2002). There is substantial evidence for substance misuse being a major risk factor for violence and aggression in patients with a major mental illness. Even so it is frequently overlooked or poorly documented. Swanson et al. (1990) reporting results from the ECAS, discovered a one year prevalence rate for violence in people with schizophrenia who also abused substances (30.33%), that was four times greater than that in people with schizophrenia alone", (8.36%), which was in turn, four times greater than that in people with no psychiatric disorder and substance misuse alone (2.05%). Further evidence can be found in Scott et al. (1998) who reported that the overall levels of violence found in patients with dual diagnosis was over six times more likely than in patients with a diagnosis of mental illness only. Evidence such as this provides a strong argument supporting GPs fear and reluctance to provide treatment for patients with a dual diagnosis who continue to misuse drugs.

It is widely accepted that an early diagnosis and intervention provides a better long term prognosis for patients with a dual diagnosis. Strathdee et al. (2002) and MacGabhann, et al found that the treatment of patients with dual diagnosis had a less successful prognosis when treated independently by both Mental Health and Addiction Services. Strathdee et al. (2002) findings indicated that a routine brief assessment on all patients by GPs could provide an early diagnosis for patients with dual diagnosis. A more comprehensive assessment could follow for those who screened positive for at least one substance misuse and one mental health problem.

When co-ordinating treatment care programmes communication with appropriate service providers is a necessary part of treatment planning. Evidence from the OPCS National Psychiatric Morbidity Survey showed that there was an increase in the number of visits to GPs by patients with a dual diagnosis. This study asked both GPs and Psychiatrists to identify what formal communication links they had with the relevant service providers. 16% more Psychiatrists than GPs indicated that they used discharge letters and 12.5% more Psychiatrists than GPs indicated that they used telephone calls as part of their co-ordination of continuing patient care. Discharge letters and phone calls to appropriate service providers would normally come under hospital discharge policies. This evidence suggests a lack of policies around GPs communication with regard to co-ordination of care for patients with dual diagnosis. Question 32 asked respondents to provide further comments that they felt would be helpful to this study. One GP indicated that the questionnaire was based more for a hospital setting. It would appear evident from this section of the questionnaire and even from the title of the section that formal co-ordination of care is more relevant to a hospital setting (**See Appendix B**). This rationalisation is therefore accepted as a reason why a greater percentage of Psychiatrists than GPs indicated using the formal communication as part of their continuing care plan in the treatment of patients with dual diagnosis.

Further Research

The current study concentrated on a comparison between GPs and Psychiatrists in their treatment of dual diagnosis in a demographic area of Greater Dublin. With Ireland's drug culture expanding nationally further research in this area on a national basis is recommended.

Limitations of this study

The concept of dual diagnosis is a relatively new phenomenon globally. This had implications for this researcher when looking for published research studies on this subject.

It is also the belief of the researcher that this is the first study to compare GPs and Psychiatrists in their treatment of dual diagnosis. It is especially true of Ireland with only one national study on the subject of dual diagnosis - this study was commissioned by the Department of Health. The National Advisory Committee on Drugs published the findings of the study under the title “Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland” in November 2004 (MacGabhann, et al).

Recommendations

In light of the findings for this research study the researcher believes the following recommendations to be a way forward for a more positive treatment approach to individuals with a dual diagnosis.

1. Project managers should incorporate some mental health education into their in - service training programmes for employees working in the addiction services.
2. The education and training of GPs should include more mental health awareness especially in the area of dual diagnosis.
3. Policy makers need to include a shared care treatment model to include all the main stakeholders in the management of dual diagnosis. This should be incorporated into policies of all service providers.

Conclusion

In conclusion on examining my own interpretation of the qualitative and quantitative content analysis for this study I feel that I took a biased approach to the subject matter as I am a clinical nurse specialist in addictions in the National Forensic Services attached to the Central Mental Hospital. In my personal experience it is extremely difficult to secure a residential treatment place for patients with a dual diagnosis. Addiction services are reluctant to accept individuals with a dual diagnosis because of their lack of mental health training.

On examination of the findings for this study it can be seen that primary care services and mental health services are working as two separate services. GPs experienced difficulties in getting specialised services to accept individual with a dual diagnosis especially if they were homeless. GPs also indicated poor communication links mental health services. Psychiatrists on the other hand experienced difficulties in accessing the appropriate addiction services. Identification with the lack of services equipped to address dual diagnosis has become more apparent over the past few years especially in the area of the forensic mental health services. This research study involved the GPs and Psychiatrists working in the Dublin area only it is only right to state that dual diagnosis is not a Dublin phenomenon and should be addressed nationally.

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Appendix A – Letter to participants

Central Mental Hospital,
Dundrum,
Dublin 14.
27/03/06

Dear Doctor,

My name is Nora Byrne and I am currently studying a Master of Arts in Addiction Studies at the DBS School of Arts. Part of the requirement for this MA is a research thesis. I am researching the comparison between primary care services (GP's) and Mental Health services (Psychiatry) in terms of knowledge and clinical practice of patients with Dual Diagnosis problems.

The working definition of Dual Diagnosis by MacGabhan, L. Scheele, A., Dunne, T., Gallagher, P., MacNeela, P., Moore, G., Philbin, M. 2004, in their study on the following, Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland, which was commissioned by the NCAD is: **“the co-existence of both mental health and substance misuse for an individual”**.

I am fully aware of how precious time is for you, so I would be very grateful if you would take the time to complete the enclosed questionnaire and return it to me in the prepaid stamped addressed envelope within two weeks of receiving it. **Please base your answers on the above mentioned definition of Dual Diagnosis.**

I would like to thank you in advance for taking the time to complete this questionnaire. Your cooperation with this is greatly appreciated.
Anonymity in respect of this questionnaire is guaranteed and all ethical issues have been addressed.

Yours sincerely

Nora Byrne, BSc (psych)
Clinical Nurse Specialist.

Appendix B.1 – Questionnaire to Psychiatrists

Section 1: General Questions

Please tick the appropriate box for each question

- Q1** *Which sector does your service fall into?*
- Primary care services (GP)
- Mental Health Services (Psychiatrists)
- Q1a Gender**
- Female
- Male
- Q1b** *Where did you train?*
- Ireland
- Abroad
- If abroad where? _____
- Q2** *Does your service treat people who have substance misuse problems?*
- Yes
- No
- Q2a** *If yes, do you treat?*
- Alcohol only
- Drugs only
- Alcohol and drugs
- Q2b** *Tick the different drugs you are dealing with.*
- Alcohol
- Cannabis
- Cocaine
-
- Heroin
- Magic Mushrooms
- Prescriptions drugs
- (give examples) _____
- _____
- Solvents
- Other
- specify*) _____
- _____
- Q3** *Estimate what percentage of your current clients have a dual diagnosis? _____%*

Section 2: Policy/Service Provision

Please tick the appropriate box for each question

Q4 *Are there some people with dual diagnosis who would not be treated in your service?*
Yes
No
If no please go to Q5

Q4a *If yes, what criteria do you use for deciding not to treat them in your service?*

Q4b *If yes, are these criteria?*
Formal
Informal
Formal and Informal

Q5 *Do you have a service policy that specifically addresses dual diagnosis?*
 Yes
 No

Q5a *If yes, describe this policy.*

Q6 *Do you have structures in place which specifically address dual diagnosis?*
Yes
No -

Q6a *If yes describe these structures.*

Q6b *Are these structures?*
Formal
Informal -
Formal and Informal

Q7 *Do you offer a specific dual diagnosis service?*
Yes
No
I don't know

Q7a *If yes please briefly describe this service.*

Q8 *Does your service formally record the number of people with dual diagnosis?*
Yes

Q8a *If yes please describe how.*

- No _____
- I don't know _____

Q8b *Is this information included in service reports/reviews?*

- Yes
- No
- I don't know

Section 3: Co-ordination of care

Please tick the appropriate box for each question

Q9 *If somebody with a dual diagnosis enters your service, how is care co-ordinated?*

Referred to mental health service to treat mental health difficulties first and then accept back.

Referred to mental health service for concurrent treatment. Through protocols that ensure combined treatment takes place.

Other
specify) _____

Q10 *What formal communication links do you have with GP services?*

- None
- Liaison worker
- Joint assessment
- Joint case management
- Combined clinics
- Service level agreements
- Other

(please specify) _____

_____ *(please*

Q11 *What informal communication links do you have with GP services?*

- None
- Other

specify) _____

(please

Q12 *How does your service interact with GP services in relation to dual diagnosis?*

Receive referrals to service from GP services when already diagnosed

Always

Never

Sometimes

If referral not appropriate to your service do you send back to GP services?

Always

Never

Sometimes

Q13 *Who does your service have specific services for?*

Q14 *Do you follow a specific treatment model for dual diagnosis?*

Yes No

Adolescents

Yes

Ex-prisoners

No

Homeless people

I don't know

Women

Other

(please specify) _____

Q14a *If yes please describe briefly how.*

Q15 *Which treatment model would you think is the most appropriate?*

Section 4: Policy/Assessment

Please tick the appropriate box for each question

Q16 *On entering your service are people assessed for dual diagnosis?*

- | | | | |
|--------------------------|--------------------------|-----------|--------------------------|
| Always | <input type="checkbox"/> | | Never |
| <input type="checkbox"/> | | Sometimes | <input type="checkbox"/> |
| I don't know | <input type="checkbox"/> | | |

Q16a *If always or sometimes, how do you Assess for dual diagnosis?*

- | | | |
|-------------------------|--------------------------|---------|
| Clinician rating scales | <input type="checkbox"/> | |
| Clinical records | <input type="checkbox"/> | Reports |
| form carers | <input type="checkbox"/> | |
| Self report | <input type="checkbox"/> | |
| Self-report scales | <input type="checkbox"/> | |
| Urine/Blood samples | <input type="checkbox"/> | |
| Informally | <input type="checkbox"/> | |
| Other | <input type="checkbox"/> | |
| (please specify)_____ | | |
| _____ | | |
| _____ | | |

Section 5: The Management of Dual Diagnosis

Please tick the box which best describes your response to the following statements

		Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Q17	People with a dual diagnosis should be treated by mental health services					
Q18	People with a dual diagnosis should be treated by addiction services					
Q19	Clinical staff in my service are adequately trained to <u>treat dual diagnosis</u>					
Q20	Clinical staff in my service are adequately trained to <u>assess dual diagnosis</u>					
Q21	A fully integrated, specialised service is the best way to effectively help people with a dual diagnosis					
Q22	Communication between addiction and mental health services is adequate to treat dual diagnosis clients effectively					
Q23	Our service effectively identifies clients with a dual diagnosis					
Q24	GPs should be more involved in the care of clients with a dual diagnosis					
Q25	I have come across prejudice in service provision against people with a dual diagnosis					
Q26	Not treating people with a dual diagnosis is justified within our service provision					
Q27	It is easy for a homeless dual diagnosed person to access appropriate services					
Q28	I have a good understanding of what dual diagnosis means					
Q29	Screening for a dual diagnosis on entry to mental health or addiction services should be routine					
Q30	A client who is on a methadone treatment programme on admission to a psychiatric unit should be administered methadone there					

Q31 *In this questionnaire I asked you to adopt this definition of dual diagnosis: “Co-existence of both Mental Health and Substance Misuse Problems for an individual”.
Up until now what has been your working definition of dual diagnosis?*

Q32 *In your opinion what are the difficulties involved with service provision for people with dual diagnosis?*

Q33 **Please use this space below to add further comments you think I may find helpful.**

Appendix B2 – Questionnaire to GPs

Section 1: General Questions (Primary Care Services)

Please tick the appropriate box for each question

Q1 Which sector does your service fall into?

- Primary Care Services (GP)
Mental Health Services (Psychiatrist's)

Q1a Gender

- Female
Male

Q1b Did you train in Ireland or abroad?

- Ireland
Abroad
If abroad where? _____

Q2 Where did you do your Undergraduate training?

- Ireland
Abroad
If abroad where? _____

Q2a Where did you do your Postgraduate training?

- Ireland
Abroad
If abroad where? _____

Q2b Does your services treat people who have substance misuse problems?

- Alcohol only
Drugs only
Alcohol and drugs

Q3 Tick the different drugs you are dealing with.

- Alcohol
Cannabis
Cocaine

Heroin

Magic Mushrooms
Prescriptions drugs
(give examples) _____

Solvents
Other

Q3a If yes, do you treat?

- Alcohol only
Drugs only
Alcohol and drugs
Ecstasy

Q3b Estimate what percentage of your current clients have a dual diagnosis? _____

specify) _____

(please

Section 2: Policy/Service Provision

Please tick the appropriate box for each question

Q4 *Are there some people with dual diagnosis who would not be treated in your service?*

Yes

No

If no please go to Q5

Q4a *If yes, what criteria do you use for deciding not to treat them in your service?*

Q4b *If yes, are these criteria?*

Formal

Informal

Formal and Informal

Q5 *Do you have a service policy that specifically addresses dual diagnosis?*

Yes

No

Q5a *If yes, describe this policy.*

Q6 *Do you have structures in place which specifically address dual diagnosis?*

Yes

No

Q6a *If yes describe these structures.*

Q6b *Are these structures?*

Formal

Informal

Formal and Informal

Q7 *Do you offer a specific dual diagnosis service?*

Yes

No

I don't know

Q7a *If yes please briefly describe this service.*

Q8 *Does your service formally record the number of people with dual diagnosis?*

Yes

No

I don't know

Q8a *If yes please describe how.*

Q8b *Is this information included in service reports/reviews?*

- Yes
- No
- I don't know

Section 3: Co-ordination of care

Please tick the appropriate box for each question

Q9 *If somebody with a dual diagnosis enters your service, how is care co-ordinated?*

Referred to mental health service to treat mental health difficulties first and then accept back.

Referred to mental health service for concurrent treatment. Through protocols that ensure combined treatment takes place.

Other
specify) _____

Q10 *What formal communication links do you have with Mental Health services?*

None

Liaison worker

Joint assessment

Joint case management

Combined clinics

Service level agreements

Other

(please specify) _____

_____ *(please*

Q11 *What informal communication links do you have with Mental Health services?*

- None
- Other

specify) _____

(please

Q12 *How does your service interact with Mental Health services in relation to dual diagnosis?*

Receive referrals to service from mental health services when already diagnosed

- Always Never
-
- Sometimes

If referral not appropriate to your service do you send back to mental health services?

- Always
- Never
- Sometimes

Q13 *Who does your service have specific services for?*

Q14 *Do you follow a specific treatment model for dual diagnosis?*

- | | Yes | No |
|-----------------|--------------------------|--------------------------|
| Adolescents | <input type="checkbox"/> | <input type="checkbox"/> |
| Ex-prisoners | <input type="checkbox"/> | <input type="checkbox"/> |
| Homeless people | <input type="checkbox"/> | <input type="checkbox"/> |
| Women | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> |
- (please specify)* _____

- Yes
- No
- I don't know

Q14a *If yes please describe briefly how.*

Q15 *Which treatment model would you think is the most appropriate?*

Section 4: Policy/Assessment

Please tick the appropriate box for each question

Q16 *On entering your service are people assessed for dual diagnosis?*

- | | | | |
|--------------------------|--------------------------|-----------|--------------------------|
| Always | <input type="checkbox"/> | | Never |
| <input type="checkbox"/> | | Sometimes | <input type="checkbox"/> |
| I don't know | <input type="checkbox"/> | | |

Q16a *If always or sometimes, how do you Assess for dual diagnosis?*

- | | | |
|-------------------------|--------------------------|---------|
| Clinician rating scales | <input type="checkbox"/> | |
| Clinical records | <input type="checkbox"/> | Reports |
| form carers | <input type="checkbox"/> | |
| Self report | <input type="checkbox"/> | |
| Self-report scales | <input type="checkbox"/> | |
| Urine/Blood samples | <input type="checkbox"/> | |
| Informally | <input type="checkbox"/> | |
| Other | <input type="checkbox"/> | |
| (please specify)_____ | | |
| _____ | | |
| _____ | | |

Section 5: The Management of Dual Diagnosis

Please tick the box which best describes your response to the following statements

		Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Q17	People with a dual diagnosis should be treated by mental health services					
Q18	People with a dual diagnosis should be treated by addiction services					
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Q31 *In this questionnaire I asked you to adopt this definition of dual diagnosis: “Co-existence of both Mental Health and Substance Misuse Problems for an individual”.
Up until now what has been your working definition of dual diagnosis?*

Q32 *In your opinion what are the difficulties involved with service provision for people with dual diagnosis?*

Q33 **Please use this space below to add further comments you think I may find helpful.**

Appendix C – Comments for Question 33

Content analysis Q33, where GPs and Psychiatrists were asked to provide feedback in the way of a comment on this research study.

- I would be very interested in the conclusions which result from your study and would be grateful if you would advise me when and where they are published.
- We should do all in our power to make society aware of the potential destructive power of addictive drugs and alcohol. This particularly applies to children and adolescents. I feel that knowledgeable personnel should be regularly invited into schools to expand on these complex issues at length.
- Your questionnaire appears to be geared towards hospital based medicine rather than GPs.
- Excellent study, increase access for GPs please.
- Survey not especially geared to GP without a specific interest in addictions.
- It might have been interesting to ask if the GPs had any training/experience as a psychiatric registrar.
- Generally consider that persons who have a dual diagnosis are relatively safe and can be managed well in a family practice setting that is less formal and in some ways less of a threat and inconvenience to the clients.

The following are some of the comments from the Psychiatrists

- I believe that addiction particularly alcohol and cannabis are significant contributors to psychiatric breakdown and hospital admission. Drug screening facilities are primitive and most disappointingly the issue of addiction/dual diagnosis was very sketchily referred to in the new mental health policy document “A Vision for Change”.

- If an individual is using drugs and is intoxicated they find it very difficult to engage in treatment. Good luck with the study.
- Service provision needs to be fully integrated for people with dual diagnosis or there would be no effectiveness in treatment.
- Alcohol treatment centre at Stanhope St. provide very good service but hugely under serviced.
- Currently the resources of CMHT is not sufficient to allow safe management of dual diagnosis.
- The dual diagnosis programme started in St. Patrick's hospital for private patients should be extended for public patients.
- The correct service/agency involvement required is dependent on the individual's unique needs in my opinion determined by an appropriate assessment. From my knowledge of dual diagnosis I am not sure if a specialised service is the right way to proceed.
- A drug addiction unit could be integrated with psychiatric services and psychiatrists while training should be made to rotate the unit.
- There is little information about dual diagnosis needs further elaboration.
- Some questions were not suitable for my area of work. Problem with GPs for long stay dual diagnosed patients being discharged. Good luck with the study.
- Situation will never improve until addiction and mental health services unite, while separate funding things will not improve.
- I am familiar with the dual diagnosis team which was set up in Glasgow and I see a role for one here.