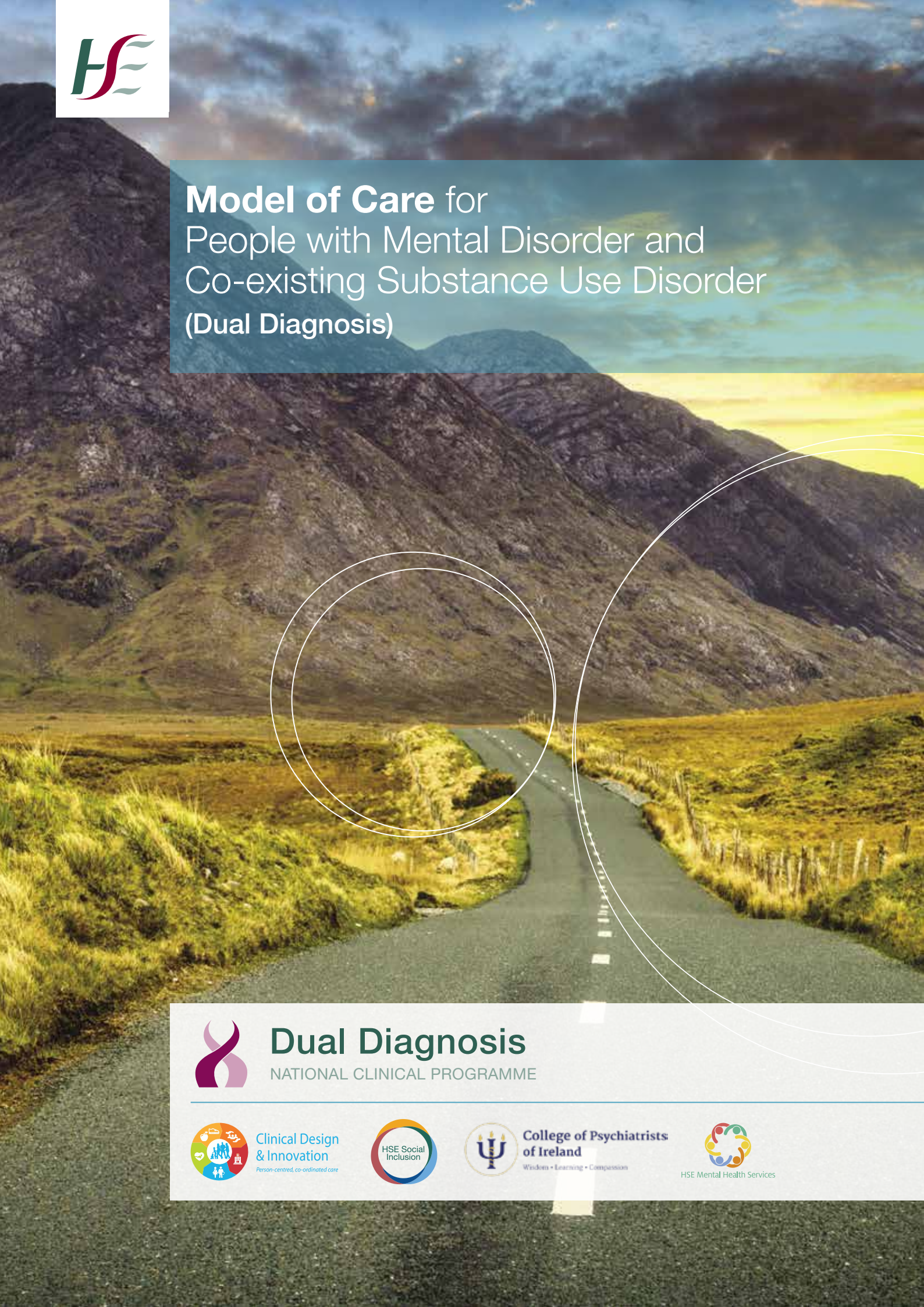

Model of Care for People with Mental Disorder and Co-existing Substance Use Disorder

(Dual Diagnosis)

Dual Diagnosis

NATIONAL CLINICAL PROGRAMME

Clinical Design & Innovation

Person-centred, co-ordinated care

HSE Social Inclusion

College of Psychiatrists of Ireland

Wisdom • Learning • Compassion

HSE Mental Health Services

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Dual Diagnosis
NATIONAL CLINICAL PROGRAMME

Model of Care for People with Mental Disorder and Co-existing Substance Use Disorder
(Dual Diagnosis)

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Foreword

On behalf of HSE Clinical Design and Innovation and Mental Health Community Operations, we are delighted to endorse and present the Model of Care for Dual Diagnosis developed by the National Working Group under the National Clinical Programme for Dual Diagnosis and endorsed by the College of Psychiatrists of Ireland. This Model of Care has been developed in partnership with HSE Social Inclusion, HSE Health and Wellbeing and the National Office of Suicide Prevention and in collaboration with voluntary bodies including Sec.39 agencies.

The Dual Diagnosis National Clinical Programme is mandated to design, develop and implement an evidence based system of supports for individuals with a Dual Diagnosis. This Model of Care caters to the needs of Adolescents and Adults through separate clinical pathways. The planned service delivery through separate Dual Diagnosis teams for Adolescents and Adults will help deliver services in a more targeted and age appropriate manner.

The plan to include Behavioural addiction disorders such as Gambling and Gaming disorders as part of the Dual Diagnosis service provision at a later stage in the second phase of the service delivery will help cater to the unmet needs of a significant number of service users in partnership with the HSE Addiction services. The recommendation to establish a HSE National Dual Diagnosis Rehabilitation centre is a step in the right direction that would be of immense benefit to service users who require access to such residential treatments.

While the Clinical Programme is intended for specific areas of need, the Dual Diagnosis services will provide a significant level of support to the Community Mental Health Teams (Adults and Adolescents) along with the HSE Addiction services. In addition, the Dual Diagnosis service will support voluntary bodies including Section 39 agencies, who are catering to the needs of this target population. This Model of Care is focussed on the delivery of services in an integrated manner, along with the provision, for delivering services through e-health when required as envisaged in the *Sláintecare*. In addition, it is in line with *Sharing the Vision*, which recommends that a tiered model of integrated service provision for individuals with a Dual Diagnosis (e.g. substance misuse with mental illness) should be developed to ensure that pathways to care are clear (recommendation 57).

Informed by national and international best practice, a review of evidence based interventions and a whole of system consultation process, this Model of Care also ensures that those affected by Dual Diagnosis have had an opportunity to inform the Model of Care, while aligning with best practice. At the core of this Model of Care are the needs of the individual requiring care, their carers and care givers and the service providers delivering supports.

Furthermore, this Model of Care is designed to support training and capacity building initiatives in partnership with other stake holders, ensuring that all staff have the skills needed to support this vulnerable community. Moreover, in order to ensure experts by experience remain at the centre of the programme, this document justifiably proposes a PPI (Public and Patient Involvement) approach.

We express our gratitude to all the members of the Working Group for drafting this Model of Care and our special thanks to service users and professionals involved in the consultation process which helped to inform the drafting of this document. We are very pleased to support this Model of Care and welcome the opportunity to further improve the service for individuals who present with a Dual Diagnosis and support their families.

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Executive Summary

Dual Diagnosis is not uncommon and research suggests that up to half of those attending Community Mental Health Teams have co-morbid substance use disorder. Dual Diagnosis is defined in different ways across countries, and Dual Diagnosis services cater to varying groups of service users depending on the scope of the definition for the implementation of Dual Diagnosis services.

The initial National Working Group for the HSE Dual Diagnosis National Clinical Programme was established between 2016 and 2018. Between 2018 and July 2021, the work of the group was paused due to the absence of a Clinical Lead. A second National Working Group was established in July 2021. As part of the process of drafting the Model of Care, this group explored the experiences of people with lived experience of Dual Diagnosis, including both service users and carers.

In the HSE, Dual Diagnosis services will be a tertiary level service providing support to Community Mental Health Teams, Community Child and Adolescent Mental Health Teams, acute inpatient psychiatric units for both adults and adolescents, HSE addiction services (HSE Social Inclusion), community, voluntary and HSE-funded organisations, including Section 39 agencies. As envisaged in the *Sharing the Vision* recommendation for Dual Diagnosis, an integrated approach will be implemented by the Dual Diagnosis services. In addition, a collaborative approach will be taken, involving HSE addiction services, HSE Community Mental Health Teams, the HSE National Office for Suicide Prevention (responsible for implementation of the National Strategy for Suicide and Self Harm: Connecting for Life), HSE Health and Wellbeing, HSE Mental Health Engagement and Recovery, Liaison Psychiatry services, maternity services, community and voluntary agencies and regional universities. Resources such as staff, training and premises will be shared between the service partners, primarily under the Clinical Governance of HSE Mental Health and in some cases under the shared Clinical Governance with HSE addiction services.

This Model of Care covers provision of services for both adults and adolescents. Dual Diagnosis teams for adults will cater to the age group of 18 to 64 years and each Adult Dual Diagnosis team will cover an approximate catchment area population of 300,000, as recommended in *A Vision for Change*. Appropriate support will be provided for services catering for those 65 years and above. A total of 12 Adult Dual Diagnosis teams are recommended to cover the nine Community Health Organisations (CHOs). Each team will be multidisciplinary in nature, led by a Consultant Psychiatrist.

The Adolescent Dual Diagnosis teams will provide services for those in the age group of 10 to 17 years. They will follow a hub-and-spoke model. Four hub Adolescent Dual Diagnosis teams are recommended as part of this Model of Care for Adolescents. The four hub teams will be multidisciplinary in nature and will also include outreach workers for youths and family therapists. Each spoke Adolescent Dual Diagnosis service will have Clinical Nurse Specialists and Addiction Counsellors.

The definition of Dual Diagnosis for this Model of Care is: 'the co-morbid disorders due to substance use and/or addictive behaviours along with the presence of mental disorder(s)'. The disorders of substance use include disorders of alcohol use.

Dual Diagnosis teams will primarily provide services to those with severe mental illness and co-morbid mild, moderate or severe disorders due to substance misuse and disorders due to addictive behaviours. However, those with a Dual Diagnosis involving less severe co-morbid disorders of mental illness will also be assessed if necessary by the Dual Diagnosis services for the purpose of a second opinion or if the diagnosis is unclear after assessment by the HSE Community Mental Health Teams (CMHTs) and HSE addiction services.

For the purpose of service provision, the service delivery will occur in two phases. In Phase 1, the Dual Diagnosis teams will provide services for those without a disorder due to addictive behaviour (which will include gambling and gaming disorder). Phase 2 of the Dual Diagnosis which will be implemented in the future will include disorders due to addictive behaviours. Phase 2 will depend on resources being provided to develop services in both HSE addiction services and Dual Diagnosis services for those presenting with gambling and gaming

disorders. Exploration and discussion is needed at interdepartmental levels to consider the possibility of service provision for the prison population with the simultaneous development of adequate mental health and addiction services across the prison services.

The provision of care will follow pathways as described in this Model of Care and service users will have access to inpatient acute psychiatric unit beds on a planned basis. This Model of Care also recommends the establishment of a National Dual Diagnosis Rehabilitation Unit, preferably in Dublin, and the provision of continued funding for appropriately funded inpatient rehabilitation beds through both the HSE addiction and Dual Diagnosis services.

Provision of training for service providers under two tiers will also be an integral part of the Dual Diagnosis National Clinical Programme. This will be delivered in partnership by the Dual Diagnosis services with the HSE addiction services, the National Office for Suicide Prevention (Connecting for Life) and HSE CMHTs.

In addition to collation of key performance indicators (KPIs) every month, evaluation of the Dual Diagnosis services will follow the Public Patient Initiative (PPI) model. There will be partnerships with regional universities as part of this process. As envisaged in *Slaintecare*, e-health will be part of the Dual Diagnosis service delivery, particularly in the service provision of Adolescent Dual Diagnosis spokes. It is also recommended to develop specific online therapeutic modules for those with Dual Diagnosis in partnership with HSE Health and Wellbeing, HSE Mental Health services and HSE Social Inclusion.

Recovery will be a key aspect of service delivery. There will be no barriers for those who are homeless, those attending probation services, people from ethnic minority communities, immigrants, refugees, asylum-seekers and vulnerable women. They will have the same level of access to the Dual Diagnosis service as any other service user in the community.

1. Introduction

Dual Diagnosis and its impact

Evidence indicates that 30-50% of people with severe mental illness have co-existing substance misuse problems (1). In a study of people attending a Community Mental Health Team (CMHT), 44% had reported problem drug use and/or harmful alcohol use in the previous year. In addition, 85% of those attending an alcohol service and 75% attending a drug service had reported suffering from a psychiatric disorder in the previous year (2).

Dual Diagnosis (DD) can occur across the lifespan (3). Clinical and epidemiological studies have shown that the frequency of occurrence of co-morbid mental disorders in those who use alcohol or other psychoactive disorders can be high. DD prevalence varies widely among those attending mental health services. In an extensive study examining more than 460,000 service users with mental health issues in Denmark over several decades, it was found that prevalence of lifetime substance-use disorder was 37% for schizophrenia, 35% for schizotypal disorder, 28% for other psychoses, 32% for bipolar disorder, 25% each for depression and anxiety, and 17% for PTSD. Of note, 25% of all included service users with mental illness had a lifetime prevalence of alcohol use disorder (4). A fourfold increased risk of substance-use disorder in those with schizophrenia and a six fold increase in those with mania were reported by the Epidemiologic Catchment Area study (5).

Providing good epidemiological data on DD, even in countries that invest much more heavily in information systems than Ireland, is a challenge. Reviews of DD epidemiology are complicated by differing definitions, different and mostly unlinked data sets, and varying qualities of methodologies. In that context, surveys using routinely collected service utilisation statistics provide useful data. In Table 1, from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), data from three countries – the UK, France and Spain – have been reported from among the general population. However, the data do not accurately reflect DD prevalence in these countries, and they also vary widely in terms of the assessment tools and definitions used. Furthermore, these data often do not include those in prison and hospital settings and also the population in marginalised sections of society who often have higher levels of co-morbidity of substance-use disorder and mental disorders.

Table 1. Prevalence of Dual Diagnosis in the general population in Europe (EMCDDA)

Authors	Country	Sample size	Assessment tools	Reference population	Type of disorder	Prevalence (%)
Leray et al., 2011 (6)	France	36,105	MINI International Psychiatric Interview (for anxiety disorders only)	National survey of the French adult population. Mental health in general population (53.9% males)	Anxiety disorders Anxiety disorders + alcohol use disorder Anxiety disorders + drug use disorder	21.6 4.4 2.8
Vázquez et al., 2011 (7)	Spain	1,054	SCID-CV	Female students (mean age 22.2 years)	Lifetime co-morbidity (includes tobacco dependence) Lifetime prevalence of psychiatric disorders (commonest disorders: nicotine dependence, depression, generalised anxiety disorder) Two or more psychiatric diagnoses	21 50.8 37
Farrell, 2001 (8)	United Kingdom	a	CIS-R and DIS ICD-10	National Survey of Psychiatric Co-morbidity (aged 16-65yrs)	Drug-dependent (mainly cannabis) among drug dependent No disorder Mixed anxiety disorder Generalised anxiety disorder Depression Phobia Panic disorder	Male: 2.8 Female: 1.5 52.9 16.3 7.3 7.1 5.5 2.5
Vázquez, 2010 (9)	Spain	554	DSM-IV	University Students	Symptoms of major depressive episode + substance dependence (n = 58) Past-month legal substance consumers (n = 540) Past-month illegal substance consumers (n = 140)	8.6 8.7 12.1

Data on the prevalence of DD in Ireland are limited. Estimates suggest a prevalence of 46% lifetime history of substance-use disorder in those with a diagnosis of a psychotic disorder (10). Otherwise, the DD data are primarily extrapolated from international studies. In future, specific research on measuring the prevalence of DD in Ireland will need to be commissioned and elicited.

Dual Diagnosis is well known to be associated with poor outcomes due to the absence of, or limited level of services to cater to the complex needs of those with DD. In comparison with service users with a single disorder, those with DD show a higher psychopathological severity and increased rates of risky behaviour, which can lead to infection with diseases such as HIV, AIDS, HCV; psychosocial impairments (unemployment, homelessness), and criminal behaviour. In addition, those with DD are more prone to risk of overdosing and often use multiple substances including prescription drugs. Taking this into account, the EMCDDA states that the burden on health and legal systems leads to higher costs for society (11).

The estimate of Dual Diagnosis among the homeless population varies. Studies suggest that up to 10-27% of the homeless population experience mental health and substance-use issues (12, 13). In this context, the 'Housing First' National Implementation Plan for 2022-2026, launched on 20 December 2021 by the Irish Government, recognises the challenges associated with Dual Diagnosis among the homeless and the need for a collaborative approach between the different stakeholders, including the Health Service Executive (HSE), to provide a wraparound service (14).

Furthermore, those with DD are at increased risk of suicide compared to those with only substance-use or mental disorders (15, 16, 17). Not surprisingly, Dual Diagnosis is often associated with criminal behaviour. In fact, it has been described as a major issue in the prison population. A French study reported 26.3% of the study population in the prison had Dual Diagnosis. The same study reported an increased – nearly six fold – risk of suicide among those with a DD in the prison population (18). The two reports, published by the Irish Probation services in 2021, identified the extent of mental health and substance misuse issues in the prison population; both reports called for collaboration between the different services to address the complex needs of this population (19, 20).

International Definitions & Behavioural Addictions

2. International Definitions and Behavioural Addictions

2.1 International definitions of Dual Diagnosis

Dual Diagnosis (DD) is defined in various ways across different countries. Historically, it referred to people with learning disability and comorbid mental illness. For example, in most parts of Canada, DD refers to those with a developmental disability and a mental health problem (21). However, over the years in most countries across the world, DD commonly refers to those with a substance-use disorder and comorbid mental illness.

Terms such as *Co-Occurring Disorders* (CODs) are used to refer to those with one or more substance-use disorders and co-morbid mental illness. In the USA, the Substance Abuse and Mental Health Services Administration (SAMHSA) uses the term Co-Occurring Disorders to refer to those with Dual Diagnosis (22). In countries like Australia, UK and Ireland, DD refers to those with substance-use disorder and comorbid mental illness.

The World Health Organization (WHO) defines Dual Diagnosis as '*the co-occurrence in the same individual of a psychoactive substance use disorder and another psychiatric disorder*' (23). The European Monitoring Centre for Drugs and Drug Addictions (EMCDDA) (24) uses the term 'comorbidity of substance use and mental health disorders' for Dual Diagnosis, and defines this as the '*temporal coexistence of two or more psychiatric disorders as defined by the International Classification of Diseases, one of which is problematic substance use*' (25). To complicate it further, the World Psychiatric Association uses the term '*dual pathology*' to refer to those with Dual Diagnosis (26).

Despite the various definitions of Dual Diagnosis itself, to make it more onerous, its definition in the context of a DD service has varied across countries. In the United Kingdom, the National Institute of Health and Excellence (NICE) defines DD as severe mental illness and co-morbid substance-use disorders, which, for the purpose of its guideline, includes alcohol-use disorders. According to NICE, severe mental illness includes schizophrenia, schizotypal disorder, delusional disorders, bipolar disorder, and severe depressive disorder with or without psychotic symptoms (27). These variations have lead to different types of services for those with DD across the world.

2.2 Behavioural Addictions

2.2.1 Gambling disorder

Currently, there are no specific services for gambling disorder in the HSE. The provision of appropriate resources for such services has been the major obstacle in establishing such services. The General Scheme of the much awaited Gambling Regulation Bill, published on 21 October 2021, (28) includes provision for a Social Impact Fund, established by contributions from the gambling industry. This fund is expected to fund services for managing gambling disorder, as well as associated services. The establishment of such services in the HSE Addiction services would be the first step towards establishing further tertiary-level services such as DD services catering for those with gambling disorder and co-morbid mental illness. Behavioural addictions are not included as part of DD disorders, often due to limited evidence for treatment interventions. This results in limited services for those who need such services. The absence of reliable data on this group further complicates the planning for any future service provision for those with DD involving behavioural addictions.

Gambling disorder was the first non-substance-related addiction to be included in DSM 5, under substance-related and addictive disorders. Recently, ICD 11 included gambling disorder and gaming disorder under the category of behavioural addictions. Problem gambling rates have been reported to be around 0.12% to 3.4% in Europe (29). The prevalence of gambling disorder in Ireland is currently unknown; general population surveys suggests a prevalence of 0.3% or around 12,000 people with gambling issues who have a significant association with substance-use disorders (30). A secondary survey using the National Drug Treatment Reporting System (NDTRS) data on gambling also indicated high prevalence of substance-use disorders, including alcohol-use

disorders, among those with problem gambling (31). The Institute of Public Health in Ireland in 2010 estimated the number of individuals suffering from gambling disorder to be around 40,000. In an online survey conducted in Ireland in relation to gambling and gambling behaviours, three-quarters of the population surveyed reported having the need to borrow or sell items in order to fund their gambling behaviour (32).

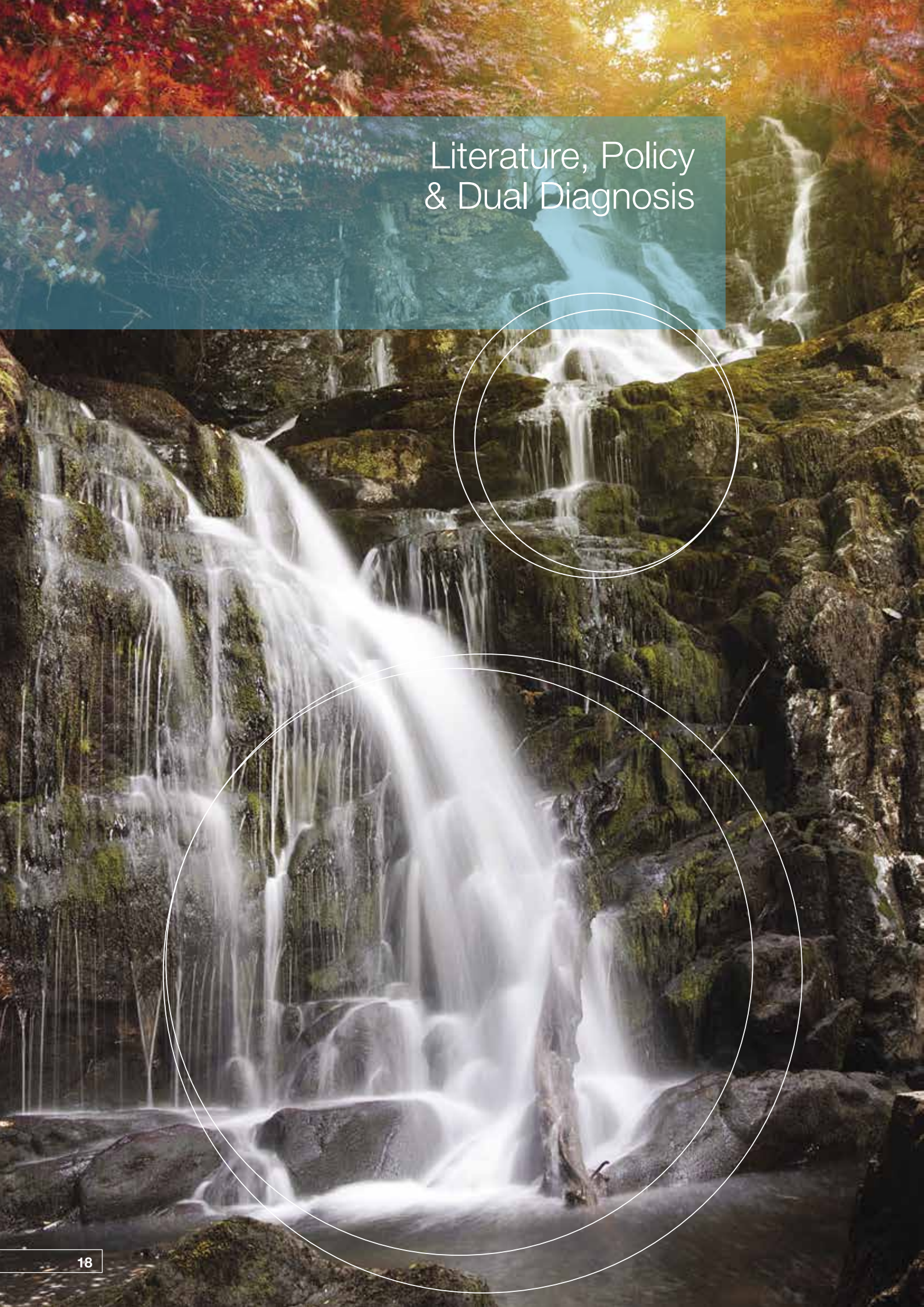
Although there is no clear evidence for pharmacological treatments along with limited evidence for inpatient treatment in gambling disorders, the role of such treatments in managing co-morbid mental health conditions – i.e. those with DD cannot be ignored, along with the effectiveness of psychological interventions (33). Early intervention in gambling disorder has been shown to be effective in reducing gambling disorder-related behaviours (34). In countries such as the UK, National Gambling Disorder Clinics provide specialist interventions.

2.2.2 Gaming Disorder

Although Gaming Disorder may be a relatively new phenomenon for Ireland and most other European countries, its inclusion in ICD 11, published by the WHO (35), emphasises its importance and the need to conduct prevalence studies. The estimate of those with Internet Gaming Disorder is around 1.96% globally (36). Furthermore, studies carried out in China indicated that it is more common among males, while there is concern about the prevalence of Gaming Disorder among adolescents (37). With around 1 billion gamers across the world at present, internet gaming is a global industry, which generated $21.1 billion in 2020, with growth of nearly 22% compared to the previous year. This has been associated with the outbreak of the COVID-19 pandemic (38).

Gaming disorder has been commonly reported to be associated with psychological disorders (39, 40). Interestingly, anxiety has been reported as a predictor of online video gaming addiction in Italy (41). Medications are not found to have any role in managing gaming disorders unless there are co-morbid mental health problems such as anxiety and depressive disorders, i.e. Dual Diagnosis. There are dedicated programmes offered in the private sector in some centres in Ireland and other parts of Europe, as well as in the USA and Asia, which essentially involve detoxification – that is, time away from accessing games either online or offline, in addition to psychological interventions. The types of inpatient treatment vary across the world and other treatment options include self-discovery camps with associated combined psychological interventions (42).

Given the above, the HSE Dual Diagnosis National Clinical Programme in partnership with HSE Addiction Services will seek funding for the initial establishment of services for Gambling Disorder, which is a behavioural addiction within the HSE Addiction services, before they are included as part of service provision for future DD services. Otherwise, DD services may become the default referral service for those with behavioural addictions. Since both Gambling and Gaming disorders are behavioural addictions, there will be significant overlap between the service provisions for these two groups.



Literature, Policy & Dual Diagnosis

3.0 Literature

3.1 United Kingdom

The introduction to the *Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide, 2002* (43) states that substance misuse is usual rather than the exception among people with severe mental health problems, and the relationship between the two is complex. Individuals with these DD problems deserve high-quality, patient-focused and integrated care. This should be delivered within the mental health services. This policy is referred to as 'mainstreaming'. One of the main difficulties identified was the presence of several agencies involved in a person's care, leading to fragmented care, and people 'falling down the cracks'.

This policy document concluded that integrated care delivered by one team appears to deliver better outcomes than serial care (sequential referrals to different services) or parallel care (more than one service engaging the client at the same time). However, it is suggested that more UK-based research is required, and that well-organised parallel care can be used as a stepping stone to integration. It was recommended that integrated treatment in the UK be delivered by existing mental health services following training and with support from substance misuse services.

National Institute for Health and Care Excellence *(NICE)* (UK)

NICE has issued several documents in this area. These have described clinical pathways, best practice in the UK setting and commissioning pathways. In 2016, *NICE* recommended not creating a dual-diagnosis service, but rather adapting existing specialist services to meet both a person's coexisting severe mental illness and substance-misuse needs and their wider health and social care needs (44). *NICE* stated that it based this recommendation on a review of the evidence, which it felt showed no evidence of benefit associated with a particular model. It referred to the advice in the 2002 Dual Diagnosis Good Practice Guide (43), which stated that care for people with coexisting severe mental illness and substance misuse should be delivered within the mental health services.

The *NICE* guideline is for those aged 14 and over with a severe mental illness. According to *NICE*, severe mental illness involves clinical diagnosis of: schizophrenia, schizotypal and delusional disorders; bipolar affective disorder, or severe depressive episodes with or without psychotic episodes.

NICE noted that there appeared to be an inequity in the way that people with coexisting severe mental illness and substance misuse were treated by services compared with other groups and it recommended that secondary mental health services should not exclude people with severe mental illness based on substance misuse and should undertake a comprehensive assessment of the person's mental health and substance-misuse needs. Separate funding streams for mental health and substance-misuse services was identified as a major limiting factor in providing appropriate services to those with Dual Diagnosis.

NICE also recommended adapting existing services. This includes secondary care mental health services offering interventions that aim to improve engagement with all services, support harm reduction, change behaviour and prevent relapse. Furthermore, *NICE* recommended that, if indicated, secondary care mental health services need to take advice from substance-misuse services (if applicable) about these interventions. In addition, it recommended that health and social care services (including substance-misuse services) be adapted to engage with and meet the needs of people with coexisting severe mental illness and substance misuse.

NICE, having reviewed the literature, concluded that there was no overwhelming evidence of benefit to indicate a particular model. This evidence included randomised controlled trials (RCTs) and observational studies covering a range of service delivery interventions, with some showing positive outcomes and value in what the models were aiming to achieve. Interestingly, *NICE* stated that there was weak evidence in the literature for assertive community and integrated treatment intervention compared with enhanced assessment and monitoring. In addition, *NICE* reported moderate to weak evidence in managing service users with Dual Diagnosis when the following were considered:

1) Brokerage case management
2) Contingency management
3) Time-limited care coordination
4) Shelter-based psychiatric clinic
5) Staff training
6) Supportive housing
7) Supportive text messaging

3.2 Australia

The Australian '*Evidence Check Review*', '*Effective Models of Care for Comorbid Mental Illness and Illicit Substance Use',* describes the silo structure of the healthcare system in Australia. It reports that, historically, service users were treated according to the sequence of disorder (based on which one was considered primary) or in parallel by different treatment providers (45). It then highlights the evidence suggesting that integration of treatment is ideal for optimal client outcomes and avoids service users falling though the gaps. However, it also acknowledges the paucity of published work in this area.

This review notes that, due to lack of data, model success is difficult to interpret, but a core minimum set of critical model, suggests that mental health practitioners/services conduct universal screening, a thorough risk assessment and complete a comprehensive assessment. It also recommends that mental health services provide supportive therapies (motivational interviewing, CBT, withdrawal management, medications), and prevention and psychoeducation regarding substance use, and involve alcohol and other drug (AOD) services/GPs where appropriate. Finally, it recommends that mental health services have policies and procedures in place for assertive follow-up, and serve as the primary care coordinator until an alternative service accepts the client.

Specific recommendations from the Australian review

1. At the service/intake level, there should be a '*no wrong door'* approach, whereby no service user is turned away from treatment, and is guided to the appropriate services if their initial point-of-contact service is not equipped to provide the required service.
2. The review recommends assertive care to address dropout, involving care coordinators.
3. At the treatment level, there should be a focus on the impairment and distress experienced by the client, along with the use of a clinically integrated, evidence-based treatment approach, incorporating, where appropriate, psychosocial and pharmacotherapy.
4. Interventions should be based on evidence-based guidelines, e-health technologies and the need to develop good rapport between services and service users.
5. At the discharge/referral level, the review recommends assertive and comprehensive treatment along with the development and agreement of referral pathways within and between services. In addition, it suggests memorandums of understanding with relevant external agencies for specialist treatment, in

addition to establishing functional relationships with other service sectors that provide acute physical healthcare, housing, education and employment for DD service users.

6. At the evaluation level, the review recommends evaluation of service delivery, which could be done through links with local research bodies in addition to the standard KPIs and systematic collection of data. It also suggests feedback be obtained from service users, families, and carers.

Trends in Australia's co-morbidity treatment

In Australia, treatment for mental health conditions, as for physical health conditions, is typically organised around a primary individual's condition. Although early reviews comparing integrated and non-integrated models were equivocal due to study limitations, the Australian review suggested that integration is essential for effective management of co-occurring conditions.

In the Australian review, the strongest evidence to support the use of integrated treatment has been reported with psychotic disorders. However, growing support for the use of a stepped care approach to treating co-morbidity is also reported. According to the review, the consensus of research evidence and clinical expertise is that psychiatric or addiction-focused treatments on their own are not sufficient to manage co-morbid mental health and substance-use problems (MHSUP). However, the review also concludes that it is not known if integrated treatment is associated with significantly better outcomes for individuals. It proposes rigorous trials to address this gap in the literature.

The *Nexus Model initiative, 2002* (46), although not a direct clinical service provider in Australia, is part of the Victorian Dual Diagnosis initiative established in 2002. This model is based on a '*no wrong door'* policy and uses an integrated approach to DD treatment, providing a coordinated person-centred service response and involving service users and families in policy and service development.

3.3 United States

In the US, the authors of the Cochrane review of 2019 (47) noted that even low levels of substance misuse by people with a severe mental illness can have detrimental effects. Thirty-two randomised controlled trials (RCTs) were included in the review, and the interventions used were:

1) Long-term integrated care
2) Non-integrated intensive case management
3) Motivational interviewing plus CBT
4) CBT alone
5) Motivational interviewing alone
6) Skills training
7) Contingency management

The authors found no compelling evidence to support any one psychosocial treatment over another for people to remain in treatment or to reduce substance use or improve the mental state of people with serious mental illness. The review was complicated by methodological difficulties, which hindered pooling and interpreting results. It is widely reported in the literature that people who have substance-misuse problems but no mental illness can be treated through a variety of psychosocial interventions, but the authors noted that using these interventions for people with Dual Diagnosis is more complex and may not be suitable in all cases.

SAMHSA (Substance Abuse and Mental Health Services Administration) (2010), Integrated Treatment for Co-occurring Disorders, Evidence-Based Practices (EBP) KIT, USA, 2010 (48)

This document focuses on severe mental illness, defined as mental illness associated with disability such as schizophrenia and traditionally falling within the purview of mental health services. The authors noted that, since the 1980s, researchers had found three consistent findings:

1. Co-occurrence is common, involving about 50% of those with severe mental illness.
2. Co-occurring disorder (DD) is associated with a wide variety of negative outcomes, with higher rates of relapse, hospitalisation, violence, incarceration, homelessness and serious infections such as HIV.
3. Parallel but separate treatment systems deliver fragmented services for those with co-occurring disorders (DD).

The report also found that most service users are unable to navigate the separate systems or make sense of disparate messages about treatment and recovery. Often, the DD service users were excluded or extruded from services in the system because of the co-morbid disorder and told to return when the other problem was under control. For these reasons, the report stated that clinicians, administrators, researchers, family organisations and service users in the USA had been calling for the integration of mental health and substance abuse services for at least the past 15 years.

The Housing First Programme for homeless people in Ireland with a Dual Diagnosis, implemented in the 1990s, was found to have improved outcomes by providing stable accommodation, although abstinence from substances was not a prerequisite for accessing housing under this programme (49). This programme has been adopted in some European countries, with good outcomes.

3.4 European Monitoring Centre for Drug and Drug Addiction

Considering the burden on the health and legal systems, the European Monitoring Centre for Drug and Drug Addiction (EMCDDA), 2016 (50) recommends the systematic detection and treatment of co-morbid mental disorders in people with substance-use disorders. It also highly recommends the use of validated instruments to assess the co-morbidity of substance-use and mental disorders. The choice of assessment instrument will depend on the context (clinical, epidemiological, research), the time available to conduct the assessment, and the expertise of the staff. In addition, the EMCDDA document states that standard screening instruments for substance-use disorders and for mental disorders should be used routinely in situations where there is lack of staff or staff expertise, which would exclude the universal application of more extended instruments. The therapeutic approach to tackle Dual Diagnosis, whether pharmacological, psychological or both, has to take into account both disorders simultaneously and from the first point of contact in order to choose the best option for each individual.

The EMCDDA also recommends a more in-depth review of service organisations in European countries. Given the heterogeneous data on the co-morbidity of substance use and mental disorders in the European Union, it recommends that a multinational study be undertaken. Evaluation through the same methodology would enable the comparison of results and allow the development of a more harmonised assessment of needs regarding the management and treatment of co-morbid service users.

Furthermore, EMCDDA states that specific items concerning psychiatric co-morbidity in substance-use disorder service users (e.g. prevalence) need to be published consistently within the existing reporting systems across Europe. Future studies to improve the evidence base for care strategies and pharmacological and psychosocial treatments for co-morbid service users are also recommended, as is a comprehensive review and research on possible early interventions to identify high-risk cases (e.g. early adolescents) for applying prevention measures.

The EMCDDA noted that psychiatric co-morbidity is highly prevalent among substance users and is associated with increased levels of clinical and social severity (50). It has been associated with poor prognosis for both psychiatric and substance-use disorders and with fewer chances of recovery. The review noted that co-morbid service users often have difficulties in accessing, and being coordinated within, the required mental health and substance-use services. The challenge of DD is related not only to its high prevalence but also to the difficulty in services users having access to co-ordinated shared care services between mental health and substance-use services and other stakeholders, and its association with poor outcomes for those affected. According to the EMCDDA, DD is often not a key issue for national and international drug policy. Furthermore, among other issues that make treatment complicated are those surrounding the assessment of service users, the types of combination treatments they require, and the specific context and settings within which services are provided to them.

There is a broad agreement in the scientific literature that the two disorders should be addressed simultaneously and with a multidisciplinary approach, involving addiction and mental health professionals working together towards common goals. However, there is still a lack of consensus regarding the most appropriate treatment setting and the most adequate pharmacological and psychosocial strategies. This has negative consequences for the service users, who encounter difficulties in identifying and accessing the best treatment for their disorders. In conclusion, the EMCDDA notes that the main barriers to treatment are the separation of mental health and drug-use treatment networks in most European countries, and the fact that treatment services may lack sufficient combined expertise to treat both types of disorder.

3.5 Health Research Board (HRB) evidence review

The HRB published an evidence-based review in 2019 of DD programmes in six places across Ireland (51). These programmes were identified as being engaged in locally driven integration efforts across the drug and alcohol task force, mental health and psychiatric services. The review sought to understand the contexts and mechanisms that may serve as facilitators or barriers to achieving positive outcomes in providing integrated care for those with substance-use disorders and mental health issues.

Three research questions were used to guide the HRB ‘rapid realist’ synthesis. The questions used and the outcomes are described below.

Research question 1

What interventions improve treatment and personal functioning outcomes for people with a Dual Diagnosis of addiction and mental health problems and in what circumstances do they work?

Outcome

This revealed: that tailoring to individual needs is crucial and outcomes need to align with the treatment implemented, with adaptability in the service delivery; that programme modifications depending on the individual service user, and meeting people where they are, are necessary; that trust between the service user and provider is needed; that technology is a helpful tool in delivering services, and that individual commitment and motivation is an important factor, as is the use of brief treatments in those with alcohol-use disorders.

Research question 2

What aspects of integrative programmes for the treatment of co-occurring substance-use and mental health problems trigger positive system outcomes and in what circumstances do these outcomes occur?

Outcome

Integrated programmes have a better outcome, with a decrease in access-to-care barriers. Organisational factors such as leadership, availability of resources, accreditation and work climate are associated with improved coordination between services. Staff with skills in both mental health and substance-use disorder are needed for better integration of services.

Research question 3

What existing models of care for adults with co-occurring substance-use and mental health problems lead to positive treatment outcomes and successful service integration?

Outcome

Key themes associated with positive treatment outcomes were: the comprehensive nature of whole-systems change to support integrated models of care across policy, systems infrastructure, organisational change, and ongoing training and support for staff, along with coordination and collaboration among services and staff. In addition, mutual respect across services, effective leadership and communication and information-sharing structures and support for continuity of care to minimise breaks in treatment resulting from care transition failures also lead to better outcomes.

Another key theme concerned care and recovery approaches, relating to stigma, values and attitudes. Positive encounters early in the contact with the service provider and continued treatment engagement were also found to be an important predictor of positive long-term treatment outcomes.

In essence, the need for integrated services with an intersectoral approach across the different divisions of the HSE, including the Mental Health and Addiction services, community and voluntary bodies, including Section 39 agencies, Housing First and other voluntary organisations working with the homeless population, with no barriers to access and improved skills among the staff providing the services were all identified as important for achieving better outcomes for service users with DD.

3.5 Current Irish policy Landscape

A number of documents and policies will inform this Model of Care.

National Advisory Committee on Drugs: Mental Health and Addiction Services in Ireland and the Management of Dual Diagnosis (2004) (52)

A study undertaken by the National Advisory Committee on Drugs in 2004 found gaps in policy and practice in relation to the management of dually diagnosed people among service providers in both the mental health and addiction fields. The key findings of the report were that 76% of the services did not offer a specific service for those with Dual Diagnosis, and the majority of service providers (75%) stated that effective management of those with DD would be provided by an integrated service. The report found that only 21% of services reported had a policy on DD, while there was no consensus on the policies in place. It advocated much closer collaboration between addiction programmes and general mental health services in order to improve outcomes for individuals with DD. Overall, this report highlighted that service users with DD respond well to case management and use of multi-profession teams. It also reported that service users with DD as a group were more difficult to treat and to manage because of greater physical, social and psychological impairment, leading to increasing costs for service users, carers, healthcare systems and Irish society at large.

A Vision for Change, 2006

According to the policy document, A *Vision for Change (AVfC)* (53), "The major responsibility for care of people with addiction lies outside the mental health system. These services [for those with addiction issues] have their own funding structure within Primary and Continuing Community Care (PCCC) in the HSE. The responsibility of community mental health services is to respond to the needs of people with both problems of addiction and serious mental health disorders". The *AVfC* recommended that "the mental health services for both adults and children are responsible for providing a mental health service only to those individuals who have co-morbid substance abuse and mental health problems". It also recommended: "General adult CMHTs should generally cater for adults who meet these criteria, particularly when the primary problem is a mental health problem". Not surprisingly, there were critics of this policy as this would effectively reduce access for some individuals with DD, particularly in the absence of any specialist services.

The *AVfC* also recommended that a specialist team be established in each catchment area of 300,000 population, to care for people with severe mental health disorder and long-standing, complex co-morbidity; that these teams be targeted at people whose mental health problems were driven by substance misuse, and that rehabilitation be a strong feature of care provision by these teams. However, these specialist teams were never formed. More importantly, this policy involved significant challenges in integrating the service provided by mental health services and the drug and alcohol services in order to cater for those with a DD with complex needs.

***Report of the Rapid Expert Review of the NDS 2009-16* (54)**

This report, reviewing Mental Health Strategy in the context of the National Drug Strategy, found that improving access to treatment for co-morbid mental disorders highlighted an important issue for improving outcomes for people with drug problems. Although *AVfC* in 2006 stated that uncomplicated addiction problems were the remit of Addiction services, the importance of improving access to mental health treatment for co-morbid mental health problems was recognised and recommendations for new services made. The problem of access to mental health services was raised time and time again during the review. There was a need identified to use the opportunity of the update of the Mental Health Strategy to recognise the importance of addiction and mental health services jointly addressing the needs of people with co-occurring addiction and other mental health problems.

Steering Group Report on a National Substance Misuse Strategy, 2012 (55)

In 2009, the Government decided to incorporate alcohol in the National Substance Misuse Strategy. The Department of Health set up a Steering Group to review the National Drug Strategy in the context of alcohol. Its report, issued in 2012, combined with the National Drugs Strategy (interim) 2009-2016, was to be treated as a single National Substance Misuse Strategy until the end of 2016.

Concerning DD, the report highlighted several issues concerning assessment, collaboration between mental health and substance-misuse services, treatment approaches, detoxification and access to residential services. It called on Mental Health to develop an integrated approach to Dual Diagnosis to maximise synergies and made the following recommendations:

1. Develop joint protocols between mental health services and drug and alcohol services with the objective of integrating care planning to improve the outcomes for people with co-morbid, severe mental illness and substance-misuse problems

2. Establish a forum of stakeholders to progress the recommendation in AVfC in relation to establishing clear linkages between the addiction services, primary care services, community mental health teams and specialist mental health teams to facilitate the development of an integrated approach to service development, including:

a. Developing detoxification services.
b. Ensuring availability of, and access to, community-based appropriate treatment and rehabilitation services through the development of care pathways.
c. Ensuring access to community mental health teams where there is a coexisting mental health condition.

***Reducing Harm, Supporting Recovery, a health-led response to drug and alcohol use 2017-2025 [Department of Health, 2017]* (56)**

This strategy aims to address the harms caused by problems with alcohol or other psychoactive substances. It recommends an integrated approach, with partnership between the statutory, community and voluntary sectors. There are five goals:

1. Promote and protect health and wellbeing
2. Minimise the harms cause by the use and misuse of substances and promote rehabilitation and recovery
3. Address the harms of drug markets and reduce access to drugs for harmful use
4. Support participation of individuals, families and communities
5. Develop sound and comprehensive evidence-informed policies and actions

These are further divided into actions. The one most relevant here is:

Strategic Action 2.1.24: Improve outcomes for people with co-morbid severe mental illness and substance-misuse problems

(a) Support the new Mental Health Clinical Programme to address DD.
(b) Develop joint protocols between mental health services and drug and alcohol services with the objective of undertaking an assessment with integrated care planning in line with the National Drug Rehabilitation Framework.

The strategy identified the lead agency for this action as being the HSE, with the expectation that the HSE would work with the Department of Health, Irish Prison Service, and community and voluntary sector. The aim is to deliver on improving access to services for those with more complex needs, one of these being people with DD.

A mid-term review of the National Drug Strategy (56a) published on 17 November 2021 identified six priorities:

1. Strengthen the prevention of drug and alcohol use and the associated harms among children and young people.
2. Enhance access to and delivery of drug and alcohol services in the community.
3. Develop integrated care pathways for high-risk drug users to achieve better health outcomes.
4. Address the social determinants and consequences of drug use in disadvantaged communities.
5. Promote alternatives to coercive sanctions for drug-related offences.
6. Strengthen evidence-informed and outcomes-focused practice, services, policies and strategy implementation.

This mid-term review also provided an opportunity to reflect on progress in implementing the strategy from 2017 to 2020 and identify new issues, including the impact of COVID-19.

Sláintecare

Sláintecare (57), the current national health policy, also calls for an integrated approach to services including for those with co-morbid mental illness and substance-use disorders, and for delivering health and social care services that meet the needs of our population and retain the best healthcare professionals, managers and staff in the respective specialities in the various divisions of the health service. The need for a collaborative approach between

various divisions of the HSE and other stakeholders such as the community and voluntary agencies is identified as important for effective delivery of services. Furthermore, *Sláintecare* also recommends the use of e-health in the delivery of services. As we know, e-health has gained increased prominence due to the widespread use of electronic means during the pandemic.

Sharing the Vision (StV), 2021

Sharing the Vision (StV) (58) provides an updated focus on the development of delivery of a model of care for individuals with a DD. It reversed the recommendation by the *AVfC* that specialist mental health services only support individuals "whose primary difficulty is mental health". In contrast, it clearly places the onus for providing DD supports in Ireland on the Mental Health services. The vision for DD provision in *Sharing the Vision* is fully in line with the *Sláintecare* recommendations. The intention is to ensure that service users and their families, carers and supporters have timely access to evidence-informed supports, as a result of an outcomes-based focus that puts people before processes.

Action 57 of Sharing the Vision states that "*a tiered model of integrated service provision for individuals with a Dual Diagnosis (e.g. substance misuse with mental illness) should be developed to ensure that pathways to care are clear*".

Sharing the Vision reinforced the provision contained in A Vision for Change in relation to the catchment areas and service provision of the specialist DD teams. Both reports recommended that a specialist team similar to other mental health services be established in each catchment area to care for people with severe mental health disorder and long-standing, complex co-morbidity. *StV* also highlighted collaborative working between the services with regard to posts such as alcohol liaison posts in acute hospitals, as well as support for the use of tele psychiatry currently being used by adolescent addiction psychiatric services providing support for those with co-morbid mental health and addiction issues.

The Model of Care now being developed is in line with the core values and principles of *Sharing the Vision,* which states *that "mental health services will be evidence-informed and recovery-oriented and will adopt trauma-informed approaches to care, based on lived experience and individual need". Sharing the Vision* seeks to provide a framework where service developments will be clinically effective, delivered in adherence to statutory requirements and based on an integrated multi-disciplinary approach. The renewed focus on partnership in care enables this Model of Care to be designed and will result in services that will take a lead role in recovery planning with individuals experiencing a DD.

The provisions of the updated Sláintecare report informed the mid-COVID *Programme for Government* 2020 which clearly states a commitment to developing the Model of Care and delivering the Dual Diagnosis Clinical Programme. This is reflected in the *HSE National Service Plan*, where the HSE commits to advance the development of the DD Clinical Programme through the Model of Care.

In July 2021, a National Working Group (NWG) was re-established by the Health Services Executive to develop this Model of Care. The purpose of the NWG is to: "develop a national model of care for specialist Dual Diagnosis services for adults and adolescents which are person centred; ensuring people receive the right care, at the right time, in an appropriate setting". The current NWG is building on work done by the previous NWG from 2018.

3.6 Current Care Levels in the Community in the Context of DD

Most of the initial contacts are at level one, where the service user attends their GP, the regional drug and alcohol services in the HSE or the voluntary and non-statutory agencies, including the Section 39 agencies that offer addiction support services and, in some cases, mental health support services in the community. Often, the service user also ends up directly in level two services when they are in crisis, leading to attendance in an A&E department either by themselves or through Gardaí. In most cases when the services user has DD, staff from the Liaison Psychiatry department would be involved.

Level three involves the Community Mental Health Teams (CMHTs); those with Dual Diagnosis are referred through their GPs or after earlier crisis presentation in an acute hospital setting. In many cases, HSE Drug and Alcohol services also provide level three care (in addition to services at level one). Specialist DD teams, involving level four

services virtually, do not exist in the HSE; hence those who need specialist DD services end up either with level three CMHTs or Addiction services or both. Since Addiction services and CMHTs in most cases lack appropriately skilled professionals and have inadequate resources for catering to those with DD, the service users often end up falling between the different levels, leading to inadequate service provision.

A significant limiting factor has also been the lack of access to inpatient beds (level five) for those with Dual Diagnosis in many cases, and in particular to specialised DD rehabilitation inpatient beds, in addition to inpatient detoxification and stabilisation beds. It is envisaged that specialist DD teams will minimise barriers to service users accessing the appropriate service.

3.7 Critical Components of a DD Service

Critical components of effective service delivery are as follows:

3.7.1 Staged interventions in Dual Diagnosis

Service users do not move linearly though the stages as described below (59). However, it is useful for clinicians at different stages to respond to stage-specific interventions (60). 'Stage of treatment' is similar to 'stage of change' and is based on service users progressing through various stages when they recover from Dual Diagnosis. The four stages are:

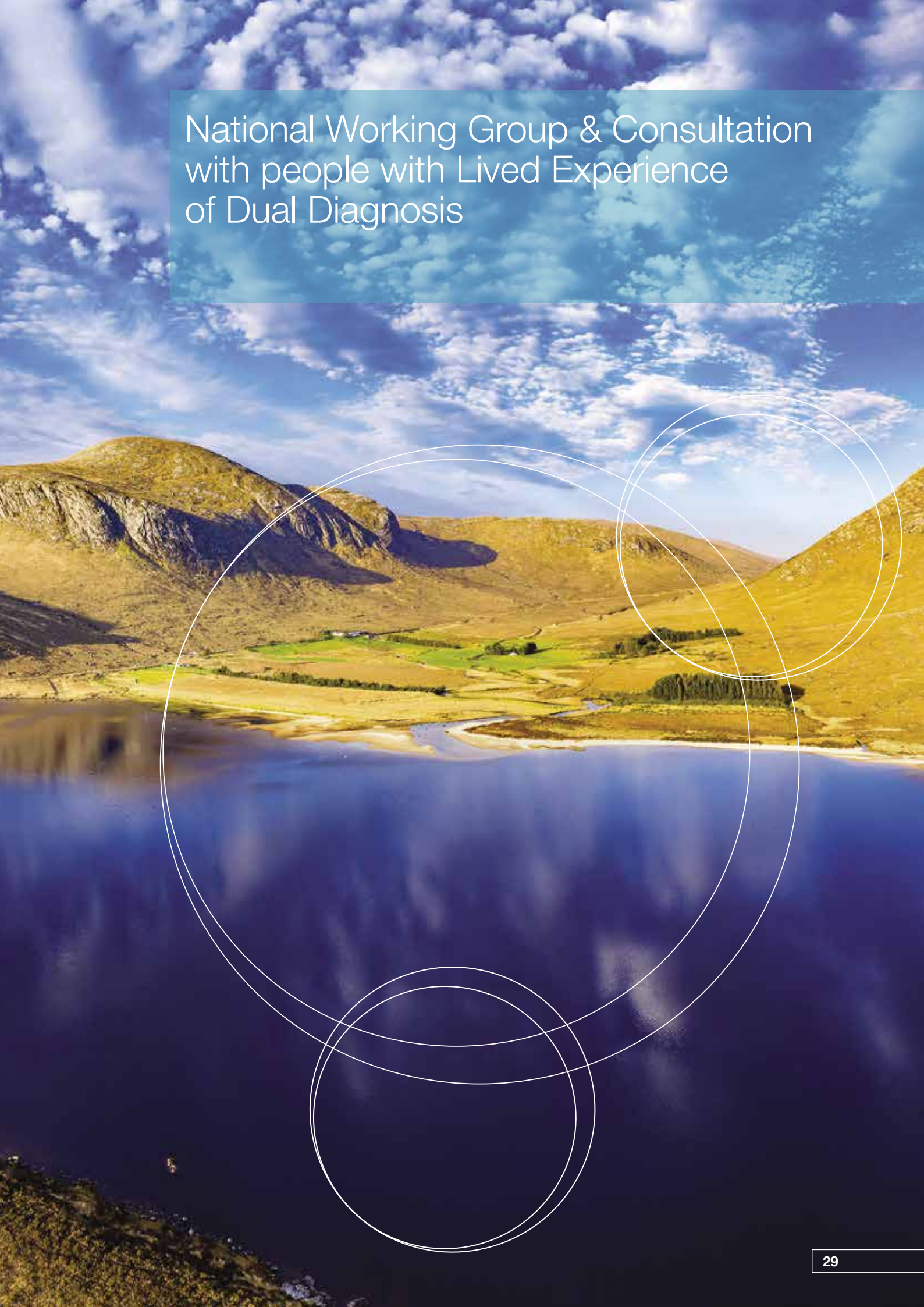
1. Engagement: forming a trusting relationship
2. Persuasion, which helps service users to analyse differences between their substance use and goals
3. Active treatment, which helps achieve the goals
4. Relapse prevention, which facilitates use of strategies to recover from relapse or prevent relapse

3.7.2 Overcoming implementation barriers

The barriers to implementation of the critical components need to be removed so that an effective DD service can be delivered (59). These barriers include:

- Policy barriers
- Organisational structure, financing and regulations are different across different stakeholders. For example, Addiction services and Mental Health services are under different divisions of the HSE and funded differently.
- Programme barriers
- Lack of clear service models, guidelines and a skilled workforce, as well as of staff trained in DD.
- Clinical barriers
- Clinical training is often done separately. For example, in the Irish context, Addiction services are primarily managed by HSE Social Inclusion, and often mental health clinicians do not have adequate training in addictions, and vice versa.
- Service user and family barriers
- Lack of psycho-education services and information on Dual Diagnosis for family members.
- Families often blame or attribute all symptoms to substances or attribute symptoms and substance use

National Working Group & Consultation with people with Lived Experience of Dual Diagnosis



4. National Working Group

4.1 Brief History of NWG

In July 2021, a National Working Group (NWG) was re-established by the Health Services Executive (HSE) to develop this Model of Care, building on the work of the previous NWG in 2018. The purpose of the current NWG is to *"develop a national model of care for specialist Dual Diagnosis services for adults and adolescents which are person centred; ensuring people receive the right care, at the right time, in an appropriate setting"*. This working group is a cross-divisional, multidisciplinary interagency community of individuals committed to developing, delivering and implementing the Model of Care to support individuals with a Dual Diagnosis. The NWG is supported in achieving this by several subgroups.

4.1.1 Recovery Engagement and Capacity-Building (RECB) subgroup

The RECB subgroup was established to support the National Working Group with three essential linked work streams:

1. To ensure the model of care incorporates a recovery focus in line with the HSE Mental Health Recovery Framework and the national policy Sharing the Vision, as outlined in the National Framework for Recovery in Mental Health guidance document.
2. To develop mechanisms for including people with lived experience of DD and their family members in the new Model of Care for DD; to ensure the Model of Care is developed in line with the core principles of co-production, ensuring better outcomes for individuals and their families.
3. To outline a suite of training and capacity-building resources to support the Model of Care through and with healthcare professionals across the HSE and the community/voluntary sector. This will result in the development of a community of practice (CoP) approach to supporting individuals with a Dual Diagnosis. Training and capacity building subgroup was part of this.

Remit of the subgroup

The objective of the RECB subgroup was to develop these three elements of the Model of Care and support their development and delivery. Cognisant of the best available evidence, including the HRB Rapid Realist Review, the RECB focussed on evidence-informed approaches and interventions that improve treatment and personal functioning for people with a DD. The HSE is committed to ensuring that individuals with lived experience are appropriately placed in positions that can support the development, implementation and evaluation of its core work, including the work of the National Clinical Programmes. This subgroup ensured that this commitment was realised through plans for recovery-oriented systems of care and training, and capacity-building programmes that are informed and supported by individuals with lived experience, both nationally and locally.

4.1.2 Medical Interventions subgroup

Remit of the subgroup

The Medical Interventions subgroup was established to ensure guidance for clinicians in relation to the medication options offered by the specialist team. These interventions are governed by the standard clinical guidelines applicable to each condition.

4.1.3 Psychological Interventions subgroup

Remit of the subgroup

Underpinned by the values and principles of partnership working, this subgroup was responsible for ensuring that appropriate interventions for individuals with a Dual Diagnosis were identified. These interventions will be provided through fully training healthcare professionals in line with best practice. The subgroup worked with the RETB and Evaluation subgroups to ensure that plans for appropriate training and evaluation systems are in place. They ensured this by:

- Identifying appropriate interventions to support individuals with a Dual Diagnosis and their caregivers.
- Developing, with support from the Training and Capacity subgroup, a suite of training to support healthcare professionals working with individuals with Dual Diagnosis.
- Informing the development of the MoC in such a way as to ensure a strong culture of psychological interventions appropriate to those seeking support.
- Engaging with the Evaluation subgroup to ensure appropriate measurement of the programme.

4.1.4 Evaluation subgroup

- Remit of subgroup
- The Evaluation, Audit and Research subgroup was responsible for ensuring that appropriate evaluation and reporting systems are in place through:
- Identifying research priorities for the programme, with qualitative and quantitative data collection
- Informing the MoC development, implementation and evaluation
- Ensuring that the clinical programme is evaluated in line with the emerging principles of PPI evaluation (see below)

PPI is the acronym for the Public, Patient and Carer Initiative which involves research carried out (as defined by the National Institute for Health Research) ‘with’ or ‘by’ members of the public rather than ‘to, about or for them’. PPI provides useful links to other organisations which would be beneficial for initiating and maintaining the research process as well as allowing for participation in other tranches of work in the area.

The Heath Research Board (HRB) has launched an implementation plan to support PPI both within the organisation itself and through HRB-supported projects and programmes, running from 2021 to 2025. The HSE has a PPI Lead in Research.

5. Consultation with People with Lived Experience of DD

5.1 Introduction

Based on the discussions in the preliminary stages of the work of the National Working Group (NWG) on Dual Diagnosis (DD), a plan was made to capture the perspective of people with lived experience of DD as it would help format the Model of Care for Dual Diagnosis. A brief real-time consultation with a cross-sectional group of people with lived experience and their family members in geographically diverse communities was completed. This was intended to help capture any contemporary variances from what is already known about challenges and perceptions about services.

Feedback was sought from people with lived experience of a DD via three main sources:

Drug and Alcohol services: The regional and local drug and alcohol task forces often bring stakeholders together in a coordinated approach to drug and alcohol strategies at community level, wherein DD is cited as an ongoing challenge for many service users. Practitioners in community-based services are often the link between mental health and addiction services to support people with a DD.

Mental Health services: Mental health problems can range from a brief episode to a more serious condition, with a number of people going on to experience severe mental health difficulties. Many people with mental health problems will be treated in a primary care setting coordinated by their GP, including referral to the Counselling in Primary Care (CIPC) service; where more specialist support is required, they will be referred to the HSE Mental Health services. The HSE provides a wide range of community and hospital-based mental health services.

DD practitioners: While there is currently no standardised national DD model, a significant level of services is provided to those with DD by the HSE National Drug Treatment Centre (NDTC) in Dublin, both by the skilled practitioners in NDTC and by those based in the various services associated with the NDTC. As well, in a number of small teams/services around Ireland, DD-trained practitioners on their own or within their MDTs provide care to people with DD.

5.1.1 Process

Following discussion and agreement at the NWG for DD, task forces and mental health services (including those with DD practitioners) were asked to elicit feedback from people with lived experience who are currently being supported on caseloads in their services.

Three key areas where people with lived experience and family members may have unique insight that could support and inform the NWG in its preliminary work were identified by the NWG:

1. General experiences of service users with a DD and their next of kin/family members.
2. Challenges associated with accessing support for those with a DD currently.
3. Suggestions from service users and/or family members or next of kin about elements that could contribute to an effective DD service.

Many services contributed to this chapter through direct feedback via practitioners who held conversations with service users about their caseloads. This consultation feedback is intended to support robust participative structures to ensure that people experiencing DD are equal partners in their own care, both on an individual basis and in the delivery of the DD MoC in CHOs in Ireland. This gathering of feedback was a once-off initial process leading to the MoC development.

5.2 People with Lived Experience and Family Members' feedback

The feedback is presented in brief under the three themes outlined above; direct quotes from people with lived experience and family members are highlighted in the shaded areas below. To protect the anonymity of participants, names of individuals and services have been replaced with generic terms.

It is important to note that this is not a research project. The aim was to elicit views at a particular point in time. All feedback were completely anonymous. Names or other personally identifiable information was not captured, received or used. The feedback was received in different formats. Most feedback contained direct quotes from service users under each of the three areas of interest. Some feedback was received in the form of practitioners paraphrasing the feedback given by the service users they interviewed. Two anonymised case studies with comprehensive information were submitted. The NWG is deeply grateful to all the respondents. The combined approaches added to the richness of the insights. Not all of the text was recorded here, but all feedback was considered and common themes were extrapolated, along with a selection of direct quotes.

5.3 Experience

The following is a distillation of the feedback from conversations with people with lived experience (including family members) about their initial experience of Dual Diagnosis and is grouped under the common themes that emerged when the feedback was reviewed.

5.3.1 Stigma and assumptions about presenting issues

The feedback indicates that service users experience high levels of stigma when they disclose substance use. They spoke of feelings of being treated very poorly when the issue of drug use was part of their presentation to the services. It appears that the treatment experience was very different for many service users when a mental health issue was the only presenting complaint. In addition, when presenting with a Dual Diagnosis, many service users felt that they were 'not being heard' and that they had a lack of input into their own care. This was cited as common and often distressing for the service user. There was a sense that assumptions were being made about their health status and diagnosis, and indeed their character because of their drug use.

> *"I am really sorry that I told the mental health practitioner that I had a problem with drugs. I don't feel they totally understand addiction and I don't feel I can trust them or they trust me."*
>
> *"I don't like the way they treat you in hospital when they find out you are an addict or recovering addict. They treat you like dirt. A lot could be changed there."*
>
> *"When you mention drugs you then have a bad name."*
>
> *"I found it very difficult to access mental health services while I was active in my substance use. The mental health place couldn't keep me, they said, because I was using at the time. There needs to be more Dual Diagnosis services. The minute doctors hear that drugs are involved they don't want to know. It's horrible. I've been in mental health places saying I'm scared, I'm going to die if you let me out."*
>
> *"In my experience you are treated less well if you are an addict in a mental health service. It is people's own opinions when they look at you, they see you often as a 'junkie' and not a person with mental health issues."*
>
> *"I rarely feel heard or listened to by services, [I recognise it's a difficult job] but some of the attitudes are extremely judgemental and people can easily pick that up and it negatively reinforces them, creates bad energy. With some services we've always felt a lack of empathy or genuine compassion, they never break the line and that distance acts like a barrier."*

5.3.2 Positive experiences

It was evident from the feedback that the initial experience was very challenging for most service users, but there were also positive experiences, which had common elements. Service users had the most positive experience where they felt 'heard' and that support for their needs was available in their own community. Positive experiences cited by people with a DD were almost exclusively from those who had engaged with services where they had received case management, with input from more than one practitioner, where both their substance use and their mental health needs were acknowledged and responded to appropriately. In some cases, the value of peer support groups and specifically SMART recovery was also cited.

> *"The Smart Recovery group have been a fantastic help to me in my recovery from alcohol addiction."*
>
> *"For my wife [the S39 service] have been such a help to her for advice and understanding and support while she supported me with my mental health and addiction."*
>
> *"I told my GP I was hearing voices and he wrote me a letter for [hospital psych unit]. When I was assessed I was told that I was a drug user, they said I had psychosis from using weed as well. I was embarrassed going in there. I found the hospital really helpful once I got on the psych unit ward. They were very nice to me in there. They released me into the community mental health team and that works really well between them and here [S.39 service]. Prior to that I was referred into a [S39 service] with a special worker around my mental health and that worked really well too. My experience has been good really, I didn't feel like anyone was judging me, in the hospital or with my GP, or afterwards in services. I have felt real safe and people have been kind and not judging which has made a difference, apart from some who did not understand [Dual Diagnosis], but overall it's been good in terms of the help I have been given."*
>
> *"I was looked after and found staff [of MH service] to be supportive and understanding."*
>
> *"I feel heard and I'm learning new skills that help me cope with my crazy thoughts and feelings."*
>
> *"My counsellor does not see medication as the only answer."*
>
> *"The service offers an alternative approach/support to the 12-step model, which is good."*
>
> *"Staff are understanding, empathetic and sympathetic to my needs."*
>
> *"I meet people in the same boat as myself… Peer support groups are good but the other people there don't often understand mental illness."*
>
> *"My son might not agree but I almost always found the Garda helpful, they helped to get my son off the streets many times to try to help him."*

5.3.3 Lack of knowledge and information deficits in relation to DD

A recurring theme throughout the feedback was the lack of information about Dual Diagnosis and lack of knowledge on dealing with it. The lack of information was not restricted to families and service users. It was said that practitioners in some mental health and addiction services appeared to lack relevant knowledge when working with people with simultaneous substance-use and mental health issues. There was also lack of knowledge about the corresponding services for each condition and the potential benefits of collaborating with different services.

> *"It wasn't easy trying to get help for him. He was told he couldn't be helped by the mental health services because of his addiction issues. I remember feeling very frustrated by the lack of information."*
>
> *"He was suffering panic attacks, they increased his meds and recommended CBT. He self-medicated with alcohol. They only focused on the panic attacks not on the alcohol issue, and certainly never connected the two to be linked which we now know are linked."*

"It was my mental health first, then came alcohol addiction. They should be treated as one – medical staff, doctors, families and addiction services should be educated about Dual Diagnosis – intertwined – cannot fix one without the other."

"The answer I kept getting back from services, whether it was in the hospital or from the health professionals, was that the addiction has to be addressed first, before they can even look at possibly diagnosing any underlying psychiatric condition."

"[X] acknowledged that mental health service is not an addiction treatment facility but he believes there is nowhere else for someone to go if they are experiencing a mental health/addiction crisis. [X] stated 'there is a fine line between mental health and addiction' and he believed he required mental health support during his admission to a psychiatric unit', despite addiction being his primary issue."

"People are often falling between 2 stools, where there is addiction, there is nearly always a mental health problem – why are they seen as so separate?"

"He admitted that he himself had no experience working with people with addictions. He also told me that he could not diagnose my son with mental illness as the addiction needs to be addressed first."

5.3.4 Addressing the support needs of family members

There was consensus among the family members/carers who contributed to the discussions that more needed to be done in terms of addressing and responding to the needs of families dealing with the everyday stress and stigma of not only the Dual Diagnosis of their loved ones but also the lack of services. In general, it was reported that engagement with the family is very important, particularly when it comes to working with young people.

"Families need support with the stress of living with someone who has severe mental health issues and is actively suicidal."

"It took a very long time for us to get the help my son needed. We knew nothing about any of the services he needed."

"I think there should be more information made available for family members. Family members need to be told what is going on when it is happening. Health professionals need to be more mindful and recognise the stress family members are under."

"Eventually he got a worker to help him but then he left and there was no one."

"When I went to my first family support group what struck me was, although we all had our individual stories, there were several parallels. We all had sons that started out with issues in school i.e. difficulties with mental illness/ADHD and other issues. They all had been involved with mental health services but most of them seem to have not received the support they needed."

"Having a specific service within the mental health service provides us, the family, with support and guidance how to best deal with our loved one... it means we also have a point of contact."

"My son has been on heroin from the age of 15. He started off taking pills, but at one stage he was put into a facility. He never wanted to be there and he expressed this. In fact he recognised and expressed serious concern about the environment and heroin use and that he would end up on heroin in this place. I always felt that my son and us [parents] were judged by services, there was a sense it was our fault or his fault. We faced a blame culture supporting him to use services, we felt they blamed us as parents for what was happening… This meant that he was often seen as a bad kid, but we felt his illness was not being treated. There was a serious lack of support."

"My relationship with my husband has recently ended due to all the stress and wear and tear of dealing with our son. Families and supportive people and structures need to be brought into the care."

5.4 Challenges

This section captures some of the experiences of the people with lived experience and family members in relation to help-seeking.

5.4.1 Transition planning and coordinated care

There was regular reference to hospital emergency departments (EDs) and the challenges with onward planning after arrival and discharge at EDs when the service user presents with substance-use disorder and mental health difficulties (examples given included drug-induced psychotic episodes, suicidal ideation/attempts, etc.). Families cited struggling with repeated visits to ED. There was evidence that often there was inadequate follow-up upon discharge from hospital, which often led to lack of appropriate support in the community. In addition, postnatal support was cited as critical for women with Dual Diagnosis.

> *"[He] ended up in A&E a few times over the years. Three years ago, he got ill from drinking, ended up in A&E and only was then referred to the mental health services. He was self-medicating with alcohol."*
>
> *"I've had some really bad experiences in hospital when I went for help. I've been hearing voices, and having hallucinations when not using substances and feeling suicidal and self-harming and the health services handed me a prescription and said see you the next time and gave me a date for weeks later. When I go back they say the same thing until I end up in hospital. It's never been easy for me to access support in the services. I don't feel good after being there in the hospital either."*
>
> *"I experienced it first hand and I count myself very lucky to be sitting here in this chair today."*
>
> *"The drug he was taking caused hallucinations, hearing voices and paranoia amongst other things. It would build up to such an extent that he would have a severe episode that results in him having to go to A&E. The outcome is always the same. They would assess him, but once the drugs are out of his system and the side effects subside he would be discharged."*
>
> *"Do staff talk to each other in different services to discuss the individual case?"*

5.4.2 Health inequities and treatment access

Many of the people with lived experiences cited the inequity of the treatment system in Ireland, reporting that only those who have the means and private insurance can get timely treatment. This included accessing DD services through the private sector. Others cited waiting times of up to 1-2 years for mental health services as they were unable to pay for private treatment. It is well documented that drug use is disproportionately concentrated in disadvantaged communities. Often substance-use disorders can be associated with serious mental health disorders which may go untreated, triggering risky self-medication. Furthermore, service users with Dual Diagnosis DD in disadvantaged communities may not have the social capital to access a private service through medical insurance. However, it is important to note that this consultation did not include those with private health insurance; they may have had similar challenges accessing services in the private sector.

> *"If you go private you can have everything."*
>
> *"I'm sure if we didn't go private, I wouldn't be having this conversation today."*
>
> *"Referral sent to [name of service] 2 and half years heard nothing. Had to go private."*
>
> *"If you don't have VHI you can't get anything, it is not good enough."*
>
> *"We had to change from the treatment centre she had chosen as she needed to be detoxed before they'd admit her… there was over 2000 euro in difference between the price of the two... for only a week extra..."*

5.4.3 Supports generally not tailored to people with DD

The norm is that services are not tailored to people with Dual Diagnosis, resulting in a range of challenges such as: increased prejudice and stigma, lack of communications around care, no capacity for holistic one-stop shop, and a detrimental impact on therapeutic treatment.

> *"A note that I would like to make is that the mental health teams often like to try to use the substance as the item causing said symptoms and it often becomes a question of which came first, the egg or the chicken, the substances or the mental health issue…"*

5.5 Suggestions for Future Provision of DD Services

This section captures reflections from people with lived experience of DD and family members in relation to improvements or suggestions to enhance DD service provision.

It is important to note that many service providers reported that DD among people who use drugs that access their services is more common than not. There was enthusiasm for the new Model of Care that is to be developed as a mechanism for addressing some of the barriers in access to services that currently exist.

5.5.1 Pathways to support and care coordination

In terms of practical suggestions for addressing access to services and given the feedback in the context of staff shortages and long waiting lists in HSE addiction and mental health services, it seems that using the services that are available and knitting them into integrated care pathways is a practical workaround. However, if both services have significant staff shortages, integrated care might be challenging. The National Drug Rehabilitation Framework of 2010 and associated protocols (62) clearly outline the need for service users to have a named key worker and a case manager. In the case of people with a DD, this seems particularly important. It seems prudent that the nomination of the case manager should be primarily based on the capacity of the service to provide meaningful case management. The feedback indicates that the mental health services have the expertise to coordinate integrated care for those with DD, but, in many cases, the actual case management (including liaison with all other relevant service providers involved in the person's care and the service user themselves) is time-intensive and therefore not always feasible. While not ideal, a pragmatic approach might be required until more focus is placed on key working/case management/care planning in terms of allocation of appropriate staff in mental health services for case management. Although the feedback suggests that the mental health services should take the lead, the lack of adequate staff skills mix in both the mental health and addiction services would indicate the need for a collaborative approach wherein the lead for the service user with DD is decided based on their individual presentation and needs. The common assessment tool being piloted and rolled out across the addiction services will help identify the needs of those with DD.

> *"It really helps when staff talk to the mental health team as well. Having a case manager has been helpful."*
>
> *"Now I have a different health professional in mental health services who is really great so now it's a different experience. He listened when I told him that I hadn't used drugs in a year after being here [S.39 service] and that I was still the same person on or off the drugs and my mental health was still the same. The power of being listened to. My experience of using here [other named S.39 service] and my current psychiatrist together has been really positive."*
>
> *"They released me into the community mental health team and that works really well between them and here [S.39 service]. Before that I was referred into a community drugs team with a special worker around my mental health [S.39 service] and that worked really well too."*
>
> *"The only way you get linked back into services is to attend A&E and get a proper trail but even if that's successful you are still left waiting weeks for an appointment, during which time you could be in a very bad way."*

"I think some of the issues are down to resources, others down to lack of education around addiction, prejudice and also a lack of understanding around case management and shared care as set out by the HSE."

5.5.2 Cross-dissemination of information and capacity-building for services

There was general consensus among service users and family members that practitioners from both the mental health and substance-use services needed to have more information about the whole area of Dual Diagnosis and each other's services. With an emphasis in *Sláintecare on early intervention and prevention at community level, access to timely and accurate information about services and supports are central. Some practical suggestions were made about how to address this and fill the information gap between the various health service providers, even within the HSE. With e-health strategies very much in focus due to the reliance on IT in the health sector during COVID-19, there is an opportunity to address information gaps in the services using such modern technologies, while complying with data protection issues. However, the experience of service users is that, while they may opt for telehealth in the absence of face-to-face consultation, in crisis scenarios and in complex presentations they prefer face-to-face consultations. Technology can only be part of the solution in some cases, and cannot replace face-to-face consultations. The option of hybrid consultations involving both face-to-face and telehealth for some sessions can be considered when services are planned in the future.*

"My experience is that the GPs often don't know about any supports out there for service users and families [with Dual Diagnosis]. I've had to tell them that this place is here, even if they had pamphlets left out that people who are maybe in a crisis could pick up, it would maybe be a starting point."

"A service user presented to A&E after a crisis, the doctor told the family member that CAMHS would be the best thing for her. She actually went to the pharmacy the next day and bought 'Kalms', the tablets. She only realised that maybe it was the service CAMHS that was meant after talking to someone else, there was no information given, there was no contact details, nothing."

"It can't be that hard to get information out to GPs about local services and how they can help someone who comes to them that has a mental health condition and is now using drugs."

"Everything is on the web now. Surely some basic information about Dual Diagnosis is possible for the services so they know what to tell people when they look for help."

"Getting help and support is hard, maintaining it is harder. There needs to be a wraparound service for people to access easily."

5.5.3 Meaningful engagement of service users in their own care, and of family members

The prevailing theme of the feedback from all areas is that service users with a Dual Diagnosis generally do not feel they are active and equal partners in their own care. Future models of DD services will need to have a robust system to ensure that, in addition to being heard, service users have an active role in their management care plan. As the HSE mental health services have a designated department with infrastructure in place for service user and family engagement, it seems appropriate to expand and build on this in the design of the future DD services.

"Service users need to be given some choice and control when it comes to the design of recovery plans, especially with regard to medication, peer support and talk therapies."

"You actually don't know what is happening, often no-one is really telling you."

"I cannot stress enough how difficult this journey is for the young people and their families. We are all trying to navigate the system, looking for support for our children/young adults, who is suffering at the hands of a system that is not designed to support them in any meaningful way. During all of this the only real support I have received has been through [S.39 service] and [S.39 family support service]."

The feedback indicates that family members can be important partners in the care and recovery process. Throughout the feedback, family members emerged in a dual role as both a) agents of change in recovery care plans and b) service users in their own right.

The lack of readily available information and capacity-building for family members currently was seen as a challenge. Filling these gaps should be a fundamental part of future service provision in the DD services.

> *"Local services need to adopt a different attitude so that service users and families are included as key stakeholders in the individual's recovery."*
>
> *"Take people in even if just overnight to help them feel safe and talk to someone who knows and understands. A phone line in the case that they can't go in, again talking to a professional... We just wanted information, that's all. But none had any for us."*

5.5.4 Trauma-informed / Integrated trauma approaches

People with substance-use disorders often have a history of trauma in their life (63) a, while those with a history of substance-use disorder tend to suffer trauma due to accidents or putting themselves in dangerous situations under the influence of substances (64). Furthermore, service users with a history of trauma and substance-use disorder also suffer from mental illness (65), while those with a history of trauma tend to suffer from mental illness in later years (66). Although many service users with a history of significant and repeated trauma in their life may present with few or no symptoms, there is a likelihood of them presenting with mental health and substance-use disorders, and their history of trauma can affect their level of engagement in the services (67). Overall, those with a history of trauma and substance-use disorder often have a poor treatment outcome (68). Trauma-informed care should be of a supportive nature and be tailored to the needs of the individual service user depending on the nature of their experience, rather than there being an attempt to treat or deal with challenges associated with the trauma (69).

Given the evidence that many of our service users' lives have been characterised by adverse childhood experiences and other traumas, it seems appropriate that the new MoC should include a trauma-informed / integrated trauma perspective. Training and capacity-building to include trauma-informed / integrated trauma approaches would be essential.

> *"Service providers should make sure to adopt a respectful, non-judgemental and dignified approach when treating service users suffering from trauma."*
>
> *"His drug use was a huge barrier, he had to get clean and stay clean in order to get help, but he was so full of fear, he couldn't stop. The night is always the worst, there's no support once it gets dark. He was scared of his own shadow."*
>
> *"Inpatient psychiatric units can be a 'frightening place' and not suitable for someone primarily experiencing addiction issues. He stated 'I did not belong there'. Having said that, [X] stated that he felt there was 'nowhere else to go' at the time and he acknowledged that he presented to ED a number of times during his mental health/addiction crisis."*
>
> *"When an addict and in the case of my son was left isolated separated from important connections, or loved ones they can spiral. A connection with a loved one or trusted person has a dramatically positive effect on them. There is often a loneliness for human contact and a connection."*

5.5.5 Residential options for service users with complex needs

There was feedback that, although not always necessary, residential treatment should be an option in care plans for people with a DD where complex needs and high levels of dependency are indicated. In Ireland, most of the residential treatments are provided by non-HSE agencies, in most cases funded by the HSE through service-level

agreements which requires them to comply with the national standards of safer, better healthcare. A key barrier cited was the high threshold that must be reached for some residential treatment services. This appeared to be mainly centred on access criteria which, in some cases, required service users to be free from certain prescribed psychiatric medications prior to entry for residential treatment. The case is made for relaxing the criteria to ensure that those that require it most get a pathway into high-support residential treatment when required.

> *"Remove the barrier to residential addiction treatment."*
>
> *"Residential treatment services won't accept me on my prescribed medications which I am willing to come off, but have to come off before I go in anywhere or you need thousands and thousands to get into any of the places that do take you – it would make you go back to addiction."*
>
> *"I had awful difficulties with [residential service] and [residential detox] due to entry requirements and catchment areas due to my mental health medication."*
>
> *"In terms of accessing drug treatment and addiction services, [X] highlighted lengthy waiting lists and time spent in an acute hospital ward whilst waiting to go to a treatment centre as issues. [X] also highlighted the issue around there being insufficient detox facilities available and the fact that a person must be required to detox themselves, often without suitable support, before eventually being provided with addiction residential rehabilitation treatment."*

5.5.6 Engagement strategies

There was consistent support for dedicated DD services where multidisciplinary teams with dual training and expertise are available. It was also recognised that, in many cases, work has to be done with individual service users before they are ready to engage with services providing DD. In that regard, there was support for an outreach element which can be provided by the HSE addiction services and/or Section 39 agencies. This was seen as particularly salient in complex cases where there are cumulative challenges.

> *"Because my son is currently on drugs he needs direct intervention, someone to meet him where he is and although they can't make him go to appointments, or other services, relationship-building could start."*
>
> *"The services are all there but they are sitting behind a desk, some of the staff I have come across are unreal [in a positive sense] but that can't be experienced by people if it's on a computer, in one location behind a desk. There is too much distance in the service, not close enough to the person, should be a hand-in-hand approach."*
>
> *"We need to try and build them up from the inside, show them love, compassion, empathy, no judgement on them, it's an illness, listen more to learn their story, what they're feeling, what path they want to go down. They should be at the centre of their care. The focus needs to be wider, more holistic. There is too narrow a focus within services. The service needs to connect with the 'heart of the patient'. Other therapies, treatments, approaches also need to be considered."*
>
> *"There is a huge need for greater outreach and connectivity where we have people working on the streets building familiarity, trust, relationships, and encouraging and supporting people to attend appointments, clinics, etc., organising visits attending with people where needed. More intense support and assistance through outreach. The service needs to serve us."*
>
> *"We need to ask, how can we help you? Start with the person and try to see the entire person not just their illness, addiction, behaviours, etc. The language used can be difficult and triggering for people – 'rehab, clean, detox', etc. – it can be very medical and harsh instead of more empathetic."*

5.5.7 The case for a dedicated DD team

There was a marked contrast in the feedback from those who sought support from either an addiction or mental health service compared with those who received support from dual-trained practitioners with expertise in DD. In cases where specific practice knowledge of DD in services was lacking and only particular perspectives from one or other service were being applied, the experience of service delivery was negative. In contrast, in a service where staff had a DD brief and relevant training, there was a positive holistic experience.

> *"He continues to need the input of multiple services to meet his needs, including homelessness services, psychiatric services, drug use support services, and more. With a clear Dual Diagnosis service the patchwork of services so often needed by service users similar to [X] could be drawn together and work to minimise the exposure to harm that the vulnerabilities of Dual Diagnosis and associated problems bring."*
>
> *"[X] stated that he feels mental health and addiction are often intertwined and he believes the mental health service should account for this by having an Addiction Counsellor on the MDT in all mental health teams. [X] stated that the mental health model itself does not fully address the addiction issue and he believes there should be a model of care introduced that deals with both mental health and addiction in the same intervention as opposed to referring service users from one facility to the other, and vice versa."*
>
> *"We have nurses/counsellors and other professionals who are qualified and interested in working with both issues."*

5.5.8 Improved communication and compatible policies between mental health and addiction services

More education in and awareness of Dual Diagnosis is required for staff in all services, people with Dual Diagnosis and their families, along with improved communication between services. The feedback indicated that local service policies can detrimentally affect service users' potential to recover.

> *"The addiction centre blamed the lack of response and improvement on the lack of action of the mental health team, instead of seeking the advice and information of the local mental health team. My time to begin treatment was also delayed and prolonged as they wanted a psychiatrist's report. I had to wait for the addiction clinic's psychiatrist who only comes one morning a month instead of simply making contact with my actual psychiatrist."*
>
> *"No communication between the two teams, led me to be re-assessed by another psychiatrist, causing re-traumatisation by recalling all the painful things in my life, to provide the same diagnosis as the mental health team, no information about what the other service was doing, frustration from addiction services that I was being discriminated against just because I had a Dual Diagnosis, and the mental health team did not want to do anything till the substance use was addressed and finished."*
>
> *"Educating close friends/family members of the patient about their Dual Diagnosis [is needed. This] comes from my experience as my parents did not know what to do or how to handle the situation as each team would often contradict each other. They need to communicate better between themselves."*

5.5.9 Practitioner observations

Although feedback from practitioners/case managers was beyond the scope of the initial request for feedback, some practitioners submitted analysis and feedback based on conversations with service users on their caseloads and observations from their previous experience of supporting people with a Dual Diagnosis. Their feedback is consistent with that of the people with lived experience. Services need to have integrated care pathways in place, with agreed case management, as a key process of the management plan. Where people receive treatments from different services with separate polices on people with DD and where practitioners in these services are not

DD-literate, the care process appears to break down. Several case studies were submitted; some excerpts are given below.

"Ensure referral processes and care pathways within and across services are consistent and that governance arrangements are in place, including local care pathways in order to meet other needs such as social care, housing and physical health."

"Mimic policy and action practice documents on integrated care pathways which have already been implemented such as that for chronic illness which like Dual Diagnosis is based on complexity."

"I suggested to the psychologist that she may take the lead as it was important for the care of this client to be case-managed given the complexity of her case. The psychologist also expressed a reluctance to commit to case management as she would be working with [X] for a limited time (i.e. the duration of the psychological intervention). Without stepping in as case manager but with the commitment of other supports involved, I used an email thread to communicate and agree on goals, further steps and onward referrals. This however was not our responsibility [s.39 service]."

"Before he linked in with mental health services, [X] had presented to ED twice with significant suicidal ideation, cutting, and attempt to jump from a high building. This was in response to voices of his dead friends he was hearing telling him to join them. These friends had been fellow drug users that he had been very close to. He had injected heroin, and taken methadone though had stopped this before the voices started. He also regularly used cannabis and drank daily. His accommodation was not secure and he was not deemed to be in the catchment area of the emergency department. He was discharged each time with drug-induced psychotic disorder diagnosed on a short course of olanzapine, advice to remain abstinent from drugs, and without follow-up from other services."

"One of the challenges we see is the patient representing to A&E with self-harm/substance misuse leading to a 'revolving door'. This in turn leads to family and patient's expectations not being met, often leaving A&E dissatisfied and frustrated, as they have not received the right support, in the right place at the right time. This has highlighted a gap within the HSE that there is a need for an identified service for Dual Diagnosis."

"During admission to our mental health facility [X] was diagnosed with Major Depressive Disorder with Psychotic Features. He engaged with treatment and has improved. It became apparent that he had established good connection with addiction facilities and his addiction counsellor attended Individual Care Plan Meeting and advocated for him and careful discharge planning. It was noted that [X] would be at increased risks of relapse into substance use and subsequently Depressive Episode, should he be discharged to unstable accommodation. Mental health service is currently working with local Homeless Supports. [Y] has also applied for residential treatment facility."

"[X] Is a patient attending mental health services for over a decade. She has a diagnosis of emotionally unstable personality disorder (EUPD) as well as polysubstance misuse. She also attends local substance misuse services for opioid substitution treatment and has done so for a number of years. Attendance with mental health services has been characterised by periods of disengagement and re-engagement in crisis. [X] has had many interventions with mental health services over the years including acute day hospital engagement, psychological interventions and hospital admission at times of acute crisis. However engagement has never been sustained for long beyond crisis periods and this has limited the ability of the service to provide dialectical behavioural therapy or other evidence-based psychological therapies for her EUPD. The challenges experienced through attending both a community mental health service and substance misuse service centre mainly around day-to-day practicalities. For example; this patient has her medication dispensed on a daily basis from the substance misuse service."

"She recently attended our acute day hospital which involves daily attendance for two weeks. [X] struggled to get to our appointments on time after attending the clinic for her medication and found the experience to be frustrating. Another challenge for our patient was the lack of communication and clarity between services in terms of medication changes and who has responsibility for prescribing. Again, [X] found this frustrating

as she sometimes spent long periods of time waiting for medication to be clarified between services. Social stresses regarding housing and relationship have also made it difficult for [X] to consistently engage. [X] suggested that more communication and collaboration between services would be helpful in allowing her to engage fully with both."

"I've just completed the NCCP Questionnaire with patient as discussed at the Case Conference and I'm pleased to report he is doing well and he celebrated one year clean and sober three weeks ago. [X] wanted me to express his gratitude to [practitioner] for helping him 'start his recovery journey'. He is currently staying in a residential service with a view to getting county council accommodation in the future. [X] reports that he has reunited with his family and sees them regularly."

"[Y]'s recollection of 6 months preceding the admission to hospital was patchy; however he reported that he was pleased with treatment he received since."

"Homeless services and Mental Health services reflected that in complex cases like the one described above more assertive outreach would be needed."

5.6 Implications of this scoping exercise

Review of the feedback from people with a lived experience (and family members), plus additional input from practitioners, revealed a number of consistent messages for the NWG for Dual Diagnosis to consider in developing the Model of Care.

1. Those who accessed a dedicated DD practitioner/service had a more positive experience of care. There is a clear rationale for the development of the MoC and specialist DD teams from the outset.
2. As the DD teams are unlikely to be in every CHO in the near future, a clear focus on building the capacity of existing services needs to be considered so that they are better equipped to provide appropriate interventions.
3. Capacity-building within existing substance-use and mental health services in relation to DD is required. This should extend to all healthcare and social care professionals who are likely to come into contact with people with a DD. This will be important in ensuring informed referrals to the new DD teams when established.
4. The level of training/capacity-building should be aimed at all tiers, from basic training/capacity-building to more comprehensive training depending on the role of the practitioner and to what extent they are likely to engage with people with a DD (e.g. members of the mental health teams will require more intensive training/capacity-building than the voluntary agencies). The feedback indicates clearly that there is a capacity/information gap about even fundamental elements of DD among many practitioners both within and outside the HSE.
5. The DD services need to include an aspect of family support. These can be provided through existing resources in the mental health services and referral to appropriate community-based family supports.
6. The MoC needs to include a case management function in line with the NDRF approach to coordinate care and navigate the shared care that is required, particularly in complex cases.
7. Subject to agreement by the service user, family members/carers need to be included both as agents of change in recovery and as service users requiring support in their own right.
8. People with a lived experience or 'experts by experience' need to be involved meaningfully in the service delivery as it rolls out through co-production.
9. Policies that do not meet the complex needs of an individual are to be identified and modified so as not to lead to disadvantage, e.g. non-dispensing of methadone in some residential services, or non-residential treatment of people taking mental health medications.
10. There need to be trauma-informed integrated care pathways.

Aims & Objectives, Definitions For The Irish Model, Service Configuration & Implementation

6. Aim and Objectives

6.1 Aim

The aim of the Dual Diagnosis Clinical Programme is to develop a Model of Care to support individuals with a DD through a multidisciplinary, specialist DD service that incorporates fully the experience of people with lived experience of mental health and substance use disorder in each mental health service catchment area.

6.2 Objectives

1. Provide a trauma-informed specialist DD service, developed in line with the core principles of co-production, ensuring better outcomes for individuals and their families.
   a. Develop a specialist DD service for adults at the level of mental health catchment area.
   b. Develop a specialist DD service for adolescents at the level of mental health catchment area.
   c. Develop a specialist DD service for vulnerable populations at the level of mental health catchment area.
2. Provide improved coordination between providers (substance use, mental health, and primary care), which will break down administrative silos and improve access to timely diagnosis, care and treatment.
3. Provide service in line with the values of person-centred practice – i.e. a holistic approach tailored to the local context and the individual's needs.
4. Provide a fully integrated system of care providing mental health and addiction support through collaboration between the HSE, other statutory, voluntary and community partners and individuals with lived experience. This approach should minimise the barriers faced by individuals accessing care.
5. Develop an appropriate and accessible referral system.
6. Provide appropriate screening using a common assessment tool and brief intervention at point of entry to services through the referring service.
7. Provide integrated and improved treatment delivery through resourced training and cross-training of substance-use and mental health service providers at multiple levels.
8. Enhance community drug services to support people who are not in need of a specialist DD team by providing training, consultation and support.
9. Define clear pathways of care.
10. Identify dedicated residential stabilisation and detoxification and rehabilitation services for individuals with a Dual Diagnosis.

7. Definition of Dual Diagnosis and DD Services for the Irish Model of Care

The definition of Dual Diagnosis for this Model of Care will be: **'co-morbid disorders due to substance use and/or addictive behaviours along with the presence of mental disorder(s)'**. The disorders of substance use include disorders of alcohol use, and the disorders of addictive behaviours will include Gambling and Gaming disorders. The diagnostic terms in this Model of Care will be based on the ICD 11 classification of the WHO. The definition will be similar for the delivery of the Dual Diagnosis services except that, in Phase 1, the DD services will not provide a service for those with addictive behaviours (i.e. Gambling and Gaming disorders). The latter will be implemented in Phase 2 of the delivery of services.

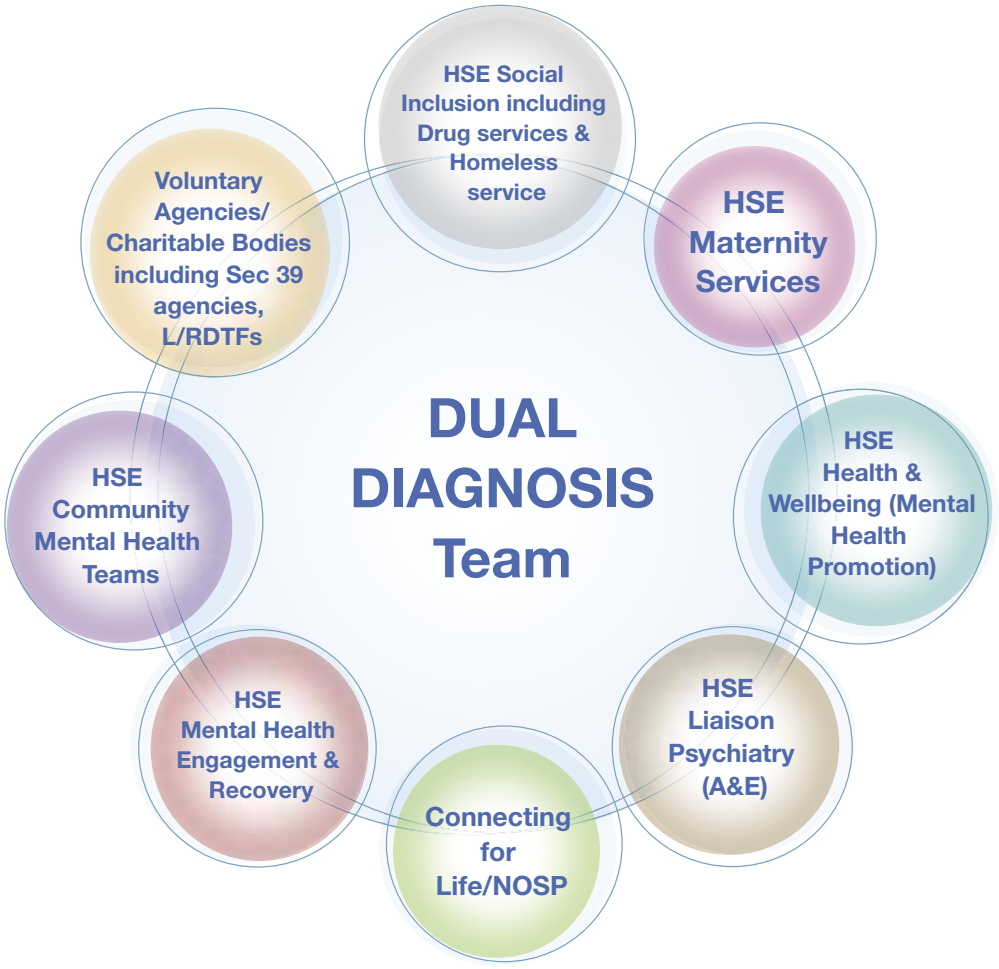
8. Service Configuration

8.1 Integrated DD Service/Collaborative Approach

The Dual Diagnosis service envisaged for Ireland will be an integrated service. The various services that will work in partnership with DD services are shown in Figure 1. DD teams will be formed by professionals funded and/or employed through different divisions of the HSE, e.g., HSE Mental Health services, HSE Social Inclusion, HSE Health and Wellbeing, HSE Mental Health Engagement and Recovery, while additional training support will be provided by the National Office for Suicide Prevention in addition to the above divisions. This will be in line with the HSE Mental Health Promotion Plan which states that mental health promotion initiatives will be developed and implemented with people who have mental health difficulties and co-existing substance-use disorders in order to promote and support positive mental health and well being for those with Dual Diagnosis.

In addition, much of the training envisaged in this Model of Care will be in partnership or resourced through the National Office of Suicide Prevention/Connecting for Life and HSE Addiction services through HSE Social Inclusion, in addition to e-resources planned in partnership with the Integrated Alcohol Programme through HSE Health & Wellbeing. There will be associated partnerships with Section 39 agencies on a case-by-case basis whereby resources such as community support and support for the homeless can be offered to the service users in a collaborative manner.

Figure 1. Integrated model for Dual Diagnosis teams



8.2 Four-Quadrant Model of Dual Diagnosis

The four-quadrant model in Figure 2 illustrates the heterogeneity of people presenting with co-morbidity of substance-use and mental disorders. Research has shown it to be a valid model. Quadrant placement correlates with psychiatric and substance-use diagnoses, psychiatric symptom severity, substance toxicology and psychiatric and substance-use health service need. The model is used in clinical and administrative settings to provide a basic framework for matching disorder severity with appropriate treatment and service intensity.

This four-quadrant model of DD will be the guiding model in defining the different groups of DD service users.

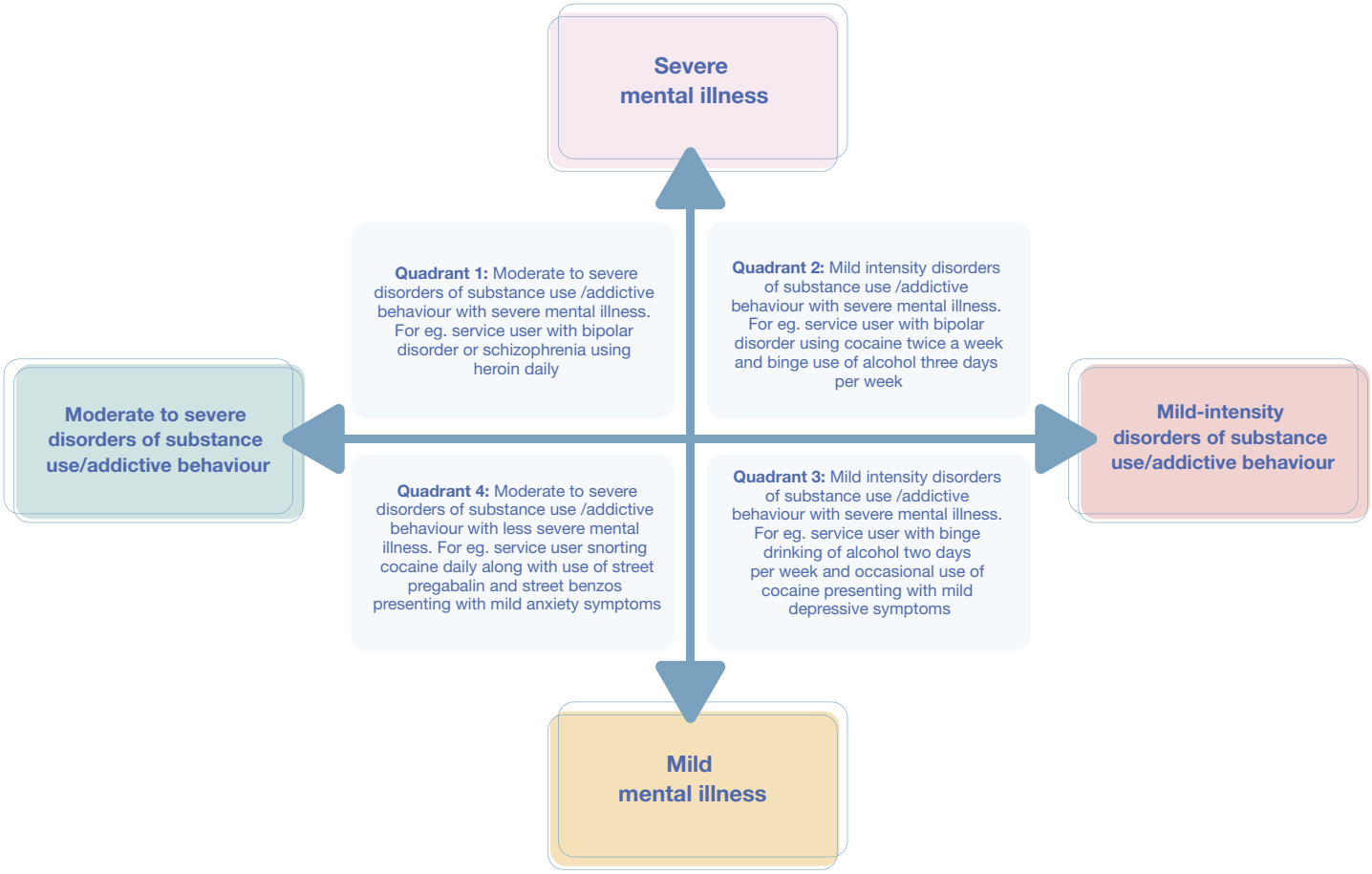


Figure 2: Four-quadrant model of Dual Diagnosis

Quadrant 1: Moderate to severe intensity disorders of substance use/addictive behaviour with severe mental illness. For, e.g., service user with bipolar disorder or schizophrenia using heroin daily.

Quadrant 2: Mild disorders of substance use/addictive behaviour with severe mental illness. For, e.g., service user with bipolar disorder using cocaine twice a week and binge use of alcohol, around three days per week.

Quadrant 3: Mild-intensity disorders of substance use/addictive behaviour with less severe mental illness. For, e.g., service user presenting with binge drinking of alcohol around two days per week and occasional use of cocaine, presenting with mild depressive symptoms.

Quadrant 4: Moderate to severe disorders of substance use/addictive behaviour with less severe mental illness. For, e.g., service user snorting cocaine daily along with misuse of street pregabalin and street benzodiazepine, presenting with mild anxiety symptoms.

The service users under quadrants 3 and 4 will be expected to be assessed primarily through the HSE Drug and Alcohol services and/or Perinatal Mental Health services. The role of Adult CMHTs will be primarily focused on assessing service users under Quadrants 1 and 2 for onward referral to the Dual Diagnosis teams, if needed.

The severity of the substance-use disorders will be based on the DSM 5 classification criteria defining various intensities of substance-use disorders.

8.3 Specialist DD teams

The remit of the specialist DD team using the quadrant model of DD (as in Figure 2), will correspond with service delivery for service users primarily in Quadrant 1 and 2.

The remit of the DD team will be:

1. Complex and chaotic clinical presentations.
2. Strong clinical suspicion of severe and enduring mental illness.

The three core roles of the specialist team are:

1. Assessment and formulation.
2. Care planning.
3. Consultation/liaison.

The three key purposes of the specialist team are:

1. Support the other Mental Health Teams with a clear treatment plan.
2. Manage the DD needs that cannot be met within the resources of Mental Health Teams.
3. Support case management in a collaborative approach with other Mental Health Teams, HSE Drug and Alcohol services, HSE Health & Wellbeing, the wider health service and other organisations such as Section 39 agencies and Local and Regional Drug Task Forces (L/RDTFs).

It is expected that the HSE Drug and Alcohol services and/or the Addiction Psychiatry teams within the HSE Addiction services will cater to the needs of the service users under Quadrants 3 and 4.

8.4 Linkages of the Clinical Pathway

Dual Diagnosis is a dynamic process. Assessment, referral and where appropriate, joint working is a key component of the pathway to ensure care delivery can be matched to this dynamic process. These components are needed to meet the service user where they are and to address any gaps in service provision. It is unlikely that any one service will be able to meet the needs of this group of service users. It is also likely that, as a service user moves towards recovery, their needs will change.

On occasions, there will be differences of opinion about which service is best placed to provide the care of an individual patient or which is the appropriate contribution of a specific service to care. The aim is to support liaison and joint working between services to discuss these differences of opinion.

If initial discussion between staff directly involved in a case does not resolve the situation, a separate management meeting should be arranged or it could be discussed as part of the regular case management meetings. At least once a month, a case management meeting led by the DD team must take place. At these meetings, discussions on case management, including new/re-referrals, outcome of assessments and discussions on any differences in opinion between the services shall take place. This meeting would be expected to include at least one staff member in each of the services involved with the service user in addition to any other service providers identified by the DD team. All these meetings will be on an invitation-only basis, organised by the DD teams in each CHO.

Where consent has been agreed, all the services involved should be informed of significant changes in the service user's circumstances. Written consent shoul be routinely obtained before information is disclosed to external agencies. The content and format of information that is being shared should be discussed with the service user and they should be involved in preparation wherever possible. In line with confidentiality policy, staff have a responsibility to share information about risk with other services.

In this pathway, it is expected that there will be a consultant psychiatrist in every adult DD team for the purpose of linkages and that this lead doctor will be on the specialist register. This is to ensure that the pathway meets the expectations of good clinical governance, follows HSE policy and gives recognition to the complex nature of DD.

Key principles for treatment by the DD service include:

1. One lead service (CMHT/HSE Addiction services/DD).
2. Identified Medical Lead in one of the services involved or in joint-working arrangement.
3. Identified key worker in the lead service.
4. Identified care co-ordinator (may be same person as the key worker).
5. Identified joint-working services.
6. Consent and confidentiality arrangements for all services involved in care.
7. Service user at the centre of the care planning and treatment.

9. Implementation of the Dual Diagnosis Services

As described earlier, Dual Diagnosis services will be implemented in two phases:

Phase 1

In the initial phase 1, DD services will be gradually rolled out across the CHOs. These services will not include provision of services for behavioural addictions, i.e., Gambling and Gaming disorders (diagnosed according to ICD 11).

Phase 2

The second phase will commence when the HSE Addiction services under HSE Social Inclusion have adequate resources to manage behavioural addictions, i.e. Gambling and Gaming disorders. In this phase, the service delivery will include those with behavioural addictions as part of their Dual Diagnosis.

Adult Dual Diagnosis Services, Referral pathways & Case Study Examples

10.1 Catchment Areas and Proposed Adult DD Teams

As recommended in *A Vision for Change*, each adult DD team will cover a catchment area of approximately 300,000 population in the age group of 18 to 64 years. The service users above that age group with Dual Diagnosis will be appropriately supported through the Older People National Clinical Programme or other appropriate services for that age profile and future collaborations shall be considered with the appropriate services/Clinical Programme to cater to the specific needs of this population group. The distribution of the proposed adult DD teams is detailed in Table 2. In CHOs with a wide geographical area, there can be two separate teams with half the number of WTEs recommended.

CHO	County	Population (18-64yrs)	DD Teams proposed
1	Donegal, Sligo, Leitrim, Cavan, Monaghan	239,737	1
2	Mayo, Galway/ Roscommon	272,671	1
3	Limerick, Clare, North Tipperary	232,740	1
4	Cork, Kerry	423,156	2
5	South Tipperary, Carlow, Kilkenny. Waterford, Wexford	304,509	1
6	Dublin South East, Dun Laoghaire, East Wicklow	246,619	1
7	Kildare West Wicklow, Dublin West, Dublin South City, Dublin South West	449,618	2
8	Westmeath, Offaly, Longford, Laois, Louth, Meath	386,767	1
9	Dublin North, Dublin North Central, Dublin North West	404,826	2
	Total	**2,960,643**	**12**

Table 2: Distribution of adult DD teams (based on 2016 Census, health atlas)

10.2 Specialist Dual Diagnosis Team Composition

The specialist DD team will function in a multidisciplinary manner. Each professional in the DD team will bring their own specific skills, but all clinicians will have substance-use disorder (SUD) treatment skills so that the team can function effectively. The DD team will function as part of the CHO Mental Health governance structures in terms of pathways, evaluation, data collection and training.

The following are recommended for a complete DD specialist team for a catchment area population of around 300,000 (18-64-year-olds):

- One Consultant General Adult Psychiatrist with a special interest in Addictions
- One Non-Consultant Hospital Doctor (NCHD) in Psychiatry
- One Clinical Nurse Manager 2 in Dual Diagnosis
- One Advanced Nurse Practitioner in Dual Diagnosis or Clinical Nurse Manager 3 in Dual Diagnosis
- Two Clinical Nurse Specialists in Dual Diagnosis
- One Senior Clinical Psychologist in Dual Diagnosis
- One Senior Mental Health Social Worker
- One Senior Occupational Therapist in Mental Health
- One Senior Addiction Counsellor
- One Addiction Counsellor
- One Peer Support Worker
- One Grade IV Clerical Officer

Additional WTEs may be shared from other HSE services depending on additional supports provided by the Dual Diagnosis teams with an agreed clinical governance structure at the local CHO level.

The grades of each, as well as additional qualifications required for each post, are described below:

Consultant General Adult Psychiatrist with a special interest in Addictions

In addition to the existing requirement to become a General Adult Consultant Psychiatrist, the applicant for the post must have at least one year of training in Addiction Psychiatry in a recognised training scheme either at the Basic Speciality Trainee (BST) or Higher Speciality Trainee (HST) level. It will be desirable to have the experience in Addiction Psychiatry at the HST level.

Non-Consultant Hospital Doctor (NCHD) in training in Psychiatry

The applicant for the post must satisfy the requirements to work at the level of Basic Speciality Training (BST) and be part of a recognised training scheme in Psychiatry.

Clinical Nurse Manager 2 (CNM 2) in Dual Diagnosis

In addition to the existing requirements to become a Clinical Nurse Manager 2 in Psychiatry, it is desirable that the applicant also have demonstrable working experience of at least two years working with those who have Dual Diagnosis.

Advanced Nurse Practitioner in Dual Diagnosis

In addition to being on the ANP register of An Board Altranais, the ANP in Psychiatry should have specialised in Dual Diagnosis or Addictions as part of their ANP registration.

Clinical Nurse Manager 3 (CNM 3) in Dual Diagnosis

In addition to the existing requirements to become a Clinical Nurse Manager 3 in Psychiatry, it is desirable for the applicant to have demonstrable experience of at least two years working with those who have Dual Diagnosis.

Clinical Nurse Specialist (CNS) in Dual Diagnosis

In addition to the existing requirements to become a Clinical Nurse Specialist in Psychiatry or a Clinical Nurse Specialist in Addictions, the applicant should have a Level 8 qualification in Addictions (for CNS in Psychiatry) or Level 8 qualification in Mental Health (for CNS in Addictions), while it is desirable to have experience of two years working with those who have Dual Diagnosis.

Senior Clinical Psychologist in Dual Diagnosis

In addition to the existing requirements to become a Senior Clinical Psychologist, the applicant must have demonstrable experience of at least one year working with this population group.

Senior Social Worker in Mental Health

In addition to the existing requirements to become a Senior Mental Health Social Worker, the applicant must have demonstrable experience of working with this population group.

Senior Occupational Therapist

In addition to the existing requirements to become a Senior Occupational Therapist in Mental Health, the applicant must have demonstrable experience of working with this population group.

Senior Addiction Counsellor

In addition to the existing requirements to become a Senior Addiction Counsellor, the applicant must have demonstrable experience of at least a year working with this population group.

Addiction Counsellor

In addition to the existing requirements to become an Addiction Counsellor, the applicant must have at least one year of demonstrable experience working with this population group.

Peer Support Worker

In addition to the existing requirements to become a Peer Support Worker, the applicant must have demonstrable working experience of at least a year in Addictions or a year working with this population group.

Grade IV Staff Member

The existing requirements for a Grade IV staff member will apply. Demonstrable working experience of at least a year in Addictions or working in Community Mental Health Teams would be desirable.

10.3 Clinical Governance of Adult Dual Diagnosis Teams and Inpatient beds

Adult Dual Diagnosis will be primarily under the Clinical Governance of the HSE Mental Health Services. The multidisciplinary team members will report to the Consultant Psychiatrist in the DD team on clinical matters and otherwise to the nominated managers at each CHO level. The Consultant Psychiatrist will report to the Executive Clinical Director in Mental Health services and the Head of Service in Mental Health, in addition to their respective Clinical Directors in each CHO. Any variation to the Clinical Governance structures, if required, must be made through a memorandum of understanding between the services involved with the explicit agreement of the Mental Health services as the DD service is an initiative of HSE Mental Health.

10.4 Inpatient Beds for Dual Diagnosis Services and Recommendations for Inpatient Rehabilitation beds and establishment of HSE National Dual Diagnosis Rehabilitation Centre

It is envisaged under this Model of Care that Consultant Psychiatrists in DD teams will have access to 1-2 inpatient acute psychiatric unit beds in their catchment area under their care for planned admissions only. This will be subject to the outcome of the current review of the acute bed capacity in the acute inpatient psychiatric units by a specialist group, wherein extra beds have been requested. In the interim, local arrangements can be considered. This shall include Dual Diagnosis teams having direct access to inpatient unit beds depending on bed capacity and also consideration for access to beds in partnership with the HSE Addiction services.

If the Dual Diagnosis team is of the opinion that the service user is required to continue in the community on methadone or suboxone that was commenced during a period of planned inpatient Dual Diagnosis admission, the Dual Diagnosis team will be responsible for making such arrangements with the local HSE Drug services.

With regard to inpatient rehabilitation, it is recommended that an appropriately staffed 10-16 bedded inpatient HSE National Dual Diagnosis Rehabilitation Centre be established, preferably based in Dublin. This is recommended to be implemented in partnership between the Dual Diagnosis National Clinical Programme (under the HSE Mental Health services) and the HSE Addiction/HSE Social Inclusion services. Until such a centre is established, it is recommended that the funding resources available through HSE Addiction services and others for inpatient rehabilitation beds in rehabilitation centres be used, in addition to funding through the HSE Dual Diagnosis services for such inpatient rehabilitation admissions. The staffing level for the National DD Rehabilitation centre is recommended to be at the level required to estabilish a 24 hour centre.

11 Referral Pathways

The referral pathways for those with Dual Diagnosis will follow three different pathways, as described below.

1. **Service users whose Dual Diagnosis would come under Quadrant 1 (moderate to severe disorders of substance use/addictive behaviour with severe mental illness) and Quadrant 2 (mild disorders of substance use/addictive behaviour with severe mental illness)**

Those under Quadrant 1 will be those service users who have been diagnosed with a moderate to severe substance-use disorder and one or more of the following diagnoses: psychotic disorder including substance-induced psychosis, schizoaffective disorder, schizophrenia, delusional disorder, bipolar disorder and major depressive disorder with psychotic symptoms. Other diagnoses can be considered on a case-by-case basis by the DD team.

Quadrant 2 service users will be those who have been diagnosed with a mild substance-use disorder and one or more of the following diagnoses: psychotic disorders including substance-induced psychosis, schizoaffective disorder, schizophrenia, delusional disorder, bipolar disorder and major depressive disorder with psychotic symptoms. Other diagnoses can be considered on a case-by-case basis by the Dual Diagnosis team.

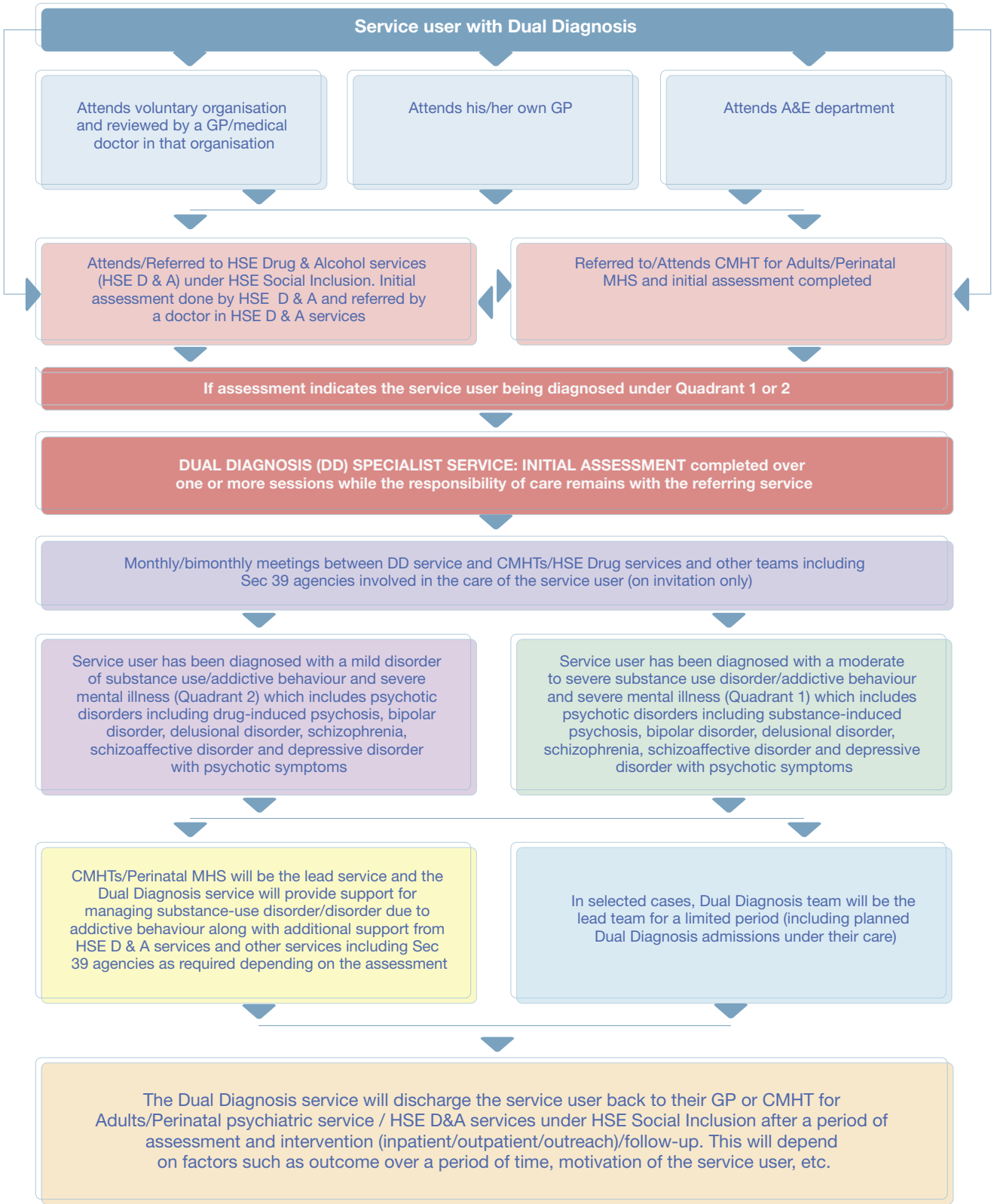
2. **Service users whose Dual Diagnosis would come under Quadrant 3 (Mild disorders of substance use/addictive behaviour with less severe mental illness) and Quadrant 4 (moderate to severe disorders of substance use/addictive behaviour with less severe mental illness)**

Less severe mental illness under Quadrant 3 and 4 will include mental illness diagnoses not included under Quadrant 1 and 2. Quadrant 3 service users will be those who have been diagnosed with mild disorders of substance use/addictive behaviour and one or more of the following diagnoses: post-traumatic stress disorder, complex PTSD, depressive disorder, generalised anxiety disorder and social anxiety disorder.

Quadrant 4 service users will be those who have been diagnosed with moderate to severe disorders of substance use/addictive behaviour and one or more of the following diagnoses: post-traumatic stress disorder, complex PTSD, depressive disorder, generalised anxiety disorder and social anxiety disorder.

3. **Hospital Consultations**

Flowchart 1. Referral pathway for Dual Diagnosis (Quadrants 1 &2)



11.1 Referral Pathways for those with DD under Quadrants 1 & 2

This will be the primary pathway for referral to the DD team. In this pathway (see flowchart 1), the service user's initial point of contact would be expected to be through their GP, an A&E department or organisations including Section 39 agencies. Considering the nature of the DD team as a tertiary service and the wide catchment area covered by each team, initial referral will be either to the Community Mental Health Teams for Adults, Perinatal Mental Health Services and/or the HSE Drug Services, or the HSE Drug and Alcohol (D & A) services if the Alcohol services are under the clinical governance of HSE Social Inclusion.

Initial assessment

Initial assessment will completed by one of the above HSE teams receiving the referral and, if the assessment indicates that the service user has a Dual Diagnosis which falls under Quadrant 1 or 2, referral to the specialist DD team will be made on a standard referral form. A sample referral form, which can be modified by the local DD team at the implementation stage, is shown in Appendix D.

Who can make the referral?

The referral from HSE Mental Health Services for Adults/Perinatal MHS can be made by the consultant or by the staff member in the team designated by the consultant to make that referral. Referrals from HSE Addiction services will be made by a medical doctor working in the HSE Drug & Alcohol services. Variation to this involving any other staff member of the HSE Drug & Alcohol services making the referral can be agreed locally at the implementation stage with the regional DD teams through service-level agreements (SLAs).

Furthermore, any variation to the above referral pathway to include Section 39 agencies can be agreed through SLAs with the local DD teams at the implementation stage, subject to those services having the professionals to support and assess service users at the level equivalent to the HSE Drug and Alcohol services and/or the Mental Health services mentioned earlier.

Referral and assessment

Further clarification can be sought by the DD team from the referrer if needed before the referral is progressed. If the referral is accepted, an initial assessment will be completed by the DD team over one or more sessions, as needed. These assessments can take the form of outpatient assessments and/or outreach assessments which can be decided by the DD team based on the clinical need. During the period of such assessments, the lead care of the service user will remain with the referring service.

Multidisciplinary team meeting with referring service and other stakeholders

After the initial assessment is completed, the outcome of the assessment and the care plan for the service user will be discussed at a meeting attended by a staff member from the referring team (on invitation); the DD team can invite other services involved in the care of the service user, including Section 39 agencies as required. If the DD team's assessment indicates that the service user will benefit from attending other services not already involved, those services can be invited to attend these meetings, with the service user's consent. These meetings involving different stakeholders will be expected to take place at least once a month or, depending on service needs, more frequently (e.g. once every two weeks).

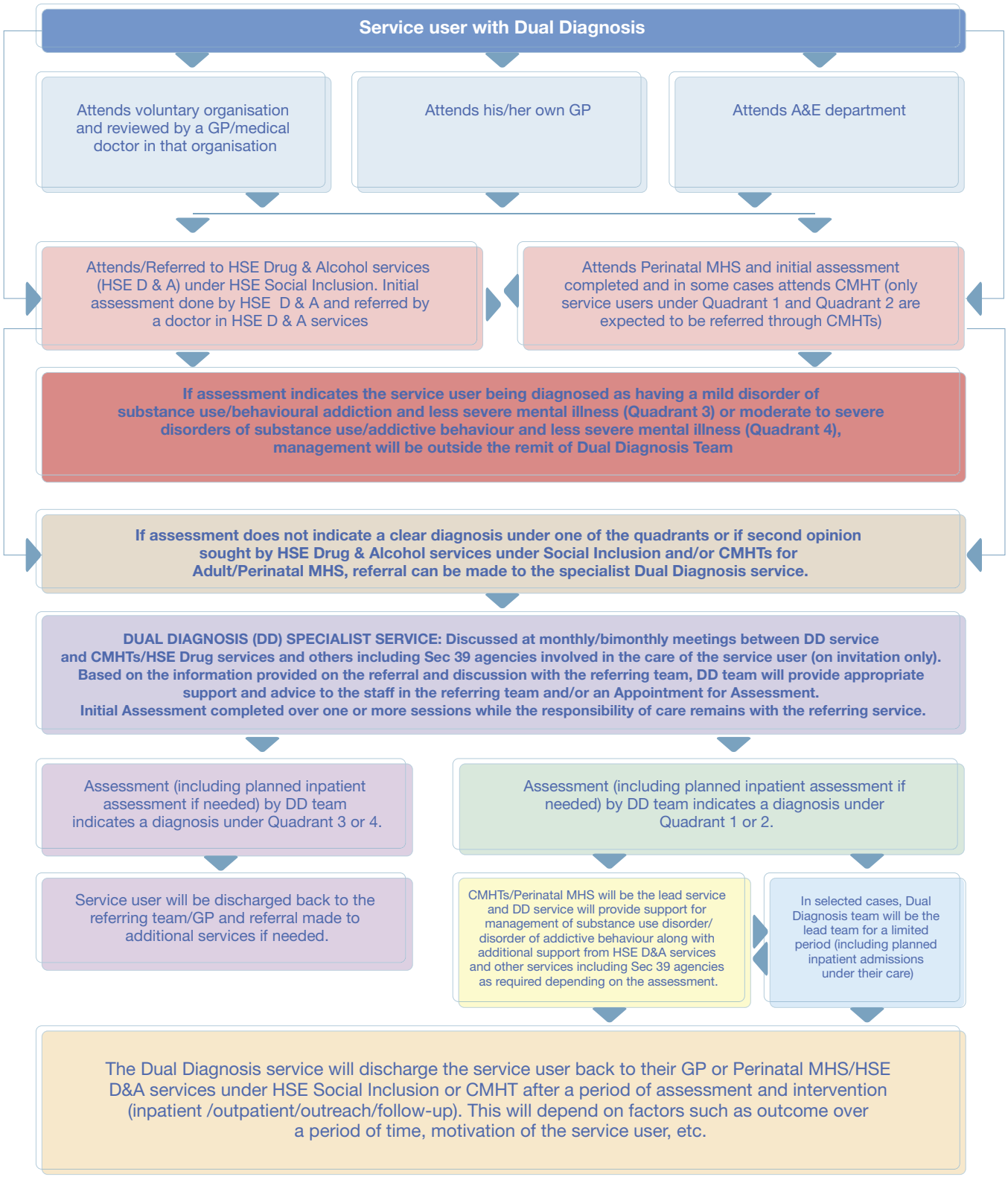
Provision of service

Following the assessment by the DD team, if the Dual Diagnosis for the service user falls under Quadrant 1 or Quadrant 2, CMHTs for Adults/Perinatal MHS will be the lead service and the DD service will provide support for managing substance-use disorder along with (as needed) additional support from the HSE D & A services and other services including Section 39 agencies, depending on their assessment. In selected cases such as planned inpatient admissions (if needed) by the DD team, the DD team will be the lead service and for a limited period in the community, if same is recommended by the DD team. This will be expected to be the case only in a relatively small percentage of referrals at a particular point in time due to the tertiary nature of this service and resource implications. In the case of all referrals, the lead care of the service user will remain with the referring team unless stated otherwise in writing by the regional Dual Diagnosis team.

Discharge

The DD service will discharge the service user back to their GP or CMHT for Adults/Perinatal psychiatric service/ HSE D&A services under HSE Social Inclusion after a period of assessment and intervention (inpatient/outpatient/ outreach)/follow-up. This will depend on factors such as outcome over a period of time, motivation of the service user, etc.

Flowchart 2. Referral pathway for Dual Diagnosis (Quadrants 3 &4)



11.2 Referral Pathways for those with DD under Quadrants 3 & 4

The services user diagnosed with Dual Diagnosis under Quadrants 3 and 4 (see Flowchart 2) will not fall under the service provision of the DD services, as described earlier, but, as in the previous pathway, would be expected to initially attend their GP, A&E department or community/voluntary organisations including Section 39 agencies. In most of these cases, initial referral will be expected to be through the HSE Drug and Alcohol Services under HSE Social Inclusion and/or the Perinatal Mental Health Services. Hence, referral under this pathway will be primarily through HSE Drug and Alcohol services or Perinatal Mental Health services.

Who can be referred through this pathway?

If the assessment by the Perinatal Mental Health Services and/or the HSE D&A under HSE Social Inclusion does not indicate a clear Dual Diagnosis under one of the quadrants or if a second opinion is sought by those services or in some cases, when the adult CMHTs requires a second opinion, a referral can be made to the specialist DD team. The referral form and the professional who can refer from these teams are the same as described in the previous pathway.

Any variation to the above referral pathway to include Section 39 agencies can be agreed through SLAs with the local DD teams at the implementation stage subject to those agencies having the professionals to assess service users at the level equivalent to HSE Drug and Alcohol services and/or the Mental Health services mentioned earlier.

What happens after the referral is made under this pathway?

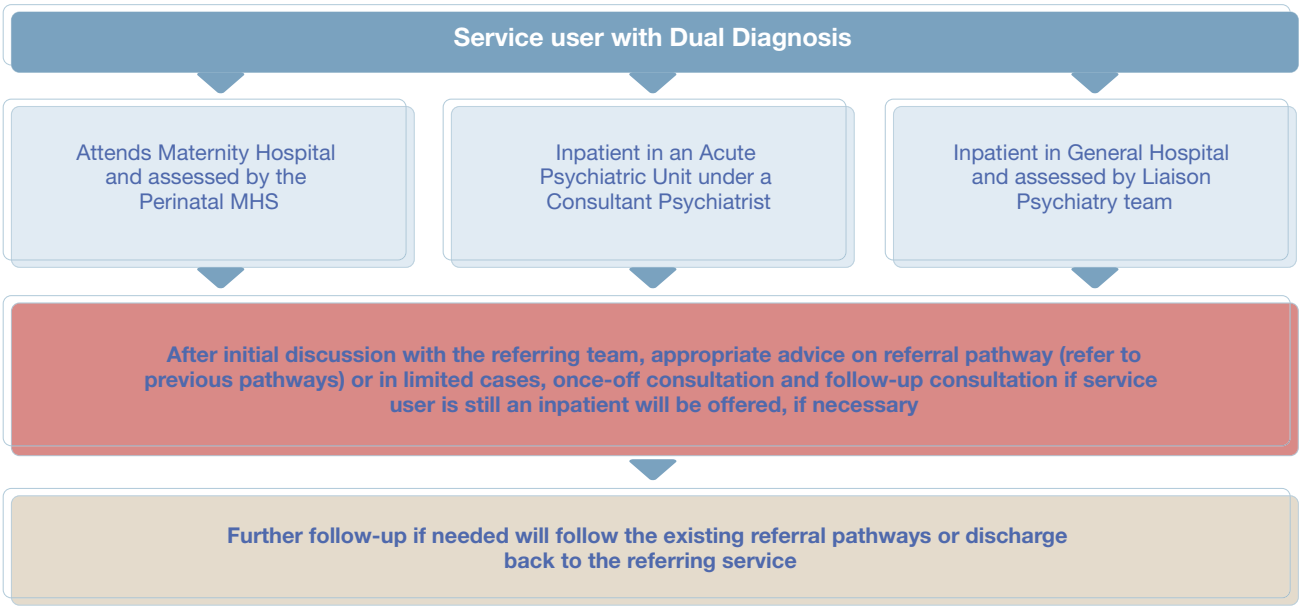
The referral under this pathway will be discussed at the monthly or more frequent multidisciplinary team meeting involving a staff member from the referring service and other stakeholders, including non-HSE organisations such as Section 39 agencies on invitation by the DD teams as needed. Based on the information provided in the referral and discussion at this meeting, the DD team will provide appropriate support and advice to the staff in the referring team. This may include advising the referring services as mentioned above on management options, and providing information on inpatient drug and alcohol rehabilitation services and an option of re-referring in the future.

However, if the Dual Diagnosis team identifies a need for further assessment, this will be provided on an outpatient/outreach and/or inpatient basis in a planned manner. The assessment can be completed over one or more sessions and/or through planned inpatient admission by the DD team, based on the clinical need. In the case of all referrals, the lead care of the service user including the period of assessment will remain with the referring team (excluding the time period of planned inpatient admission under the DD team, if it is recommended by the DD team) unless stated otherwise in writing by the regional Dual Diagnosis team.

Assessment outcome

If the assessment by the Dual Diagnosis team in this referral pathway indicates that the service user's Dual Diagnosis falls under Quadrants 3 or 4, the service user will be discharged back to the referring team. However, on assessment, if the diagnosis under Quadrant 1 or 2, the service user will be followed up in the pathway as described earlier for those under Quadrants 1 and 2.

Flowchart 3. Referral pathway for Dual Diagnosis (hospital consultations only)



11.3 Referral Pathway for Hospital Consultations

All requests for consultation referrals should follow the referral pathway shown in Flowchart 3. In very limited and exceptional circumstances, once-off (in most cases) hospital consultations can be offered by the local DD teams at their discretion. These would be resource-dependent.

This pathway would include those service users who are already inpatients (not under DD team) in an acute psychiatric unit under the care of a consultant psychiatrist and those in HSE Maternity hospitals who have been assessed by the HSE Perinatal Mental Health services. In additon, this referral pathway can include referral requests made by the Liaison Psychiatry team after assessment in the General hospital inpatient wards. No referrals shall be accepted from any other sources other than through the Liaison Psychiatry team and Perinatal MHS in the General hospital and Maternity hospital settings respectively, after assessment by those services.

Responsibility for care of the service user will remain with the referring service and/or their inpatient consultant if hospital consultations are offered, in these limited and exceptional circumstances.

11.4 Consultation Services for Perinatal Psychiatry

The Dual Diagnosis services will provide a consultation service for Perinatal Psychiatry team following the pathway described for consultations (Flowchart 3). This will be after initial assessment by the Perinatal Psychiatry team and subsequent referral to the Dual Diagnosis team. Alternatively, the Perinatal Psychiatry team can make the referral using the standard referral pathway to the DD team. Any provision of the consultation service to the Perinatal Psychiatry team will be subject to appropriate resources such as office spaces being provided by the regional Maternity services. It is envisaged that these services will be offered on a required basis, and the level of input at the CHO level can be decided between the DD team and the Perinatal Psychiatry team in their respective CHOs.

Referrals can be made by the HSE Drug and Alcohol Liaison midwives (who are planned to be recruited in the future) to the DD services if they are professionally trained to complete mental health assessments and after the required psychiatric assessment having been completed by the Perinatal Psychiatry team and subject to the clinical governance of those midwives falling under the HSE Addiction services.

12.0 Case Study Examples for DD Services

Case study for Quadrant 1

Mr X is a 23-year-old with a history of schizophrenia from the age of 18, known to the Community Mental Health Team, with several admissions in the previous five years. He also has a co-morbid diagnosis of heroin misuse, using 3-4 bags of heroin every day for the past two years along with smoking of cannabis, 5-6 joints every day and misusing street Diazepam (up to 50mg per day depending on how much he could afford) for the last five years. His admissions have been precipitated by non-compliance with psychiatric medications on a background of relapse on substance-use disorder soon after each discharge from the psychiatric unit. He presents agitated with significant commanding auditory hallucinations and persecutory delusions on admission. Mr X has linked in with both a Sec. 39 community drugs project and HSE Addiction services in the past in relation to brief interventions, harm reduction/needle exchange and social support, but chose not to consider opiate substitute treatment as an option. He is also linked in with homeless services as he stays in a homeless hostel at present. He is referred to the DD team on the standard referral form after he agrees to this.

On referral, the DD team liaises with the CMHT to obtain further history or clarifications. A planned assessment is completed with Mr X; his motivation for engagement with the DD services, his expectations from the services and his priorities for treatment and support are elicited. Also, consent is obtained from Mr X to get required information from the HSE Addiction services, Section 39 agency, homeless services and his GP.

With Mr X's consent and input, a case management and shared-care planning approach is taken to his treatment. The CMHT key worker, the DD team, GP, his homeless hostel key worker and addiction service key worker work collaboratively with Mr X to develop his care plan.

With the agreement of Mr X, his care plan is developed along the following lines:

- A planned inpatient admission to the psychiatric unit at a future date.
- Planning and funding approval from either the HSE Addiction services or DD team to attend an inpatient/addiction residential treatment centre to facilitate the transfer of Mr X from the inpatient psychiatric unit to the inpatient rehabilitation facility.
- Agreements are put in place for the HSE Addiction services to continue opioid substitution treatment (OST)/opioid agonist treatment (OAT) on discharge from the inpatient rehabilitation facility if necessary, along with the homeless team making arrangements to facilitate stable accommodation on his discharge from the inpatient rehabilitation facility
  .

The DD team will be the lead team for the care of Mr X during his inpatient admission to the psychiatric unit. The inpatient psychiatric admission will be on a planned basis after the above arrangements are in place. This admission will involve detoxing for street benzodiazepines while simultaneously stabilising (followed by detoxing if appropriate) with methadone or suboxone in addition to stabilising the mental state of Mr X with the appropriate psychotropic medications. During the inpatient admission, Mr X will have access to and support from his key workers in the HSE Addiction service, Sec. 39 community drug service, and the homeless service key worker, in addition to professionals from the CMHT. The DD team will have access to all the CMHT notes on Mr X during this admission.

On discharge from the inpatient rehabilitation facility, the lead care of Mr X will be provided by CMHT. The DD team will provide one or two follow-up appointments and link in with the different stakeholders as required, including the GP, before he is discharged from the DD services. Mr X will continue to link in with his community addiction services key worker and access methadone/suboxone treatment from the HSE Addiction service if required. He will also be encouraged to attend Aftercare services on discharge from the inpatient rehabilitation facility.

Case study example for Quadrant 2

Ms Y is a 36-year-old single mother of two children known to the CMHT, with a history of bipolar disorder complicated by a co-morbid diagnosis of binge use of alcohol (up to 8 cans of lager taken three times a week) and misusing cocaine (2-3 lines of powder cocaine 2-3 days a week). Ms Y requires frequent inpatient admissions to the inpatient psychiatric unit due to acute manic symptoms including acts of aggression towards others. She has a history of leaving herself in dangerous situations due to her manic symptoms and substance-use disorder. Her two children were taken from her care two years earlier and left in the care of the father of the children, who lives in the same town.

She is referred by the CMHT to the DD team on the standard referral form. She has also attended the Integrated Alcohol Service (IAS) in the past and is known to TUSLA. On receipt of the referral, the DD team will discuss with the referring professional in the CMHT over the phone if clarifications are required from the referral, or will ask the member of the CMHT to attend the next DD monthly multidisciplinary and interagency meeting. Following this, an assessment will be completed by the DD team on a planned basis while the care of the service user remains with the CMHT. The assessment will include the aims and goals of the service user, and their motivation to engage with the DD services, and will address the challenges leading to her relapse. Ms Y appears to be motivated to address her addiction issues and follow advice. With her consent, the DD team will also link in with the IAS, Tusla and GP to obtain her relevant history.

Following this and the assessment with Ms Y's consent and input, a case management and shared-care planning approach is taken to her treatment. The CMHT key worker, the DD team, GP, Tusla and the IAS project worker work collaboratively with Ms Y to develop her care plan. The treatment plan may include admitting her under the care of the DD consultant psychiatrist in the inpatient psychiatric unit. During the admission, she will be facilitated to have access to the IAS project worker and Tusla.

Before such a planned admission, Ms Y's goals, aims and motivation need to be considered, and plans after inpatient psychiatric admission must be put in place. This can include a planned transfer to a residential treatment service funded by the HSE Addiction, DD or Mental Health services. The discharge from the inpatient rehabilitation facility should be followed by Ms X engaging in aftercare services and with the IAS team. The DD team will support the CMHT at this stage by offering one or two follow-up appointments and link in with the CMHT, HSE IAS and Tusla. Ms Y's GP is informed of the above plan and her progress throughout the provision of care.

Case study for Quadrant 3

Mr Z is a 28-year-old factory worker presenting with suicidal thoughts. He has a background of binge use of alcohol at weekends. He drinks alcohol only when he is not working. He drank eight pints of lager and around 10 units of spirit before he attempted to hang himself following an argument with his partner, leading to his last inpatient psychiatric admission. He is referred to the DD team by the CMHT in similar circumstances. The team liaises with the treating team in the inpatient psychiatric unit to obtain further information.

The DD team advises the inpatient treating psychiatric team regarding further management. This may include detoxing him from alcohol if he has been using alcohol more frequently than reported, resulting in alcohol withdrawal symptoms. Also, the DD team may assess Mr Z while he is under the care of the inpatient consultant psychiatrist (for the CMHT area) and advice on a period of inpatient assessment with only detoxification from alcohol and no psychotropic medications. During this period, other contributing factors such as trauma or other ongoing psychosocial stressors if any, can be assessed, and a management plan devised accordingly, with the involvement of Mr Z.

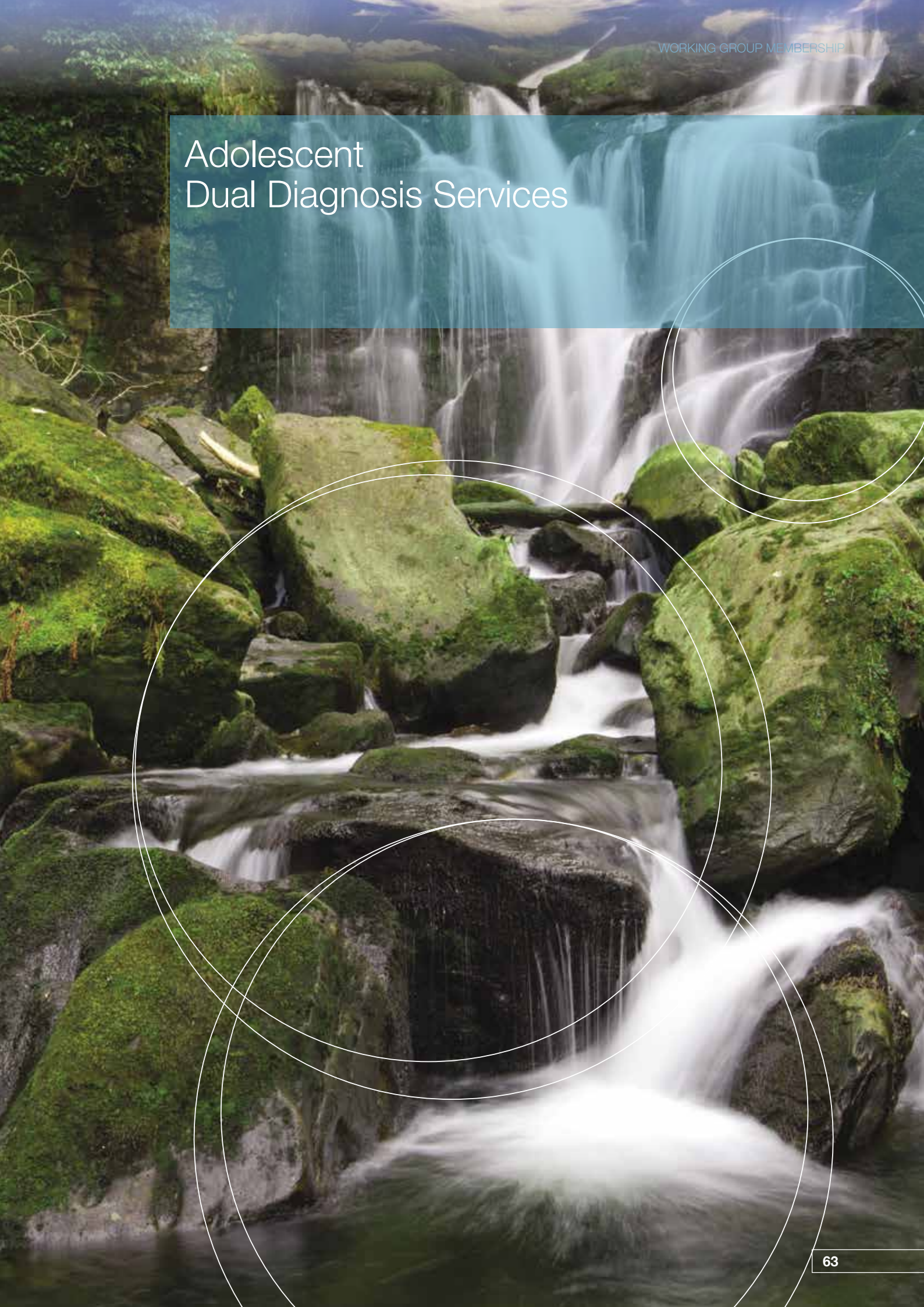
He can also be linked in with the necessary MDT members of the inpatient unit/CMHT such as the clinical psychologist, social worker, and with the occupational therapist based on his needs. He will also be referred to the HSE IAS if there is no addiction counsellor in the CMHT. Depending on the serial mental state examination reviews of Mr Z over a period of time (around 7-10 days) and his motivation to abstain from alcohol, further management can be planned by the CMHT. The DD team will not be involved after the initial assessment and management advice to the inpatient consultant covering for the CMHT.

Case study for Quadrant 4

Ms W is a 30-year-old woman who presents frequently to the A&E and also to the crisis intervention team of the psychiatric team out of hours, with symptoms of anxiety and requesting to be prescribed Pregabalin and benzodiazepines. She also reports a history of snorting cocaine on a daily basis (around a gram every day) in addition to using street Pregabalin (up to 500mg per day) along with up to 40mg of Diazepam. Ms W has been attending the addiction counsellor in the HSE Addiction services and also the CMHT, and has been staying in a bed-and-breakfast through the homeless team. She is also on probation. The HSE Addiction services completes the referral to the DD team as the CMHT has found her difficult to engage with, over the last two years.

On receipt of the referral, the DD team liaises with the HSE Addiction services and also link in with the CMHT to obtain necessary information before further advice is provided to the CMHT and HSE Addiction services. This may include advising the CMHT to admit Ms W on a planned basis if she is motivated to stop using street tablets and cocaine, along with approval of funding for her transfer to an inpatient rehabilitation facility on completion of detoxification (during the planned admission to the inpatient psychiatric unit). Ms W may be a candidate for Housing First, given the complexity of her situation and the impact of homelessness on her drug use. With this in mind, the DD team refers her to the HSE Homeless Action Team, who, with her agreement, assess her for housing support. Ms W's keyworker in the Homeless service convenes a case management group, with representatives from HSE Addiction services, HAT, CMHT, the Homeless services and Probation. They work with her to develop a care plan, focusing on safe and secure accommodation, ongoing support for her treatment, and engagement in occupation such as training or a special category CE scheme. In cases like this, the DD team can provide once-off consultation while she is in the inpatient unit or a joint assessment with the CMHT to advice on

Adolescent Dual Diagnosis Services



13. Adolescent Dual Diagnosis Services

Table 3, taken from the *Report of the Working Group on the treatment of under-18-year-olds presenting to treatment services with serious drug problems (Department of Health and Children, 2005) described the four-tier model of delivering services to adolescents with addiction issues.*

Table 3. Four-tier model of adolescent addiction treatment

	Specialist Skills	Type of Adolescent accessing service	Type of intervention for addiction difficulties	Intervention delivered by	Examples of services at this Tier *	Intensity and Duration
Tier 1	Specialist skills in neither adolescent mental health nor addiction	Considering or commencing experiment with drugs or alcohol	Basic advice Onward referral	An individual	Teacher, GP, Probation officer, Youth Worker, A&E, nurse, social worker	Low intensity and on-going
Tier 2	Specialist skills in either adolescent mental health or addiction	Abusing drugs or alcohol and encountering some problems with same	Basic counselling Brief intervention Harm reduction	An individual	Child and Family Service, Addiction service, Teen Counselling, JLO, Local or Regional Drugs Task Force projects, home school liaison officer, Youthreach, educational psychologist	Low intensity and medium term duration
Tier 3	Specialist skills in both adolescent mental health and addiction	Substantial problems due to drug or alcohol abuse	Specialist addiction counselling Family therapy Group addiction therapy Substitution treatment	A multi-disciplinary team	The specialist adolescent addiction service	High intensity and short to medium term duration (1-6 months)
Tier 4	Specialist skills in both adolescent mental health and addiction	Drugs or alcohol dependence with severe associated problems	Specialist addiction counselling Family therapy Group addiction therapy Substitution treatment	A multi-disciplinary team	Specialist in-patient or day hospital adolescent addiction services	Very high intensity and short duration (2-6 weeks)

**Tiering only refers to adolescent addiction assessment and treatment; for example services may specialise in areas such as child mental health, crime reduction, child welfare etc. but no addiction.*

This report identified the need for all the four tiers to work together in delivering the appropriate services to adolescents. It highlighted the need for Tier 3 staff to have the training to manage those with substance-use disorder and co-morbid mental health issues.

A Vision for Change recommended enhancing the adolescent addiction services in Dublin to become DD services, and to create two other DD teams outside Dublin – in Cork and Galway. It said the Adolescent DD team should include the following multidisciplinary team members:

- One Consultant Child and Adolescent Psychiatrist with a special interest in Substance Misuse
- One Non-Consultant Hospital Doctor (NCHD) in training
- One Clinical Psychologist
- Two Clinical Nurse Specialists
- One Social Worker
- Three Counsellors
- Two Family Therapists
- Two Youth Workers

13.1 Age Profile of Adolescents for DD service

In line with the WHO definition of adolescents, referral to the Adolescent Dual Diagnosis services will be for those aged 10 to 17 years.

13.2 Hub and Spoke Model

The hub-and-spoke model will be used for delivering the Adolescent DD services across Ireland. There are currently two CHOs (CHO 7 & 9) with consultant-led multidisciplinary Tier 3 adolescent addiction services. The current staffing levels of these teams is about 40% or less when compared to the recommended resources for the Adolescent DD team in *A Vision for Change.* These teams currently assess and manage mild co-morbid and some moderate co-morbid mental health issues. With additional resources, as identified in the team structure above, these services could be enhanced to function as Adolescent DD services so they can manage more complex co-morbid mental health issues while still undertaking their core work of treatment of substance-use disorders.

In addition to increasing the staff complement in these services in North and South Dublin, establishing two more Adolescent DD teams outside the Dublin area, as recommended in A Vision for Change, is recommended. These four teams (including the two teams in Dublin) will act as the hubs providing services to the various CHOs as well as supervising the Adolescent DD team members located in each CHO (non-hub CHOs).

13.2.1 Spokes

Each CHO (non-hub CHO) is recommended to have the following two Adolescent DD team members:

- One Clinical Nurse Specialist (CNS) who should have a Level 8 qualification in Addictions (for CNS in Psychiatry) or a Level 8 qualification in Mental Health (for CNS in Addictions). Two years' experience working with adolescents is desirable. This is in addition to the minimum requirement to qualify as a CNS in Psychiatry/CNS in Addictions.
- One Addiction Counsellor with one year's demonstrable experience of working with this population group, in addition to the minimum requirement for the post.

This will be in line with the Report of the Working Group on the treatment of under 18-year-olds presenting to treatment services with serious drug problems. It identified the need for Tier 3 teams requiring staff competencies in assessment and management of substance-use disorder and co-morbid mental health problems. Depending on the catchment area population, the number of CNS and addiction counsellors in the non-hub CHOs will be proportionately increased, as in Table 4. It is suggested that Advanced Nurse Practitioner posts in Dual Diagnosis Child and Adolescent Psychiatry be developed in the spokes as an alternative to CNS posts, subject to clinical supervision by a Child and Adolescent Consultant Psychiatrist with a specialist interest in Substance use disorders being available.

13.2.2 Location of spokes and their clinical governance

The CNS and Addiction Counsellor are recommended to be located within the Addiction services in each CHO region (non-hub CHOs). Since in some CHOs there are interlinked and common clinical governance structures between Addiction services (HSE Social inclusion) and Mental Health services, the clinical governance should be decided between the Addiction services in HSE Social Inclusion and Mental Health services, based on the local governance structures in each CHO.

Although the CNS and Addiction Counsellor will be located within the HSE Addiction services in HSE Social Inclusion, they can bring their expertise on Dual Diagnosis/addiction issues into direct clinical or multi- disciplinary team meetings with CAMHS as required. This co-working of cases facilitates the integration of this service with local CAMHS teams.

A memorandum of understanding regarding clinical governance and access to the CAMHS teams must be in place between the HSE Mental Health services and HSE Social Inclusion in each CHO with the spoke team members. This must be agreed before the CNS and Addiction Counsellor commence their work.

A mechanism will need to be agreed, at the level of Executive Clinical Director in Mental Health services/Clinical Lead in Addiction services, to permit prompt resolution of any differences of opinion regarding lead responsibility for a client's needs – if, for example, views differed on the relative severity of either an addiction problem or a mental health issue.

13.2.3 Hubs

The following team members are recommended as part of the composition of the multidisciplinary Adolescent Dual Diagnosis teams in the hubs:

- One Consultant Child and Adolescent Psychiatrist with a special interest in Substance Misuse
- One Non-Consultant Hospital Doctor (NCHD) in training
- Two Clinical Nurse Specialists (CNS) in Dual Diagnosis who should have a Level 8 qualification in Addictions (for CNS in Psychiatry) or a Level 8 qualification in Mental Health (for CNS in Addictions). Two years demonstrable experience of working with adolescents with DD is desirable. This is in addition to the minimum requirement to qualify as a CNS in Psychiatry/CNS in Addictions. Alternatively, one Clinical Nurse Specialist as above and one Advanced Nurse Practitioner in Child and Adolescent Psychiatry who has specialised in Dual Diagnosis or Addictions as part of their ANP registration
- One Clinical Nurse Manager 2 in Dual Diagnosis with at least 2 years of demonstrable experience working with this population group, in addition to the minimum requirements for the post
- One Senior Clinical Psychologist with at least one year of demonstrable experience working with Adolescents with DD
- One Senior Addiction Counsellor with at least one year of demonstrable experience working with this population group, in addition to the minimum requirements for the post

- One Addiction Counsellor with at least one year of demonstrable experience working with this population group, in addition to the minimum requirements for the post
- One Senior Social Worker with demonstrable experience of working with this population group
- One Senior Occupational Therapist with demonstrable experience of working with this population group, in addition to the minimum requirements for the post
- One Family Therapist with at least one year of demonstrable experience working with this population group, in addition to the minimum requirements for the post
- One Outreach Worker working with youths, with at least one year of demonstrable experience working with this population group, in addition to the minimum requirements for the post
- One Grade IV Administrator

Clinical governance for the above team members in the hubs will be primarily within the HSE Mental Health services. Currently, SASSY (Substance Abuse Service Specific to Youth), covering Dublin North City and County, and YoDA (Youth Drug and Alcohol Services) providing services in Dublin South-West and Dublin South City, offer DD services (both within the HSE) to those with moderate-intensity mental health issues and co-morbid substance-use disorder. Both these services are part of the two Adolescent Teams in Dublin providing addiction services that would be expected to become the Adolescent DD team hubs in Dublin.

13.2.4 Hubs and spokes connection

At present, the consultants in the two Adolescent DD teams (based in Dublin) provide supervision for the trained professionals in Adolescent DD outside the Dublin area. This varies from as required to planned supervision, once every three weeks or so. This arrangement will continue between the hubs and spokes as they get established across the country. When all the four hubs are established, the frequency of team supervision between the hub and spokes team members can be increased with same being decided between the hubs and spokes depending on the level of need.

13.3 Inpatient Treatment and Rehabilitation of Adolescents with DD

If inpatient treatment for acute mental illness is indicated for those with DD, current arrangements where existing inpatient beds in the regional Child and Adolescent inpatient units are used for this purpose will continue. When all the hubs are established, the Consultant in the Adolescent DD team in the hubs should have access to these inpatient beds at the regional level, subject to an increase in capacity of 1-2 beds in each of the adolescent inpatient units following the outcome of the current review of bed capacity of the acute adolescent inpatient units.

The current set-up whereby adolescents with mild to moderate-intensity mental health issues requiring inpatient rehabilitation beds for addiction issues are admitted to the HSE-funded centre in Kilkenny will continue for adolescents with DD requiring residential addiction treatment. This treatment setting in Kilkenny is psychology-led and medically supported. It can manage co-morbid moderate but not acute or severe mental health issues.

Furthermore, the current practice of those with a history of DD requiring inpatient treatment being managed initially in the child and adolescent inpatient units will continue, followed by inpatient addiction treatment in the HSE-funded centre in Kilkenny, if the treating team identifies this need.

13.3.1 Distribution of proposed Adolescent Dual Diagnosis team hubs and spokes

The distribution of proposed dedicated Adolescent DD team hubs and spokes, based on the 2016 census in addition to the number of CNS and addiction counsellors in the spokes is shown in Table 4.

Table 4: Distribution of proposed dedicated Adolescent Dual Diagnosis team hubs and spokes -Based on 2016 Census (Heath Atlas)

CHO	County	Population 10 – 17 years old	Percentage of pop. 10 – 17	No. of existing CAMHS Teams	No. of CNS in Dual Diagnosis (WTE) recommended (Spokes)	No. of Addiction Counsellors (WTE) recommended (Spokes)	Consultants working with DD service users	Adolescent DD Teams needed (Hubs)
1	Donegal, Sligo, Leitrim, Cavan, Monaghan	44,945	11.6	8	2	2		1 (Based in CHO 2/ Galway)
2	Mayo, Galway/Roscommon	48,531	10.7	6	N/A			
3	Limerick, Clare, North Tipperary	41,790	10.9	6	2	2		
4	Cork, Kerry	71,282	10.4	10	N/A			1 (Based in CHO 4/Cork)
5	South Tipperary, Carlow, Kilkenny, Waterford, Wexford	57,603	11.3	7	2	2		

CHO	County	Population 10 – 17 years old	Percentage of pop. 10 – 17	No. of existing CAMHS Teams	No. of CNS in Dual Diagnosis (WTE) recommended (Spokes)	No. of Addiction Counsellors (WTE) recommended (Spokes)	Consultants working with DD service users	Adolescent DD Teams needed (Hubs)
6	Dublin South East, Dun Laoghaire, East Wicklow	37,147	9.5	6	N/A		1 CAMHS Consultant	1 (Based in CHO 6 and 7/ Dublin)
7	Kildare, West Wicklow, Dublin West, Dub South City, Dub South West	70,752	10.1	10				
8	Louth	73,294	11.7					
	Meath							
8	Longford, Westmeath, Laois, Offaly			12	2	2		1 (Based in CHO 9/ Dublin)
9	Dublin North, Dublin North Central, Dublin North West	58,082	9.3	8	N/A		1 CAMHS Consultant	
	Total	503,426		73	8	8	2	4

13.4 Referral Pathways for Adolescents with Dual Diagnosis

The referral pathways for adolescents with Dual Diagnosis will follow three different pathways, as follows:

Pathway 1. **Adolescents whose Dual Diagnosis come under Quadrant 1 (moderate to severe disorders of substance use/addictive behaviour with severe mental illness) and Quadrant 2 (mild disorders of substance use/addictive behaviour with severe mental illness)**

Those under Quadrant 1 will be those service users who have been diagnosed with a moderate to severe-intensity substance-use disorder/disorder due to addictive behaviour and one or more of the following diagnoses: psychotic disorders including substance-induced psychosis, bipolar disorder, delusional disorder, schizophrenia, schizoaffective disorder and depressive disorder with psychotic symptoms. Other diagnoses can be considered on a case-by-case basis by the Dual Diagnosis team.

Quadrant 2 service users will be those who have been diagnosed with a mild substance use disorder/disorder due to addictive behaviour and one or more of the following diagnoses: psychotic disorders including substance-induced psychosis, bipolar disorder, delusional disorder, schizophrenia, schizoaffective disorder and depressive disorder with psychotic symptoms. Other diagnoses can be considered on a case by case-by-case by the Dual Diagnosis team.

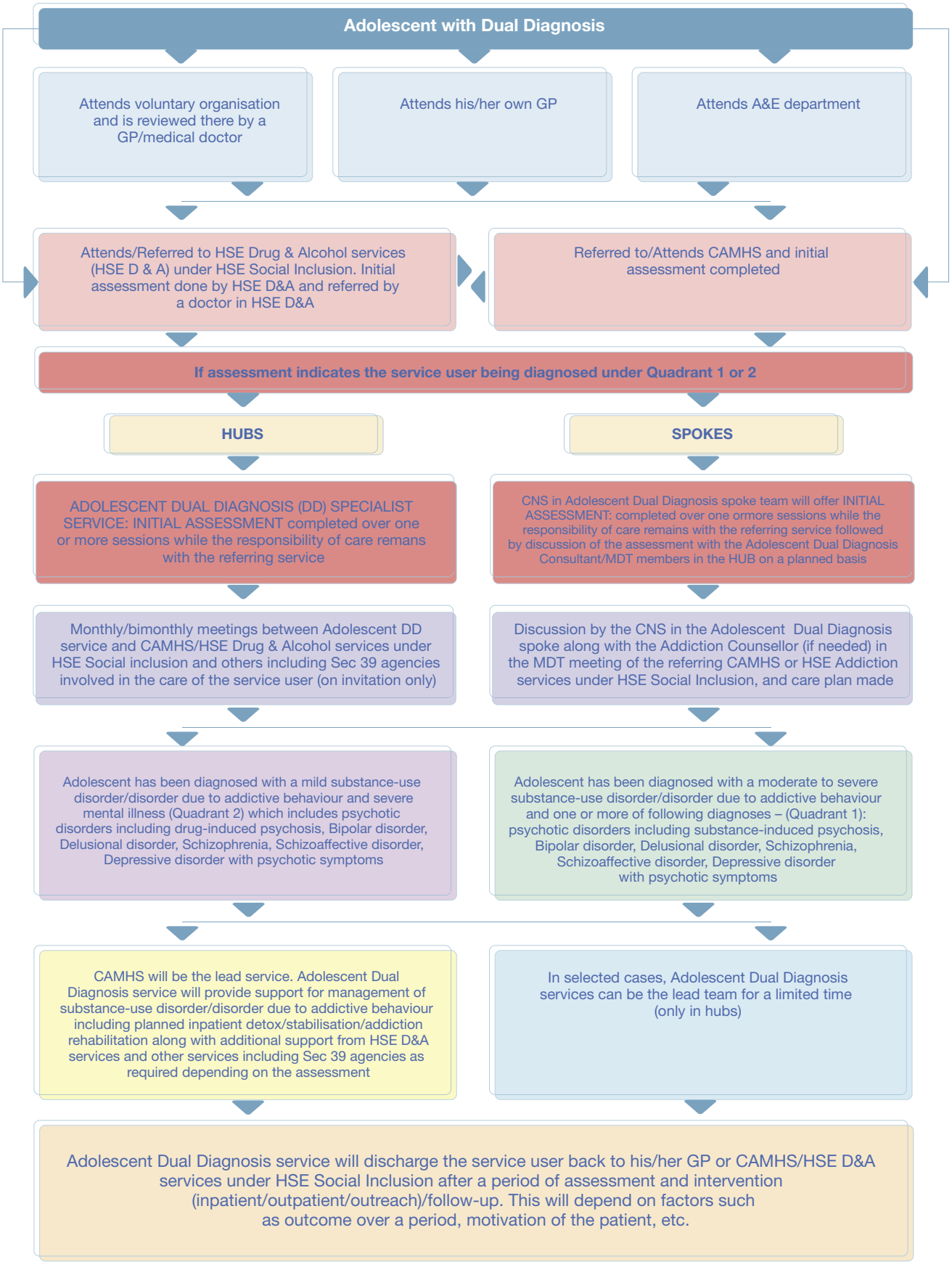
Pathway 2. **Service users whose Dual Diagnosis would come under Quadrant 3 (mild disorders of substance use/addictive behaviour with less severe mental illness) and Quadrant 4 (moderate to severe disorders of substance use/addictive behaviour with less severe mental illness).**

Less severe mental illness under Quadrant 3 and 4 will include mental illness diagnoses not included under Quadrant 1 and 2.

Pathway 3. **Hospital consultations**

These will be referrals primarily from the Adolescent acute inpatient psychiatric units and will be made to the hub or the spoke team.

Flowchart 4. Referral pathway for adolescent Dual Diagnosis Service Users (Quadrants 1 & 2)



13.4.1 Referral Pathway for Adolescents with DD under Quadrants 1 & 2

This will be the primary pathway for referral of adolescents to the Dual Diagnosis services. In this pathway, the service user's initial point of contact will be expected to be through their GP, A&E department or organisations including Section 39 agencies. Considering the nature of the Adolescent DD services as a tertiary level of service and the wide catchment area covered by each Adolescent DD service, initial referral will be either to the Child and Adolescent Mental Health Services (CAMHS) and/or the HSE Drug services or the HSE Drug and Alcohol services (D&A) if the Alcohol services are under the clinical governance of HSE Social Inclusion.

Initial assessment

Initial assessment will be completed by one of the above HSE teams receiving the referral. If the assessment indicates that the adolescent has a DD which falls under Quadrant 1 or 2, referral to the specialist DD services will be made on a standard referral form. The referral form (see sample in Appendix D) can be modified by the local Adolescent DD services at the implementation stage.

Who can make the referral?

The referral from the CAMHS can be made by the consultant or staff member in the team designated by the consultant to make that referral. The referrals from the Addiction services in HSE Social Inclusion will be made by a medical doctor working in the HSE Addiction/Drug & Alcohol services. Variation to this with regard to any other staff member of the HSE Drug and Alcohol services/HSE Addiction services making the referral can be agreed locally at the implementation stage with their regional Adolescent DD team hubs through SLAs.

Furthermore, any variation to the above referral pathway to include Section 39 agencies can be agreed through SLAs with the Adolescent DD services at the local level at the implementation stage. This will be subject to such agencies having the professionals to support and assess adolescents at the level and competency equivalent to HSE Drug and Alcohol services and/or the CAMHS.

Referral and assessment

Further clarification can be sought by the Adolescent DD services from the referrer if needed before the referral is progressed. If the referral is accepted, an initial assessment will be completed by the Adolescent DD services over one or more sessions, as needed. These assessments can take the form of outpatient assessments and/or outreach assessments, which can be decided by the Adolescent DD services based on the clinical need. In the case of all referrals, the lead care of the service user will remain with the referring team unless stated otherwise in writing by the regional Adolescent Dual Diagnosis hub team.

Multidisciplinary team meetings with referring service and other stakeholders

Hubs

In the case of referrals to Adolescent DD team hubs, after the initial assessment is completed, the outcome of the assessment and the care plan for the service user will be discussed at a meeting attended by a staff member from the referring team if needed; the Adolescent DD team can invite other services involved in the care of the service user, including Section 39 agencies, as required. If the Adolescent DD hub team's assessment indicates that the service user will benefit from attending other services not already involved, those services can be invited to attend these meetings. These meetings involving different stakeholders will be expected to take place at least once a month or, depending on service needs, more frequently (e.g. once every two weeks).

Spokes

In the case of referrals to spokes services, following the initial assessment, discussion will take place with the Adolescent DD Consultant/MDT members of the hubs on a planned basis or in some cases as soon as possible. If any immediate risk factors are identified during the assessment, the CNS in the Adolescent DD spoke team will immediately refer the adolescent with the consent of their parent/guardian to the local emergency department or CAMHS services either directly or through their GP.

In the case of most of the referrals to the spokes services, it is envisaged that, after the initial assessment is completed, the outcome of the assessment and the care plan for the adolescent will be discussed at the MDT meeting of either the referring CAMHS or HSE Drug and Alcohol services by the CNS in the Adolescent DD spoke team, accompanied, if needed, by the Addiction Counsellor from the Adolescent DD spoke service. This can be in done in person or remotely through HSE approved secure modes of communication.

Provision of service

Hubs

Following the assessment by the Adolescent DD team, if the Dual Diagnosis for the adolescent falls under Quadrant 1 or Quadrant 2, CAMHS will be the lead service, and the DD service will provide support for managing the substance-use disorder/disorder due to addictive behaviour, including planned inpatient detoxification/ stabilisation along with (as needed) additional support from HSE D&A services and other services including Section 39 agencies, depending on their assessment.

Spokes

Following the assessment by the CNS in the Adolescent Dual Diagnosis spoke team, if the Dual Diagnosis for the service user falls under Quadrant 1 or Quadrant 2, CAMHS will be the lead service and the DD service will provide support for managing substance-use disorder, including planned inpatient detoxification/stabilisation along with (as needed) additional support from HSE D & A services and other services including Section 39 agencies, depending on their assessment.

In selected cases, the Adolescent DD team (only in hubs) can be the lead service, based on the assessment by the Adolescent DD service, for a limited time. This is expected to be the case in only a relatively small percentage of referrals at a particular point in time due to the tertiary nature of this service.

Discharge

The Adolescent Dual Diagnosis service will discharge the service user back to their GP or CAMHS/HSE D&A services under HSE Social Inclusion after a period of assessment and intervention (inpatient/outpatient/outreach)/ follow-up. This will depend on factors such as outcome over a period, motivation of the service user, etc.

Flowchart 5. Referral pathway for adolescent Dual Diagnosis Service Users (Quadrants 3 & 4)

13.4.2 Referral pathway for adolescents with DD in Quadrants 3 and 4

Adolescents diagnosed with DD under Quadrants 3 and 4 will not primarily fall under the service provision of the Adolescent DD services, as described earlier. As in the previous pathway for Quadrants 1 and 2, adolescents with a DD in Quadrants 3 and 4 would be expected to initially attend their GP, A&E department or voluntary organisations including Section 39 agencies. In most of these cases, initial referral will be either to the CAMHS or the HSE Drug and Alcohol Services under HSE Social Inclusion.

Who can be referred through this pathway?

If the assessment by the CAMHS and/or the HSE Drug services or the HSE Drug and Alcohol services (D&A) under HSE Social Inclusion does not indicate a clear Dual Diagnosis under one of the quadrants, or if a second opinion is sought by those services, a referral can be made to the specialist Adolescent DD services. The referral form and the professional who can refer from these teams will be the same as described in the previous pathway for Quadrants 1 and 2.

Any variation to the above referral pathway to include Section 39 agencies can be agreed through SLAs with the local DD teams at the implementation stage, subject to those agencies having the professionals to assess service users at the level equivalent to HSE Drug and Alcohol services and/or CAMHS, as mentioned earlier.

What happens after the referral is made under this pathway?

The referral under this pathway for the hub teams will be discussed with a staff member from the referring service. In the case of referral to the spokes service, CNS in the Adolescent DD team (or the Addiction Counsellor) will follow up by making contact with the referring team (CAMHS/HSE Drug & Alcohol services under Social Inclusion) either in person or remotely to further discuss the referral.

Based on the information provided in the referral and discussion during these meetings, the Adolescent DD services will provide appropriate support and advice to the staff in the referring team.

However, if the Adolescent DD service identifies a need for further assessment, this will be provided on an outpatient/outreach basis in a planned manner. The assessment can be completed over one or more sessions, based on the clinical need. In the case of all referrals, the lead care of the service user will remain with the referring team (including the period of initial assessment if needed) unless stated otherwise in writing by the regional Adolescent Dual Diagnosis hub team.

Assessment outcome

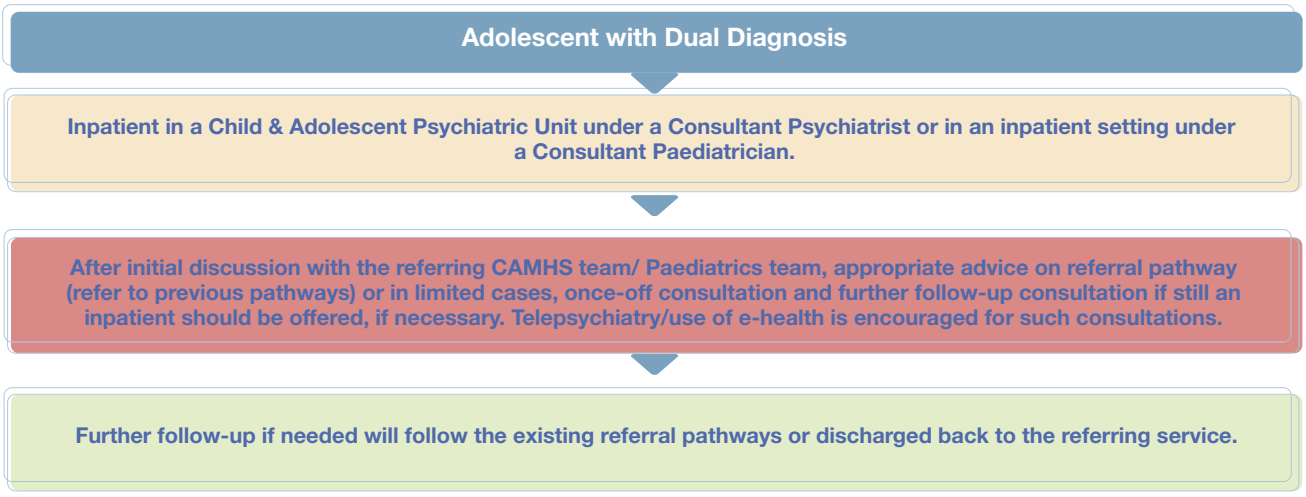
If the assessment by the Adolescent DD team in this referral pathway indicates that the service user's Dual Diagnosis falls under Quadrants 3 or 4, the service user will be discharged back to the referring team. However, on assessment, if the diagnosis falls under Quadrant 1 or 2, the service user will be followed up in the pathway as described above for those under Quadrants 1 and 2.

13.4.3 Referral pathway for hospital consultations

All requests for consultation referrals should follow the referral pathway as described below if possible. All such referrals must first be discussed by the referring team with the Consultant in the hubs team or a staff member designated for that purpose. In the case of spokes, referrals must be discussed by the referring team with the CNS in the spokes service.

In most cases, it is expected that appropriate advice to the referring team, without a need to assess the adolescent regarding further management, would be sufficient. However, on discussion with the referring team where the consultation service is indicated, the use of tele psychiatry/e-health is strongly encouraged if possible, considering the wide catchment area covered by each Adolescent DD service. The responsibility for the care of the service user will always remain with the referring Consultant if hospital consultations are offered in these limited circumstances. Following consultation, if a need for Adolescent DD services is identified, follow-up can be provided in the community on discharge following the existing pathways, as outlined above.

Flowchart 6. Referral pathway for hospital consultations only (Hubs & spokes)



Roles of The Multidisciplinary Team Members

14 Roles

14.1 The Role of the Nurse in Dual Diagnosis

The National Working Group is committed to meeting the needs of those presenting with a Dual Diagnosis. With this in mind, the group examined the professional competencies in nursing that are applicable and desirable for working with this vulnerable and complex client group. The group recognises the importance of individuals with a DD and their families having access to a highly skilled, competent, recovery-oriented workforce. Mental Health Nursing makes up the largest proportion of the mental health workforce (48%) (70). Therefore it is essential that their skills, knowledge and competencies are used in an effective manner and are at an advanced level capable of adapting to the evolving need and challenge of working with DD across the spectrum of services.

Various policy documents and strategies have influenced the development of the nursing and midwifery specialties in Ireland. The Report of the Commission on Nursing, *A Blueprint for the Future* (66), has been highly influential in the development of these specialties. The report led the way for the appointment of specialist nurses to enhance the quality of nursing care and provide specialist nursing advice. The National Health Strategy Document *Quality and Fairness: A health system for you* (71) recommended the development of further clinical specialist posts in nursing and midwifery within the framework of the national council. The current National Maternity Strategy Revised Implementation Plan for 2021-2026 (72) supports the establishment of Drug Liaison Midwives in maternity hospitals to provide drug and alcohol support services in the perinatal period in line with the National Drug Strategy (73). This is now being implemented in the maternity hospitals. The nursing posts recommended for Dual Diagnosis services would include Clinical Nurse Specialists and Advanced Nurse Practitioners in addition to the Clinical Nurse Manager 2 and 3 grades.

Advanced Nurse Practitioner (ANP): Advanced Nursing is carried out by autonomous, experienced practitioners who are competent, accountable and responsible for their own practice. They are highly experienced in clinical practice and are educated to Master's degree level (or higher) (74). Competencies for Advanced Practice Nursing have been documented in six domains (see Appendix F). All ANPs will also be in a position to prescribe medication and alter prescriptions as required within their scope of practice.

Clinical Nurse Specialist (CNS): Specialist practice encompasses a major clinical focus, which comprises assessment, planning, delivery and evaluation of care. A CNS will have undertaken formal recognised post-registration education relevant to their area of specialist practice at a minimum Level 8 or above on the NQAI framework (75).

The five core competencies inherent in the role of clinical nurse/midwife specialist as determined by the National Council for the Professional Development of Nursing & Midwifery, as described in the Framework for the Establishment of Clinical Nurse/Midwife Specialist Posts (4th ed.) (75) are outlined in Appendix G.

Nurses have been working in specialist alcohol and drug roles for decades; their early roles and responsibilities are well documented. The role has expanded with the evolution of the Clinical Nurse Specialist and the Advanced Nurse Practitioner as well as with the expansion of nurse prescribing, and the settings have diversified in both statutory and third-sector organisations. These include primary and secondary care settings, A&E, needle and syringe programmes, and homeless services.

Nurses working in DD services can make a positive contribution to achieving a range of health and social care outcomes by delivering interventions such as:

- Physical and mental health triage, assessment and care – nurses can bring enhanced awareness of mental and physical health co-morbidities
- Management of infections and adverse effects relating to poor injecting practice
- Hep B vaccination and blood-borne viruses (BBV) testing
- Dispensing, monitoring and reporting on effects of medicines
- Identification and management of alcohol-related liver disease
- Identification and management of alcohol-related dementia

Guidelines from Rethink (76) aimed at practitioners working within the DD field and recommendations from the British Psychological Society and Royal College of Psychiatrists categorise the main interventions in substance-misuse and mental health services (see Table 5). Specialist interventions in mental health and substance misuse are in addition to the nurse's general roles of assessment, care planning and evaluating (77).

Table 5. Nursing interventions in substance-misuse and mental health services

Psycho-social	Pharmacological
Counselling	Detoxification
Cognitive therapy	Psychotropic prescribing
Psychotherapy	Abstinence
Family Intervention	
Dialectical behavioural therapy	
Art therapy	
Drama therapy	
Motivational Interviewing	
Group therapy (including self-help)	

For the scope of this Model of Care and in line with the NMBI competencies for CNS and ANP, the nurse's role in DD can be best described under the following interventions:

- Assessment
- Physical health
- Psychosocial interventions
- Pharmacological Interventions (prescribing, symptom recognition, monitoring, concordance, education)

Assessment

Assessment is the first and most important part of the nursing process, and is continuous. Nurses routinely perform bio-psychosocial assessments and care-plan accordingly. Assessment frameworks, screening tools and clinical observations are the key repertoire of nursing skill. In Dual Diagnosis, the nurse will assess mental health status, alcohol and drug use and physical wellbeing, and make a psychosocial assessment.

Physical health

Alcohol and drug misuse can be harmful to the individual's physical health both in the short and long term, so early detection and assessment is important. There is evidence to suggest that some people with a Dual Diagnosis find it difficult to access primary care until they reach a health crisis. Diagnostic overshadowing for this population has become a particular worrying concern, whereby physical health issues are overshadowed by, or interpreted as part of, the individual's mental health presentation (78). The nurse provides opportunistic access for the service user to a health professional who can take a holistic approach to care, providing the bio-psychosocial assessment and care planning.

Specific areas where nurses can play a key role include:

- Physical examination of vital signs and when to take action
- Wound care (if within sphere of competence)
- Vaccinations and BBV testing
- Medication management (side-effects, concordance, interactions)
- Medication prescribing if within scope of practice
- Knowledge and management of long-term conditions (e.g. diabetes, asthma, COPD, epilepsy, liver disease, pain)
- Identification and management of acute health problems through health screening (e.g. deep-vein thrombosis, cellulitis, infections/abscesses, hypertension, and cardiac, respiratory or endocrine problems)
- Responding to symptoms that may result from adverse reactions to substances, including New Psychoactive Substances (NPS)
- Identification of harmful non-dependent alcohol use by drug users, which may be exacerbating their hypertension, mental health, cardiac or other physical health conditions, or interacting with prescribed medication or illicit drugs
- Prevention through vitamin supplements and/or early identification of Wernicke's encephalopathy
- Onward referral and liaison with primary care and specialist secondary care (e.g. haematology, hepatology, coronary care, dentistry and optometry)
- Identification of and advice on body mass index (BMI), nutrition and weight management

Pharmacological interventions

Taken together with psychological and social interventions, medication can be an important part of care plans for individuals experiencing mental health issues. Service users with a Dual Diagnosis may need legitimate prescriptions for their DD; these may include antipsychotic medication (oral or IM), antidepressants and retroviral medications. Thus they may be exposed to risks associated with polypharmacy (79, 80). Qualitative studies indicate that education, medication management, skills training and administration of medication are common roles of the DD nurse. Non-concordance correlates with poor treatment outcomes, and the previously mentioned nursing interventions may improve adherence. In this context, pharmacological interventions by nursing can be broken down into:

- Intoxication
- Overdose
- Withdrawal
- Detoxification
- Abstinence/relapse prevention
- Mental health management – acute and stabilisation phase

Nurses bring expertise in the administration of medicines and safe medication management, including reviews of medication regimes. They also provide service users with relevant information, including about both the perceived

benefits and risks of the prescribed medication (79). Nurses should be aware of the effects of substances, both prescribed and non-prescribed, as well as the actions and interactions of substances, overdose procedures, the administration and supervision of medication, and adherence issues (81).

Although usually the medication is prescribed by a doctor, nurses are often responsible for administering and monitoring medication; they thus need to have an understanding of pharmacology and related issues.

The Nursing and Midwifery Council of Ireland (NMBI) is responsible for regulating these areas of professional practice for nurses. The relevant publications that set out the expected standards of practice for nurses in relation to pharmacological management include:

Guidance for Registered Nurses and Midwives on Medication Administration (82)

Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives (83).

Nurse Prescribing

The benefits or nurse and midwife prescribing of medicinal products have been consistently reported in the literature. The ability to prescribe has reportedly improved both access to medicines and the timelines of interventions for those seeking treatment.

The *National Report on Nurse and Midwife Medicinal Product Prescribing* (84) indicates that 1,475 nurses and midwifes are registered as prescribers. Of these, 187 are from Mental Health Services, based across various mental health clinical areas. There are two prescribers in Drug Treatment settings, two in Mental Health Addiction services and one in Mental Health liaison services. Hence, the development of DD nurse prescribers and ANPs would be beneficial in terms of better service delivery for both for the Adult and Adolescent DD services.

Psychological and social Interventions by nursing in DD teams

Communication skills and the development of the therapeutic relationship is a key training element in nursing and underpins the delivery of psychosocial interventions. Mental health nurses have an advanced knowledge of psychosocial interventions, their techniques and delivery.

DD psychological and social interventions that can be offered by nursing include motivational interviewing and cognitive behavioural therapy (CBT) or both in combination, depending on the service user's needs. Other psychosocial interventions which may be offered by the DD nurse are individual person-centred counselling, group work, structured day programmes, self-help groups, drop-ins, cognitive therapy, psychotherapy, family interventions, art therapy and drama therapy (76). Nurses involved in therapeutic interventions outside their core nursing skills would need to have appropriate accredited training/qualifications before such interventions are delivered.

14.2 Role of Occupational Therapist (senior grade) on DD Team

Occupational therapy is concerned with promoting health and wellbeing through occupation. Occupations are the everyday activities that people do as individuals, in families and with communities to occupy time and bring meaning and purpose to life. They include all activities a person needs to, wants to, or is expected to do (85).

The primary goal of occupational therapy is to enable people to participate in their meaningful activities of everyday life. This can be achieved by working collaboratively with a person to enhance their functional skills, adapting the occupation or modifying the environment. Taking part in balanced, meaningful and purposeful occupations promotes and maintains good health and wellbeing.

Mental illness and addiction can lower a person's ability to engage in their necessary and desired occupations. The experience of Dual Diagnosis for some individuals can lead to a loss of meaningful roles, unhealthy habits and routines, loss of independent living skills, housing instability, loss of social networks, etc. As a result, a person may have to develop or re-establish the roles and identities most meaningful to them. Occupational therapists bring a distinct skillset and knowledge base to help service users overcome mental health and substance-use issues, and attain their goals for optimal health and wellbeing (86).

Assessment

Through a client-centred and recovery-oriented approach, occupational therapists assess the impact of a person's Dual Diagnosis on their everyday life. Standardised and non-standardised assessments can be completed through interview and observation of occupational performance ('doing') to guide intervention. During the assessment process, the following areas are considered to provide a comprehensive understanding of a person and their occupational challenges:

- Roles (vocational, caregiver, family member) and interests
- Habits, routines and time use
- Functional performance skills – motor, sensory, cognitive, social, intrapersonal
- Independent living and community integration skills
- Environment – social, home, cultural and physical

Occupational Therapy Assessments that can be used include:

- Occupational Self-Assessment (OSA) (87)
- Occupational Circumstances and Interview Rating Scale (OCAIRS) (88)
- Canadian Occupational Performance Measure (COPM) (89)
- Cognitive Assessments – Executive Function Performance Test (90), Allen Cognitive Level Screen (ACLS) (91)
- Functional Assessments
- Assessment of Motor and Process Skills (AMPS) (92)
- Model of Human Occupation Screening Tool (MOHOST) (93)
- Engagement in Meaningful Activities Survey (94)
- Vocational Assessments – Worker Role Inventory (95)

Intervention

Informed by the assessment process, the occupational therapist together with the service user will develop goals and an intervention plan to support their recovery. Intervention strategies distinct to occupational therapy are occupation-based; that is, they use engagement in meaningful activity as the therapeutic agent of change (96, 97). These are effective in developing a sense of mastery that may have been lost through substance use or mental ill-health.

The intervention approach will depend on the need and preference of the individual and can be provided via a group or one-to-one. Strategies informing the intervention may include activity analysis and grading, the therapeutic relationship, cognitive behavioural and psychoeducational approaches, motivational interviewing, exploration of motivation and readiness for lifestyle change.

Occupational therapy interventions may include:

- Development/reestablishment of healthy habits and routines
- Exploration of alternative leisure interests and recovery of meaningful leisure activities
- Exploration of vocational interests, developing skills through education, work-oriented tasks or training to re-engage in meaningful worker role activities

- Enhancement of functional performance skills – e.g. organisation and planning skills, problem-solving and decision-making skills
- Development of the skills to live more independently (ADL, personal and self-care skills)
- Development of community participation skills – building community networks, accessing transport, graded integration
- Enhancing communication and socialising skills
- Assessing and modifying the environment to support occupational engagement
- Lifestyle redesign

The Occupational Therapist, as part of the Dual Diagnosis teams and in collaboration with the service user, will regularly review and adapt the intervention plan to ensure it is meeting the person's needs and supporting their recovery. Occupational Therapists (OTs) involved in therapeutic interventions outside their core OT skills would need to have appropriate accredited training/qualifications before such interventions are delivered.

14.3 Role of Social Worker (senior grade) on DD Team

"The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance wellbeing. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work" (98).

Social workers work with individuals to help them to maximise their potential and quality of life. They assess the needs of individuals, and support them to access the appropriate service to meet their needs. The core values and principles of social work include acceptance, individualisation, confidentiality, promoting social justice and advocacy, empowerment of individuals, families and communities, non-judgemental practice, and the right to self-determination (99).

Social workers have a core set of skills that they use when working with individuals with mental health difficulties and/or addiction issues. These are transferable skills that can be used in various settings, offering a range of services to individuals and their families. Such work includes:

- Case management
- Care planning
- Conducting psychosocial assessments
- Family work
- Psychoeducation and support
- Counselling and therapeutic support
- Liaison with various agencies including the probation services and development of multi-agency intervention plans where appropriate
- Engagement with individuals and signposting to appropriate services in the community where relevant (for example, TUSLA, local authorities, safeguarding teams, social welfare)
- Advocacy and support

It is important that the social worker on a Dual Diagnosis team adopts a flexible and adaptive approach. They will

meet the individual where they are at, in the context of their surroundings and work collaboratively from there. This person-centred and individualised approach encourages a recovery-oriented focus.

Social work is based on several different models of work, including the Social Determinants of Health Framework. This model is relevant to the role of the social worker on a DD team as it maps the relationship between the individual, their environment and their condition. It places the individual at the centre of the work, and allows the social worker to focus on the varying influences on their health that can be modified. These influences include personal behaviour, social and community influences and more fundamental factors such as living and working conditions, housing, etc. (100). The importance of this framework is that it acknowledges the wider social conditions that influence mental health and addiction (101).

Adopting a systemic approach, social workers assess and provide support to people in the context of their relationships and deliver interventions in response to the identified needs. When working with people who have a Dual Diagnosis, the social worker pays particular attention to the impact the diagnosis has on their lives, including on employment, housing, income, family/carer relationships and social isolation. The diagnosis is only one aspect of a wider social context; when tailoring interventions to meet people's needs, it is crucial for the social worker to have a good working knowledge of the harm reduction approach, and to understand the use of substances as a coping mechanism or survival response.

Specific work relating to Dual Diagnosis includes:

- Case management: Given the complex nature of this work, the social worker on a Dual Diagnosis team may act as case manager for some of the service users. This refers to working with individuals with a view to ensuring continuity of care and the co-ordination of services to maximise their wellbeing and quality of life. Co-ordinating these inputs is key to a multi-agency holistic approach.
- Provision of support in relation to retrospective abuse disclosures: Working with the individual and various agencies (including TUSLA where appropriate)
- Family and carer support: Providing support and information to families and carers of individuals, including psychoeducational work, and running carer support groups; and supporting families to cope with the loss of a loved one
- Provision of tailored services and supports to parents who attend services: Facilitating childcare arrangements, liaising with TUSLA, supporting parents who are in residential facilities to maintain their relationships with their children.
- Report writing as required
- Counselling work: This may be individual counselling, through use of core counselling skills, or skills more specific to addiction counselling, or family work.
- Advocacy: Promoting human rights and social justice within the wider community through education and advocacy work. Social workers have a commitment to social justice by working to eliminate health disparities (101).
- Reducing stigma: The social worker aims to reduce stigma and stereotypes in society, such as those that a label of Dual Diagnosis can bring. This can be done through psycho-education with community staff, family work, etc.
- Practical support: housing, finances, social welfare applications
- Engagement of stakeholders
- Promotion of empowerment

Social workers engage in continuing professional development. Many have additional training in areas such as Systemic Family Therapy, Cognitive Behavioural Therapy, Dialectical Behavioural Therapy, and Counselling. Additional training that would be useful in this field of work includes: Motivational Interviewing, Maastricht Interview Skills, Behavioural Family Therapy, CBT, Addiction Studies, Eolas Facilitation, WRAP, DBT skills, and having a good working knowledge of Trauma-Informed Care, Peer Support, and Co-Production. Social workers involved in therapeutic interventions outside their core social work skills would need to have appropriate accredited training/ qualifications before such interventions are delivered.

Social workers will continue to work in line with national policy and best-practice guidelines as part of the Dual Diagnosis teams. Key policies and guidelines that underpin their work in this area include *A Vision for Change, Sharing the Vision 2020*, *Children First Act 2017*, *and The National Framework for Recovery in Mental Health* and the *National Policy for Safeguarding Vulnerable Adults 2014* (53, 58, 102, 103, 104).

14.4 Role of Clinical Psychologist on DD Team

Clinical psychology is a specialist area of psychology focusing on the spectrum of mental, emotional and behavioural disorders. It integrates the science of psychology with the assessment, diagnosis, and treatment of a wide variety of complex human problems (105). Psychologists have long been viewed as having specific competencies relevant to the assessment and treatment of substance-use disorders (SUD), especially as substance-use problems commonly follow standard behavioural principles and processes. Such difficulties frequently take place within a constellation of other psychological health difficulties, while a number of psychological principles and treatment approaches are of demonstrable benefit in motivating positive substance-use behaviour changes. Moreover, the fundamental clinical skills and therapeutic interpersonal styles imparted during psychology training are fundamental to positive treatment outcomes for problematic substance use (106). Additionally, Clinical Psychologists are health professionals with specialised training in the diagnosis and psychological treatment of those mental health difficulties that typically co-occur with SUD among individuals with a Dual Diagnosis.

A key focus of Clinical Psychologists working in the area of Dual Diagnosis will be about providing supportive, collaborative and evidence-based psychological interventions to produce positive changes, as guided by the client's general biological, social and psychological needs, and their salient co-occurring mental health difficulties. Such interventions may include effective addiction treatments such as Motivational Interviewing, cognitive and behavioural approaches and the Relapse Prevention models, as well as evidence-based psychological approaches for co-occurring mental health difficulties.

When appropriate, the Clinical Psychologist may also employ a range of suitable assessment scales and psychometric tools to assist in collaboratively determining treatment goals, clarify individual needs, contribute to greater diagnostic clarity, measure baseline behaviours and functioning, track treatment improvements, and monitor follow-up outcomes in a range of domains, including:

- General health, wellbeing and functioning (e.g. the individual's personal needs, quality of life, strengths and difficulties, experience of pain or physical symptoms, level of social functioning, quality of parenting-related and family relationship behaviours, etc.)
- General mental health factors (the individual's level of general psychological distress, experience of anger, risk of suicide or self-harm, subjective levels of hope, optimism, and motivation, etc.)
- Specific mental health factors (the individual's experience of psychosis; exposure to and level of trauma; presence of PTSD, mood disorder, panic, phobic, and OCD symptoms, level of body dysmorphia and disturbed eating patterns, features of personality disorder, etc. as appropriate)
- Substance-use factors (patterns of harmful or risky drug use, dependence, withdrawals, craving, and stage of recovery, etc.)

Other key activities include contributing to and supporting peer-reviewed research initiatives and clinical best-practice guidelines; engaging in diverse psychology, addiction and mental health-related training for wide-ranging professional and lay audiences, and promoting stigma reduction at all levels in the community.

Other key activities include contributing to and supporting peer reviewed research initiatives and clinical best practice guidelines; as well as engaging in diverse psychology, addiction, and mental health related training for wide ranging professional and lay audiences.

14.5 Role and Function of Addiction Counsellor on DD Team

The role of the addiction counsellor working in the area of Dual Diagnosis is to provide a professional counselling, psychotherapy, education and information service in the area of addiction, substance-use disorder and emotional difficulties.

The primary focus is to establish a therapeutic relationship by providing a safe, trusting and supportive environment in which issues pertinent to life experiences can be explored. To allow for the unique needs of clients, the counsellor must have grounding in an evidence-based theoretical framework as well as flexibility in approach. The notion that one size of therapy will fit all is not compatible with addiction counselling; the counsellor must value the idea that individuals can exercise choice in the therapeutic process.

At the heart of the therapeutic relationship is the centrality of the client, their experience and their capacity for personal growth. By listening attentively, the addiction counsellor can offer feedback, encouragement and reassurance to help restore the person's ability to cope. Typical issues addressed in the counselling relationship include trauma, self-harm, bereavement, relationship difficulties, anxiety and depression in the context of substance use.

As well as providing a professional counselling, psychotherapy, education and information service, the Senior Addiction Counsellor role is a position of management and leadership. The role of the senior counsellor is to oversee and govern the practice of addiction counselling in the organisation. This includes fulfilling the education and training requirements to provide clinical supervision as a key function of the role.

Medical & Psychological Interventions

15 Medical Interventions

15.1 Pharmacological Management of Substance-use Disorder in DD Services

15.1.1 Opioid Substitution Treatment/Opioid Agonist Therapy

Opioid Substitution Treatment (OST), or Opioid Agonist Therapy (OAT) (107) involves prescribing an opioid medication to assist service users seeking treatment for dependent use of heroin or other opioids. Opioid substitution treatments are effective in substantially reducing illicit opioid use, HIV risk behaviours, death from overdose, poor health and criminal activity. They also reduce adverse financial pressures and other stresses on drug users and their families. Only methadone and buprenorphine-based products are licensed and approved in Ireland as an OST/OAT. Any person commenced on OST/OAT must be notified to a Central Treatment List (CTL). Furthermore, any prescriber must be trained and approved by the HSE/ICGP.

During the initiation of an OST/OAT, most service users will be expected to have their daily dose of an OST/OAT dispensed and consumed under direct supervision for 5-7 days per week. It is important to closely monitor the service user's progress during the first month of induction on OST/OAT, when there is a small increase in the risk of death. In addition, well-supervised consumption of OST/OAT reduces the risk of diversion of prescription drugs to people outside of treatment, which can have fatal consequences. The responsibility for the level of supervision lies with the prescriber, in consultation with the multidisciplinary team and service user.

In outpatient settings, once stability is achieved, the level of supervision may be relaxed to allow take-home doses; this may reflect the service user's progress in treatment or a change in personal circumstances. Some service users may drop out of treatment if they are not permitted take-home doses. Supervised OST/OAT consumption should be available to all service users and provided for a length of time appropriate to individual needs and risks. *Clinical Guidelines for Opioid Substitution Treatment (OST)* plays an intrinsic role in supporting service users to recover from drug dependence. Assessment and recovery care-planning is an ongoing process. Once the service user is stabilised on OST/OAT, collaborative and active care planning (e.g. using mapping tools and motivational approaches) to consider options across a wide range of personal recovery goals is an important part of a recovery-oriented culture. Treatment should seek to maximise outcomes across a range of domains, including drug and alcohol misuse, health and psychosocial functioning (108).

Before considering OST, a comprehensive assessment of the service user must be performed. A standard bio-psychosocial mental health assessment and a focused drug and alcohol history should be obtained to establish extent of use, variety of substances, and dependence. Urine drug screen should be performed to confirm opioid dependence. Risks need to be assessed at all stages, including those related to overdose, unsafe injecting practices and unsafe sex. Wider risks may include self-harm, child protection issues, suicide ideation, intent to harm or harm to others, domestic violence, and risk related to crime and debt intimidation of individuals and families.

The aim of OST/OAT is to reduce drug use, reduce risk-taking behaviour, reduce morbidity and mortality, reduce offending, promote stabilisation and onward progression, improve health, and improve quality-of-life functioning as a productive member of society who becomes personally fulfilled. For some people, it will include becoming drug-free.

Stages of OST/OAT

Opioid substitution/opioid agonist treatment has four stages: induction, stabilisation, maintenance and detoxification. Methadone, a mu-opioid agonist, is a recommended first line for OST. The dosage of methadone at each stage of OST should be according to HSE OST guidelines (98). Advice is to start low and go slow. Using other respiratory depressants – e.g. heroin, benzodiazepine or alcohol – increases risk of overdose. Methadone can also prolong QT interval and interact with other drugs. It is recommended to apply the guidelines outlined in *Clinical Guidelines for Opioid Substitution Treatment and Clinical Guidelines for Opioid Substitution Treatment: Guidance Document for OST in the Hospital Setting (107, 109).*

15.1.2 Use of lofexidine

Lofexidine, an alpha 2 adrenergic agonist, is licensed for the management of symptoms of opioid withdrawals. It is unlicensed for opioid detoxification and is not recommended for people with substantial opioid dependence. The dosage of lofexidine for managing opioid withdrawal symptoms should be according to standard guidelines such as the Maudsley prescribing guidelines (110). Since Lofexidine is often associated with hypotension, regular monitoring of blood pressure and heart rate must be in place before it is commenced.

15.1.3 From methadone to buprenorphine and vice versa, and 'precipitated withdrawals'

When a service user is changing from methadone to buprenorphine, the first dose of buprenorphine must not be prescribed until the person has developed clinically evident opioid withdrawal symptoms, which may be at least 24 hours after the last dose of methadone. In such cases, the methadone dose should be <30ml/mg once a day. There is a high risk of 'precipitated withdrawal' if buprenorphine is given at a higher dose or before opioid withdrawal symptoms are evident. The same scenario applies to those who are started on buprenorphine while they are misusing heroin; otherwise precipitated withdrawal will occur. However, in those changing from buprenorphine to methadone, no such precautions are necessary.

15.1.4 Opioid overdose

Opioid overdose can be potentially fatal. Staff caring for service users on OST need to be aware and trained in identifying opioid overdose and its emergency management. Symptoms of opioid overdose include lethargy, pale skin, 'bluish' tinge in lips/fingernails, pinpoint pupils (not with everyone), lack of response to noise or touch, not being able to arouse, loss of consciousness, breathing problems (e.g. slow/shallow breathing, heavy snoring/ rasping breaths or not breathing at all). Opiate overdose should be treated with standard resuscitation techniques and naloxone (0.4-2.0 mg IM/SC, repeated every 3-4 minutes as per guidelines) (110).

Symptomatic management during opioid detoxification

Medications used for symptom relief during and following opioid detoxification include Quinine sulphate for muscle cramps, and Hyoscine butyl bromide for gastrointestinal spasms. In addition, Loperamide for diarrhoea, Metoclopramide hydrochloride for nausea and paracetamol for headaches and bone pain can be considered. The doses of these medications should be in accordance with the HSE OST guidelines (108).

15.1.5 Opioid detoxification using methadone or buprenorphine

Often, with many service users who engage for the first time, opioid detoxification may not be an option (although options for detoxification from alcohol, benzodiazepines can be considered at the same time). However, there will be situations where such an approach is considered appropriate. Complex factors such as multiple substance misuse, including alcohol-use disorder, homelessness, underlying mental health issues, unemployment, lack of family support, etc. will often help decide the risk of relapse associated with opioid detoxification. For detoxification doses, professionals can refer to guidelines such as the Maudsley guidelines. In general terms, a service user maintained on methadone OST will need to gradually reduce the dose until it reaches 50ml/mg or below before any inpatient detoxification is considered.

15.2 Alcohol

Medically assisted inpatient alcohol withdrawal is a process in which an individual's physical and mental health is monitored while being provided with medicines and psychosocial support to relieve physical and psychological withdrawal symptoms on alcohol cessation.

When undertaking assisted withdrawal, the service user is required to stop alcohol intake abruptly. Its effects are replaced in a safe and structured manner by medication that has cross-tolerance. Then medication can be reduced at a rate that prevents withdrawal symptoms, but without promoting over-sedation, and ultimately stopped altogether. The process involves providing a large enough initial dose to prevent severe withdrawal symptoms, including seizures, delirium tremens, severe anxiety or autonomic instability, and to ensure withdrawing the medication before physical dependence. The assessment of the service user should take into account their motivation to engage in detoxification, current physical and mental health, the environment, social support, consideration of any contraindications (e.g. past history of seizures or delirium tremens in case of community detoxification) and future treatment plans and goals. An after-care plan should be in place so that the service user continues to be supported to remain alcohol-free in the period following detoxification and supported to develop the skills needed to maintain long-term sobriety.

The Alcohol Use Disorder Identification Test (AUDIT) and the Severity of Alcohol Dependence Questionnaire (SADQ) are the two recommended tools to assess alcohol dependence. The Clinical Institute Withdrawal Assessment of Alcohol Scale revised CIWA-Ar is recommended to assess the severity of withdrawals and the amount of pharmacological support required to manage alcohol withdrawal symptoms (110). Medically assisted alcohol detoxification can be offered in community or inpatient settings. This would depend on a number of factors, including amount of alcohol consumed, SADQ score, previous history of withdrawals and seizures, etc. (110). Benzodiazepines are the treatment of choice for medically assisted alcohol withdrawal. They exhibit cross-tolerance with alcohol and have anticonvulsant properties. Chlordiazepoxide is commonly used because of its low potential for dependence. Short-acting benzodiazepine (e.g. Oxazepam or Lorazepam) can be used in service users with liver impairment (100). Parenteral Thiamine (Vitamin B1) and other vitamin replacement is an important adjunctive treatment for the prophylaxis and/or treatment of Wernicke's-Korsakoff syndrome and other vitamin-related neuropsychiatric conditions. These medications should be prescribed as per standard alcohol detoxification guidelines, such as the one in the Maudsley prescribing guidelines (110).

15.3 Medications for relapse prevention in substance-use disorders

Relapse prevention is an essential part of maintaining abstinence in those with Dual Diagnosis. It is important that medication used for relapse prevention is accompanied by psychosocial interventions. Medication licensed for relapse prevention is primarily for alcohol-use disorders (such as acamprosate, disulfiram and naltrexone) and opioid-use disorders (naltrexone). There is insufficient evidence for the role of medications in relapse prevention for other substance-use disorders.

Disulfiram can only be used in those completely abstinent from alcohol. Before a decision is made about prescribing Disulfiram, the service user must be made aware of the serious risks associated with the use of alcohol and alcohol products (such as hand gels, some cough syrups, some cosmetic products, etc.) and it is essential to assess the motivation of the service user before Disulfiram is commenced. Similarly, Naltrexone must not be used in those actively using any of the opioids or opioid agonist products (including some analgesics containing opioids). Prescribers must also be aware of the other contraindications to initiating these medications for relapse prevention.

Dosage for these medications must be according to the prescribing guidelines. The service user should be made aware of the possible adverse effects associated with such medications. Consideration should be given to a medical assessment that includes blood investigations for liver function and renal function tests, and baseline blood pressure measurement.

15.4 Medically assisted benzodiazepine detoxification

Benzodiazepines have a high potential for dependence. Benzodiazepine dependence can be either iatrogenic (low daily doses prescribed over many years) or non-iatrogenic (high doses, illicitly obtained, consumed intermittently). The approach to benzodiazepine should be that of a gradual withdrawal. A gradual reduction in dose by about 10-20% fortnightly is recommended (110).

For service users using benzodiazepine for a longer period, benzodiazepines should be converted to an equivalent dose of diazepam as this is longer-acting and less likely to be associated with withdrawals. Standard guidelines should be followed for a benzodiazepine withdrawal schedule.

15.4.1 Benzodiazepine overdose

Overdose on benzodiazepine is potentially life-threatening. It is important to recognise the signs and symptoms. The common features of benzodiazepine overdose are confusion, dysarthria, nystagmus, lethargy, ataxia, areflexia, hypotonia, seizure, shallow breathing, hypotonia and hypothermia. Flumazenil is recommended for treatment of benzodiazepine overdose. It should be administered intravenously. The recommended dose of IV flumazenil is 200 micrograms over 15 seconds. This can be repeated after 60 seconds if there is no improvement in conscious level (110).

15.4.2 Cocaine, amphetamines, cannabis and pregabalin misuse

There is no specific pharmacological intervention for management of cocaine, amphetamines, cannabis and pregabalin misuse. Symptomatic and supportive management is advised in those misusing those substances. It is advised not to use benzodiazepines in such dependencies due to the risk of cross-dependency to benzodiazepines.

16. Psychological Interventions

Psychology has been described as a data-based scientific discipline that aims to understand how behaviours are related to internal processes and the environment; there should be a guarantee that the applications of such psychological methods are based on scientifically based psychological principles (i.e. through the use of systematic empiricism, production of public knowledge and examination of solvable problems) (111). Despite the diversity of practitioner roles (e.g. nurses, social workers, occupational therapists, medics) in modern multidisciplinary teams, all professional members will draw on a range of psychological principles, theories and practices when employing psychological or psycho-social interventions in supporting and assisting their service users.

According to Wanigaratne et al. (112), psychological interventions are based on one or more theories of human behaviour. They involve a relationship between therapist and client, within which various issues relating to their development, experiences, relationships, cognitions, emotions or behaviour are considered. While the goal of psychological therapy varies with the model used, it is usually targeted to increase the client's self-understanding and/or promote cognitive, emotional or behavioural changes. Such psychological interventions may aim to assist service users change their substance-using behaviour or address co-existing disorders such as depression, anxiety or post-traumatic stress disorder (PTSD) (112).

While many evidence-based psychotherapies have been demonstrated to be effective for a wide range of mental health concerns, there is limited compelling evidence to support specific psychological Dual Diagnosis (DD) treatment interventions, whether alone, in combination, one type over another, or against treatment as usual.

As concluded by Hunt et al. (113), *"there is currently no high-quality evidence to support any one psychosocial treatment over standard care for important outcomes such as remaining in treatment, reduction in substance use or improving mental or global state in people with serious mental illnesses and substance misuse".* Systematic reviews and meta-analyses have similarly been limited by a focus on disparate conditions or substances, giving rise to a lack of clinical homogeneity and resultant challenges to data pooling and intervention comparisons (114). Additionally, such reviews have often lacked a focus on realist questions (the context, mechanisms, facilitators and barriers to treatment effectiveness) (115). There is also a dearth of relevant Irish research. Given the above, recommended psychological and psychosocial approaches for Dual Diagnosis tend to be far more equivocal and less exact and specific than for other areas of treatment (116, 117, 118).

In light of the above challenges, the recommended interventions include:

- Motivational Interviewing
- CBT interventions
- Family-based interventions
- Mindfulness-based Interventions, especially Mindfulness-Based Relapse Prevention and Mindfulness-oriented Recovery Enhancement
- Trauma informed / Integrated trauma interventions

These interventions to support individuals with a DD have been guided by:

- Peer-reviewed research and expert consensus identifying interventions as evidence-based, as well supported or as a promising/emerging evidence base.
- The availability of manuals or other measures to ensure treatment fidelity, consistency or integrity, and thus prevent therapy 'drift'.
- Likelihood of available sources of accredited training.
- Likelihood of being acceptable, consistent or congruent with the needs and resources of members of the two 'target quadrants'.
- Likelihood of being both effective (producing a positive meaningful effect under normal clinical conditions) and efficient (producing the desired effect in an economical fashion, given potential time, resource or staffing constraints).

It is important to note that many of the interventions, either individual or group-based, are not discipline-specific, and may be provided by different members of the MDT who are trained and competent in their delivery. Constantly evolving psychological and psychosocial approaches and their continued utility, effectiveness and appropriateness should be reviewed and updated regularly. Training, upskilling and supervision in these approaches should thus be a central part of continuous professional development and training for MDT members (see Table 6 for a full list of training).

Training & Capacity Building

17 Training and Capacity-building

Following an action research project in 2019, education and training for all healthcare professionals was identified as essential in order to work effectively with Dual Diagnosis in the long term (119). Additionally, addressing gaps in knowledge, whether it relates to mental health issues or substance misuse, was found to encourage staff in the separate services to establish links with each other, which in turn may help with the improvement of service delivery. Hence, it is suggested that this training should include mental health professionals being trained in addiction-related knowledge and vice versa with addiction service professionals.

The training and capacity-building subgroup was established to support the National Working Group with the development of a suite of training and capacity-building interventions to support the programme to roll out the Model of Care through, and with the healthcare professionals across the HSE and voluntary sector. The overall aim is to develop a 'community in practice' approach to supporting individuals with a DD. This will include training to support practitioners' understanding of mental health, addiction and Dual Diagnosis. The use of e-health and e-learning will feature in the development and implementation of the training programme throughout the HSE, with each CHO being required to ensure training is provided and staff are supported to attend.

The training and capacity building subgroup were tasked to **"***Develop a two-tiered suite of training to support healthcare professionals supporting individuals with Dual Diagnosis".*

This objective is being realised by:

- Identifying the training needs of the healthcare professionals supporting individuals with a DD and their families.
- Developing a two-tiered suite of training to address these training needs.
- Ensuring a cross-divisional approach to the development and delivery of the training programme, in particular involving Mental Health, Social Inclusion, Health and Wellbeing, and Connecting for Life.
- Developing a database of training, trainers and training events available in each of the regional DD team areas.
- Using the findings from the training needs analysis to identify gaps in current training options.
- Drafting business cases for additional training and funding required to support the clinical programme.

Training is an essential component of supporting staff in managing service users with DD in various settings. Considering the various skillsets of service providers in the community and in hospital settings, training has to be targeted according to the needs of the service providers. Training will be provided in collaboration with Connecting for Life, HSE Social Inclusion services and also by the Dual Diagnosis services through the National Clinical Programme.

The types and descriptions of the training provided are described below:

17.1 Types of training

SAOR – Support, Ask and Assess, Offer Assistance

SAOR (Support, Ask and Assess, Offer Assistance) offers a step-by-step guide for practice, to guide workers in using a person-centred approach throughout their conversation, encounter or engagement with a person using their service. The aim of SAOR training is to enable the service provider to have a short helpful conversation with someone about their alcohol or other drug use using the SAOR Screening and Brief Intervention model. The training, based on the second edition of SAOR (2017), is delivered using a blended learning approach.

Participants complete a short e-learning module on HSeLanD, the national online learning and development portal, in advance of a one-day skills practice workshop.

START – Suicide Prevention Skills Online

LivingWorks Start is an online, interactive training programme that will give the service provider the skills and knowledge to keep others safe from suicide, help to identify people at risk, confidently ask them about the topic of suicide, and connect them with resources that can help them stay safe. The programme uses a mix of guided online content, video and interactive questions. The service provider can pause and recommence the programme at their own convenience. On average, the programme takes an hour and thirty minutes to complete. It is accredited by the *Psychological Society of Ireland*. Training is open to Irish residents, aged 18 and over. In most cases, the service provider can request a free *LivingWorks Start* licence from their local training coordinator.

Understanding Self-Harm

The *Understanding Self-Harm* workshop provides opportunities to improve knowledge, awareness and understanding of self-harming behaviour. Participants consider how personal attitudes and experiences might affect their helping role with a person who self-harms. It aims to clarify what self-harm is and what leads people to engage in the behaviour, and considers its relationship with suicide. The causes, reasons behind the behaviour and the functions are discussed. Positive approaches to engaging with and caring for someone who self-harms are presented. Active participation is encouraged as part of this workshop.

STORM – Skills Training on Risk Management

The *STORM*® (Skills Training on Risk Management) training courses increase confidence and competence by enhancing the communication skills needed to engage someone in distress, work collaboratively, assess vulnerability and prevent suicide. The aim of the training is to develop and enhance skills and confidence in assessing and managing self-harm. This two-day training is delivered to HSE Mental Health staff only (due to licence restrictions).

eSuicideTALK

eSuicideTALK is a one to two-hour online exploration module in suicide awareness. The programme, organised around the question 'Should we talk about suicide?' offers a space to safely explore some of the more challenging issues relating to suicide. It encourages everyone to find a part they can play in preventing suicide. Its goal is to help make direct, open and honest talk about suicide easier. The training is open to Irish residents, aged 18 and over, who can access eSuicideTALK for free by registering online.

Supporting people bereaved through suicide

Post-suicide intervention services address the needs of individuals personally affected by a suicide to aid them through the bereavement and grieving process. This workshop is a one-day training about bereavement and grieving, particularly in the context of suicide. It is aimed at professionals and key contact people who, in the course of their work, come into contact with those bereaved through suicide. The programme is also delivered to community groups around the country by the HSE Resource Officers for Suicide Prevention and Suicide Bereavement Liaison Officers.

Collaborative Assessment and Management of Suicidality (CAMS)

The *Collaborative Assessment and Management of Suicidality (CAMS)* is a flexible therapeutic framework in which the service user and provider work together to assess the service user's suicidal risk and use that information to plan and manage suicide-specific, 'driver-oriented' treatment. It can be used for a wide range of suicidal service users across outpatient and inpatient treatment settings and in the context of various psychotherapies and treatment modalities. The framework fundamentally involves a participant's engagement and cooperation in assessing and managing suicidal thoughts and behaviours and the therapist's understanding of the service user's suicidal thoughts, feelings and behaviours.

ASIST – Applied Suicide Intervention Skills Training

ASIST (Applied Suicide Intervention Skills Training) is a two-day skills-building workshop in suicide first aid. Participants are trained to reduce the immediate risk of a suicide and increase the support for a person at risk. The workshop provides opportunities to learn what a person at risk may need from others in order to keep safe and get more help. Those taking part in the training will feel challenged and safe, work interactively with others in small groups, learn a suicide first-aid model that provides a framework for skills practice, and experience powerful audio visuals.

SafeTALK – Suicide Alertness for Everyone

SafeTALK (Suicide Alertness for Everyone) is an internationally recognised half-day training programme that prepares participants to recognise and engage with people who may be having thoughts of suicide and to connect them to first-aid resources for those with suicidal thoughts. It is suggested that most people with thoughts of suicide don't truly want to die, but are struggling with the pain in their lives. Through their words and actions, they invite help to stay alive. *SafeTALK*-trained helpers can recognise these invitations for help and take action by supporting people to connect with life-saving resources, supports and services.

Broadly, training is based on two tiers of service providers, including community organisations/statutory bodies (see Table 6), along with the recommended training for each tier. It is expected that there will be overlap in professionals in Tier 1 and Tier 2. The individual training needs of the professional will depend on their scope of practice in their clinical setting.

Table 6. Tiers of training for service providers

Tier 1 Training		**Tier 2 Training**	
Target Audience: community service providers including GPs, Public Health Nurses, GP Nurses, Homeless Services, Youth Services, Family Support, Employment Support Services, Community Workers, Probation Services, Local Authorities, Education Services		**Target Audience:** Clinical staff in mental health, addiction services and hospitals. This can also include disciplines such as nurses, social workers, psychologists, OTs depending on their scope of practice, along with the doctors.	
Training	Provider(s)	Training	Provider(s)
Dual Diagnosis and referral pathways **Description:** This will help the audience to identify those with Dual Diagnosis at their point of contact and refer them to the appropriate service. This session will give the audience knowledge of the various service providers, the role of various service providers and pathways to referral.	Dual Diagnosis services in partnership with HSE Connecting for Life	Dual Diagnosis, illicit drugs, and Management of Dual Diagnosis service users **Description:** This session will provide the audience with a knowledge of the four quadrants in Dual Diagnosis, managing those in each quadrant in an outpatient or inpatient setting. In addition, this session will also provide knowledge on the various illicit substances on the street along with assessment of illicit substance use and behavioural addictions in service users.	Dual Diagnosis services in partnership with HSE Connecting for Life

Screening and Brief Intervention Project for Alcohol and Substance Use SAOR (Support, Ask and Assess, Offer Assistance, Refer)	HSE Social Inclusion	Screening and Brief Intervention Project for Alcohol and Substance Use – SAOR (Support, Ask and Assess, Offer Assistance, Refer)	HSE Social Inclusion
START Training – Suicide Prevention Skills Online	HSE Connecting for Life	STORM (Skills Training on Risk Management)	HSE Connecting for Life
ASIST (Applied Suicide Intervention Skills Training)	HSE Connecting for Life	ASIST (Applied Suicide Intervention Skills Training)	HSE Connecting for Life
Understanding Self Harm	HSE Connecting for Life	Understanding Self Harm	HSE Connecting for Life
eSuicideTALK	HSE Connecting for Life	Supporting people bereaved through suicide in the community	HSE Connecting for Life
SafeTALK	HSE Connecting for Life	Collaborative Assessment and Management of Suicidality (CAMS)	HSE Connecting for Life

Training in psychological and psychosocial interventions

The following psychological and social interventions are suggested as part of the training for the multidisciplinary service providers in both Tier 1 and Tier 2, depending on their role in service provision (see Table 7). Not all the suggested interventions are expected to be available in all the regions, but can be considered depending on the needs of each service provider and resources being available to provide the training.

1. Motivational Interviewing/MET (SUD and Behavioural addictions)

Motivational interviewing has been defined as a *"collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion"* (120).

This approach can be used as a stand-alone intervention and as precursor to any other evidence-based treatment intervention. It is an intervention for those with substance-use difficulties, at-risk gamblers and individuals with other health-risk behaviours, especially where there is low motivation to change. Key activities include promoting engagement; exploring client ambivalence; focusing on open-ended questioning; use of affirmations, reflective statements and summarising; eliciting change talk, and collaboratively helping the client to develop their change plan.

2. Cognitive and Behavioural-based Interventions

Cognitive and behavioural-based interventions that are manualised, have key components, or have fidelity protocols. They include:

a) Contingency Management

Contingency management interventions are highly effective treatments for substance-use and related disorders. They are based on principles of basic behavioural analysis, a type of behavioural therapy in which individuals are 'reinforced', or rewarded, for evidence of positive behavioural change (121).

b) Cognitive Behavioural Coping Skills (CBCS)

Cognitive behavioural coping skills therapy is based on learning-theory principles. It places an emphasis on overcoming skill deficits and increasing the individual's ability to cope with those high-risk situations that commonly precipitate relapse (122).

c) Relapse Prevention CBT (RP-CBT)

Trying to avoid relapse is one the greatest challenges facing individuals wishing to change or reduce problem behaviours (e.g. drug use and gambling). Most people who attempt to sustain positive behaviour changes will experience lapses that often lead to a full relapse. RP-CBT has a specific focus on helping people who are struggling with drug-use difficulties to develop those skills needed to identify and anticipate external situations and/or internal states where they are most vulnerable to problem drug use, to avoid such high-risk lapse or relapse-related situations, and to use a range of cognitive and behavioral strategies to cope more effectively and better manage these scenarios.

d) Community Reinforcement Approach (CRA)

The Community Reinforcement Approach (CRA) is a comprehensive behavioural programme that uses a number of core modules to treat drug-use problems. Based on the premise that environmental contingencies play a key role in encouraging or discouraging substance use, it employs multiple environmental 'reinforcers' to assist in the individual's recovery process, with the aim of making an abstinent lifestyle more rewarding than substance use (123).

3. Trauma-informed Care

This is a strengths-based service delivery "grounded in an understanding of and responsiveness to the impact of trauma; that emphasizes physical, psychological, and emotional safety for both providers and survivors; that creates opportunities for survivors to rebuild a sense of control and empowerment" (124).

Trauma-informed care is based on the following premises:

- Trauma has long-term adverse effects on physical and mental health, potentially contributing to chronic health and behavioural health conditions.
- High levels (+/- 70%) of trauma are found among SUD population.
- SUDs are highly co-morbid with PTSD and mood-related psychopathology.
- Awareness of PTSD and SU co-morbidity in high-risk groups is critical to better understanding of the mechanisms of addiction, and to improving prevention and treatment strategies.
- People with MH and SU disorders may experience trauma in complex ways.
- Health professionals often have their own trauma histories and may experience the effects of secondary (or vicarious) trauma through their work.

4. Seeking Safety

Seeking Safety is a low-cost, present-focused, coping skills therapy to help individuals achieve safety from trauma/PTSD and SUD. It has a compassionate character, honouring clients' survival of experiences and respecting their strengths, and is a flexible, first-stage model that can be used from the beginning of treatment commencement.

Key principles of Seeking Safety are based on:

- Safety (in relationships, thinking, behaviour, emotions) is an overarching goal.
- Integrated treatment (working on both trauma and SUD simultaneously).
- Focusing on ideals to counter the individual's loss of ideals in both trauma and SUD.

Four domains are covered- cognitive, behavioural, interpersonal, and case management. Within these, 25 treatment topics are flexibly delivered. They include 'Safety, Asking for Help, Boundaries in Relationships, Healthy Relationships, Community Resources, Compassion, Creating Meaning, Discovery, Recovery Thinking, Taking Good Care of Yourself, Commitment, Integrating the Split Self, Self-Nurturing, Red and Green Flags, and Life Choices.

The emphasis is on engagement and use of tangible strategies, which may be used with a range of vulnerable groups (severe/chronic, homeless, ethnically diverse, ABI/TBI, cognitively impaired, illiterate) by a broad range of providers (clinicians, emergency workers, advocates, paraprofessionals, and peer-led).

5. Family Behaviour Therapy (FBT)

FBT aims to help improve family communication, enhance problem-solving skills, and provide a comprehensive education package covering illness, treatment and relapse prevention strategies. This therapy is of particular benefit when working with the adolescent population presenting for treatment.

6. Mindfulness-based Interventions

This includes:

a) Mindfulness-Based Relapse Prevention (MBRP)

Mindfulness-based Relapse Prevention (MBRP) employs core aspects of Relapse Prevention (RP) with practices adapted from Mindfulness-based Stress Reduction and Mindfulness-based Cognitive Therapy. As recognition of high-risk relapse situations are central to the treatment, participants are taught to recognise early warning signs of relapse, increase awareness of internal and external cues previously linked with substance use, develop more effective coping skills, and increase their self-efficacy.

b) Mindfulness-Oriented Recovery Enhancement (MORE)

Mindfulness-Oriented Recovery Enhancement (MORE) employs mindfulness training with 'Third Wave' cognitive-behavioural therapy, and positive psychological principles with a view to improving health and wellbeing, notably problem drug use, stress, and both physical and emotional pain.

7. Modified MI/MET for psychosis/schizophrenia spectrum disorders (individual and group formats)

This approach was developed for people with psychosis and low motivation to cease problem substance use. It was adapted from traditional Motivational Interviewing principles to accommodate both the potential unique cognitive challenges and reduced motivation to stop drug use among such individuals.

A collaborative, motivational, and harm-reduction approach, it includes the following elements:

- Developing a working alliance
- Helping the individual to evaluate the advantages and disadvantages of substance use (decisional balance)
- Formulating personalised goals
- Encouraging an environment and lifestyle that promotes abstinence
- Teaching crisis management skills

Other modified motivational interviewing approaches may use different strategies according to the individual's needs and motivational level, and may thus require longer periods for engagement and treatment (125).

8. Modified CBT for Psychosis (includes RP and MI strategies)

In this approach, CBT is modified to account for cognitive limitations associated with psychotic disorders, and by focusing on a small number of core skills. The initial focus is on 1) problem-solving and social skills and then 2) craving and triggers for substance use. Those specific challenges pertaining to SUD with psychotic disorders are also covered as part of this approach.

Structured small group sessions emphasise social and RP skills. Improved social skills and abstinence are highly reinforced to enhance self-efficacy. In addition, abstinence may be positively reinforced by small financial rewards for drug-free urine samples (i.e. Contingency Management).

9. Generic DD Treatments

a) The Integrated Dual Disorder Treatment (IDDT) model

This model aims to improve quality of life for those with a co-occurring severe mental health and substance-use disorder by integrating substance use with Mental Health services. It employs psychological, educational and social interventions, and emphasises individualised achievement of salient quality of life, abstinence, symptom management, and independent living goals through a series of gradual changes over time (using the stage-of-change model).

b) The Matrix Model

This is an integrative approach that uses aspects of several of the general treatment elements considered effective for SUD.

c) Dual Recovery Therapy (DRT)

This approach integrates Relapse Prevention, Motivational Enhancement Therapy (for low motivation) and 12-step principles for SUD, with social skills training for Mental Health disorders using inter-related group and individual sessions. Communication and problem-solving skills are taught through role play. The therapist monitors the interface between the mental health and substance-use disorder to regulate relative treatment emphasis. The treatment focus later shifts to addressing unhelpful relationships and promoting healthy relationships.

d) The Substance Abuse Management Module (SAMM)

This approach is based on harm reduction, relapse prevention and social skills training (enhancing problem-solving and communication skills) to promote abstinence and improved recovery. It teaches a limited, specific subset of skills for ease of execution and learning. Specific, crucial skills for avoiding substances and for illness management are taught and practised (e.g. dealing with craving, communication skills). It emphasises the value of repeated practice and rehearsal of skills. The therapist may play an active role as a coach, providing positive and helpful feedback in role-play activities.

e) Targeted for SUD and Bipolar Affective Disorder (BPAD)

i) Early Recovery Adherence Therapy (ERAT)

As part of this, counselling is directed towards the early recovery phase from an acute BPAD episode. Treatment focuses on promoting abstinence and combines the principles of MI, RP and psycho-educational approaches to manage BPAD and SU (126).

ii) Integrated Group Therapy for Bipolar Affective Disorder and substance use (IGT)

This therapy focuses on promoting abstinence, medication adherence, education about relapse--related warning signs and early symptom recognition, assisting with relapse prevention, and improving overall functioning, including mood stability and interpersonal relationships (127).

10. Solution-Focused Brief Therapy (SFBT)

SFBT, while not being specifically focused on drug use, may have good general utility for outpatient target populations. It is a forward-focusing, positive approach, based on the principle that individuals know what they need to do to improve their lives, and that, with proper guidance and support, they will be able to realise their future goals.

11. Decider Skills Programme

This proactive skills-based learning programme uses education, discussion and personal practice. It can be used while on a waiting list, as a brief therapeutic intervention, and as part of a more comprehensive treatment plan. It is based on CBT and DBT principles, which have a good evidence base. It focuses on four key emotional areas: distress tolerance, mindfulness, emotion regulation and interpersonal effectiveness.

17.1.1 Training suggested for Nursing

1. TIDAL Model
2. Anxiety & Stress Management (for nursing and other MDT members)
3. Choice Theory/Reality Therapy
4. Concordance Training
5. Person-Centred Counselling (for nursing and other multidisciplinary team members)

   Among these, the Person Centred counselling approach prioritises the individual's personal goals, desires, needs and wants so that they are central to the treatment process. This may mean elevating the individual's defined needs above those identified by the healthcare professionals.
6. Psycho-education (for nursing and other MDT members)

   Psycho-education is a form of education and information-sharing that is offered to individuals and their families who are suffering from any health condition that may impair their ability to lead their lives. Such education may have many benefits, including better understanding of key illness management factors, increased treatment compliance, greater self-efficacy, and reduced stigma.

17.1.2 Training suggested for Occupational Therapists

1. MOHO – Model of Human Occupation
2. PEOP – Person-Environment-Occupation-Performance Model
3. CMOP-E – Canadian Model of Occupational Performance and Engagement
4. Occupation-based interventions focusing on developing occupational performance and recovery
5. Occupation-based interventions (for Occupational Therapist and other MDT members)

The interventions focusing on developing occupational performance and recovery include:

- Developing/re-establishing of healthy habits and routines.
- Exploring alternative leisure interests and recovering meaningful leisure activities.
- Exploring vocational interests, developing skills through education, work-oriented tasks or training to re-engage in meaningful worker role activities.
- Enhancing functional performance skills – e.g. organising, planning, problem-solving and decision-making.
- Developing the skills to live more independently (ADL, personal and self-care skills).
- Increasing community participation skills – building community networks, accessing transport, graded integration.
- Enhancing communication and socialising skills.
- Assessing and modifying environment to support occupational engagement.
- Redesigning lifestyle.

17.1.3 Training suggested for Social Workers

1. **Behavioural Family Therapy (BFT)** (not to be confused with Family Behaviour Therapy)
   This evidence-based programme for families of individuals with mental health difficulties is a skills-based programme that focuses on communication and problem-solving skills, and sharing information on illness, treatment and relapse prevention strategies with the family as a whole. Training for BFT is available through the HSE for the MDT members in the HSE.
2. **Family Talk**
   The Family Talk intervention is an evidence-based programme, designed for mental health professionals working with parents experiencing depression and/or anxiety, to foster resilience in their children and the family unit.
3. **Parents Plus**
   This is a series of parenting courses/workshops that support families raising children; and work on prevention for disadvantaged and at-risk families, and as interventions for high-need families dealing with complex problems.

4. **Systemic Family Therapy** (training suggested for Social Workers and other MDT members)
This approach is for families of individuals experiencing psychological difficulties. It is based on the premise that psychological and interpersonal difficulties occur within the context of social interaction and how individuals make sense of their lives. This approach supports individuals and families by understanding and addressing the individual's distress within the context of their family or other systems, and by supporting and encouraging positive action towards change that will ease their distress

Table 7: Training suggested to support psychological interventions

Psychological Interventions: Training suggested
For Psychologists:
1. Motivational Interviewing / MET (SUD and Behavioural addictions)
2. Cognitive and Behavioural-based interventions, to include:
a) Contingency Management
b) Cognitive Behavioural Coping Skills (CBCS)
c) Relapse Prevention CBT (RP-CBT)
d) Community Reinforcement Approach (CRA)
3. Trauma-informed Care
4. Seeking Safety
5. Family Behaviour Therapy (FBT)
6. Mindfulness-based Interventions, to include
a) Mindfulness-based Relapse Prevention
b) Mindfulness-oriented Recovery Enhancement
7. Modified MI/MET for psychosis/schizophrenia spectrum disorders (individual and group formats)
8. Modified CBT for Psychosis (includes RP and MI strategies)
9. Generic DD Treatments
a) The Integrated Dual Disorder Treatment (IDDT) model
b) The Matrix Model
c) Dual Recovery Therapy (DRT)
d) The Substance Abuse Management Module (SAMM)
e) Targeted for SUD and BPAD
i) Early Recovery Adherence Therapy (ERAT)
ii) Integrated Group Therapy for bipolar disorder and substance use (IGT)
10. Solution-focused Brief Therapy (SFBT)
11. Decider Skills Programme

For Nursing:

1. TIDAL Model
2. Anxiety & Stress Management (nursing and other MDT members)
3. Choice Theory/Reality Therapy
4. Concordance training
5. Person-centred Counselling (nursing and other MDT members)
6. Psycho-education (nursing and other MDT members)

For Occupational Therapists:

1. MOHO – Model of Human Occupation
2. PEOP – Person-Environment-Occupation-Performance Model
3. CMOP-E – Canadian Model of Occupational Performance and Engagement
4. Occupation-based interventions focusing on developing occupational performance and recovery

For Social Workers:

1. Behavioural Family Therapy (not to be confused with Family Behaviour Therapy)
2. Family Talk
3. Parents Plus
4. Systemic Family Therapy (Social Work and other)

The above is not an exhaustive list and more can be added as the DD clinical teams continues to evolve and identify levels of best practice.

Evaluation & Public Patient Initiative (PPI)

18.1 Evaluation Framework

In any new initiative, it is good practice to establish a framework for evaluation. This requires an outline of the aims and objectives of the initiative, in this case the creation of a Model of Care (MoC) for Dual Diagnosis (DD). The objectives, and whether they are met, will provide a benchmark. Other aspirations for the MoC can also be evaluated by the National Clinical Programme through the key performance indicators (KPIs). Empirical data are required, both quantitative and qualitative for the purpose of evaluation.

18.2 Qualitative Research

The evaluation subgroup of this Clinical Programme will be using a Public Patient Initiative (PPI) approach to the qualitative work. Consultations with the Health Research Board (HRB) and the Health Service Executive (HSE) took place before a final decision on adopting this methodology was made. Both the HSE and the HRB have explicit structures to support a PPI approach, particularly where the views and experience of individuals and communities with lived experience are given high value.

In essence, the approach places strong emphasis on engaging with people with lived experience in the research process. The group acknowledged that this approach takes time as training is involved, but it is expected that the outputs can bring about real change.

Evaluating the implementation of the proposed MoC is a critical element of the work of the NWG. This is being effected through the evaluation subgroup. The evaluation should assist in addressing concerns such as timely access to care, quality of care, involvement of service users in treatment plans, diagnostic criteria, treatment pathways, the role of lived experience, the role of the family in treatment responses, and service-user satisfaction.

These issues can be addressed through a combination of quantitative and qualitative methodologies. Addressing these issues will enable adjustments to the MoC to be made in the initial sites and any subsequent sites, when resources are made available to further develop this Clinical Programme.

18.2.1 Outline research proposal for qualitative studies

Creating a Model of Care for Dual Diagnosis: a Qualitative Needs Analysis

This needs analysis is intended to address several issues around access to and delivery of care for people experiencing Dual Diagnosis in the initial Dual Diagnosis site(s). The purpose of the research is to explore, primarily, the following concerns:

- Timely access to care.
- Quality of care.
- Service-user involvement in care plans.
- The role of lived experience.
- The role of families and communities in responding to DD issues.

The above is best achieved by qualitative research in the form of a number of survey instruments and data-gathering styles, including:

- One-to-one in-depth guided interviews
- Focus-group interviews
- Guided written reflections

There should be a focus on those with lived experience of DD, including peer support workers (PSWs) (suggested number of participants, n=6; service users, n=6, and family members of service users, n=6).

18.2.2 Proposed approach – PPI

The best-fit approach for this needs analysis is to take a PPI approach to the research at the outset. PPI, which involves co-created and co-produced research with a focus on collaboration, is becoming increasingly important in how health research is conducted.

The Irish Health Research Forum describes PPI as: "Occurring when individuals meaningfully and actively collaborate in the governance, priority setting and conduct of research, as well as in summarising, distributing, sharing and applying its resulting knowledge."

PPI contributors are experts in their own lives and experiences, providing a holistic view of living with and through an experience, enabling a more focused sense of what is relevant. They challenge stereotypes, can help question bias and have a stake in the success of the research.

PPI is primarily about starting a conversation, in which all involved are equal that may open up a number of new avenues. PPI also provides several useful links to other organisations which would be beneficial in both initiating and maintaining the research process as well as allowing for participation in other tranches of work in the area.

The Heath Research Board (HRB) has launched an implementation plan to support PPI both within the organisation itself and through HRB-supported projects and programmes, running from 2021 to 2025. Among supported organisations are universities and other relevant organisations. The HSE also has a PPI Lead in Research.

Who should be part of a PPI group?

Ideally, the PPI group (in this instance) should comprise a number of peer support workers (PSWs) who have personal experience in the area of mental ill-health, substance use or both.

The proposed framework would be as follows:

Engage potential PPI participants from a group of PSWs

Initial meeting

Set up an initial meeting to explain the purpose of the research with a view to gaining insights from the group regarding:

- their experience and their view of research
- their expectations of research and its outcomes
- their willingness and capacity to engage in the research
- the expectations of the research team in terms of the PSWs' role, training, time commitment etc.
- their availability and level of commitment
- other issues, including payment

Provide training

Based on the initial meeting, several training sessions will be envisaged and this would help enable confidence in the use of recording equipment, interviewing styles, ethical guidelines, etc.

Support recruitment, data-gathering and dissemination

If the PSWs suggest that service users and family members are well placed to participate, it will be the role of the

PSW to recruit, interview and provide data to the research team, who are responsible for data analysis and writing up the findings. Support and guidance should be provided throughout the research process itself as well as during dissemination following completion of the report.

Ethics

If there are challenges in accessing an expedient pathway to ethics approval, this may require (it is suggested that) the research team to invite a number of key figures involved in PPI to act as a scientific advisory committee to oversee the research process and ensure that it adheres to ethical and Data Protection Impact Assessment (DPIA) requirements, both on a practical and academic level.

Possible issues

As with any research proposal, a number of issues may arise, including:

1. The need to recruit PSWs through a gatekeeper to ensure that they have the capacity for informed consent.
2. Ensuring that all material for the study is accessible if there are literacy issues.
3. Ensuring that the PSWs are well enough to work when needed.

18.3 Quantitative Research

The quantitative research will comprise several surveys, including a feedback survey for individuals accessing the service, and pre-commencement and post-commencement surveys of service providers.

18.3.1 Feedback survey of service users

This will be an integral part of service delivery evaluation as the feedback from service users will help tailor the service according to their needs and also further improve service delivery.

Service users attending the DD service or those who have been discharged from it will be requested to complete a self-administered questionnaire on a cross-sectional basis. This can be done every three to six months or more frequently depending on the level of service delivery of individual DD teams.

Any outstanding complaints or issues arising from the feedback survey will be dealt with through the existing complaints procedures in the HSE, and it is recommended to make every effort to address the issue at the level of service delivery (see Appendix A for the feedback questionnaire).

18.3.2 Pre- and post-commencement survey of service providers

This survey will be completed by members of staff providing services to those with DD. It can be carried out among staff in the HSE Drug and Alcohol, Community Mental Health and Perinatal Mental Health services, and other organisations such as Section 39 agencies.

This survey will be completed in two stages. The pre-commencement survey (see Appendix B) should be completed before the commencement of the Dual Diagnosis service. The post-commencement survey (Appendix C) can be completed after one year of establishment of the DD service in their CHO among the staff members involved in the pre-commencement survey.

The findings of these two surveys should feed in to the service delivery of the local DD teams, support the delivery of appropriate training in their CHO and further enhance communication between various services, if necessary.

18.3.3 National data on Dual Diagnosis

Depending on future agreements, the Dual Diagnosis National Clinical Programme will endeavour to work in partnership with the Health Research Board/National Drug Treatment Reporting System (NDTRS), HSE Social Inclusion, and HSE Health and Wellbeing to collect DD data across Ireland. It will also seek to obtain this data through national data collection methods that may be implemented across the HSE in the future.

Data on the prevalence of Dual Diagnosis will include people with substance-use disorder, including disorders due to alcohol use and behavioural addictions of Gambling and Gaming with co-morbid mental illness such as anxiety disorders, depressive disorder and psychotic disorders.

The demographic details to be collected will include age, gender, ethnicity, employment status, relationship status, and homelessness (if any).

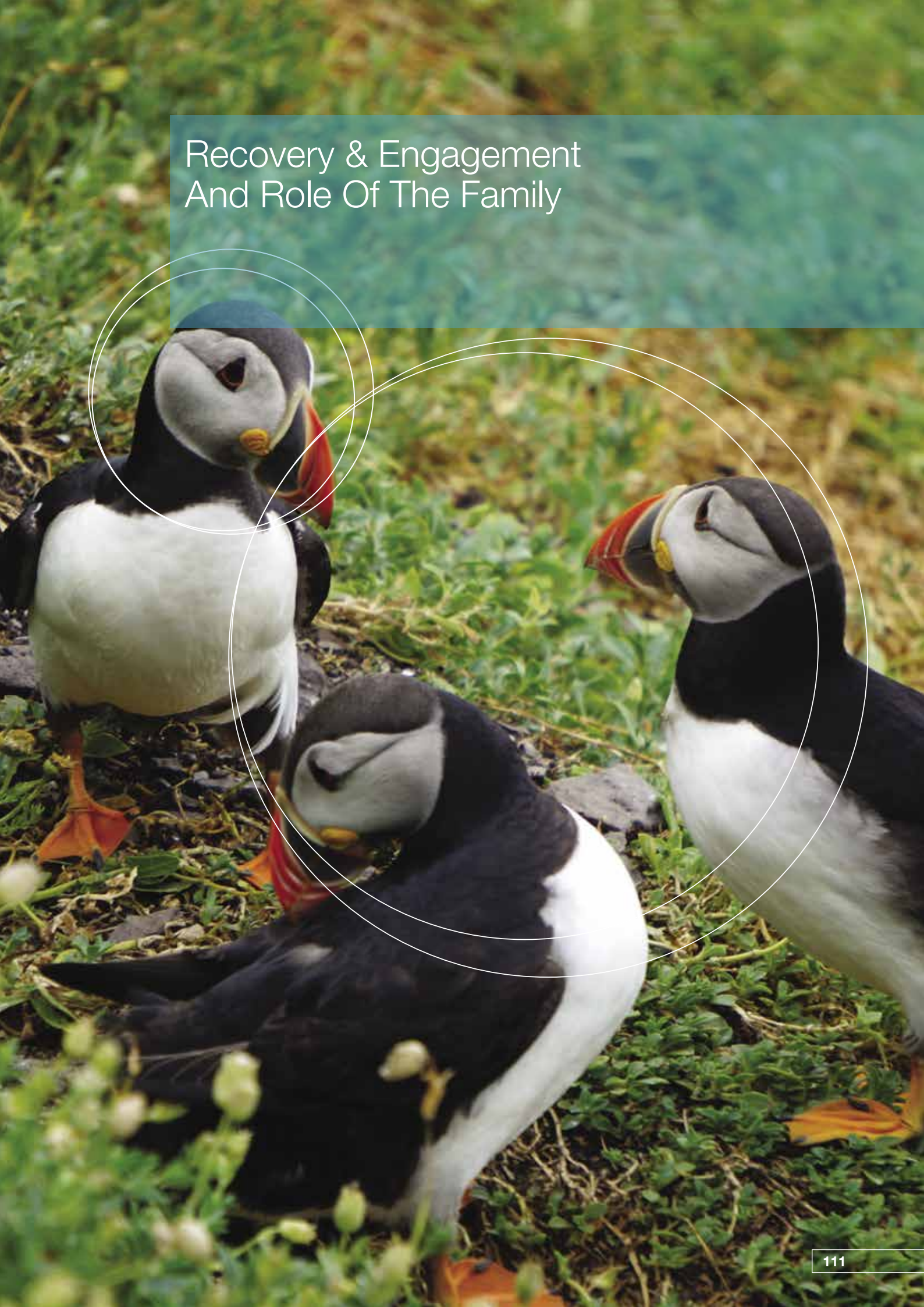
18.3.4 Monthly data collection for the DD services (KPIs)

The following data will be collected on a monthly basis as part of the performance indicators of each Dual Diagnosis service, and will be used to evaluate the service delivery at the CHO level for planning future service planning.

Year:	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Total	
Total number of referrals														
Number of referrals from HSE Drug & Alcohol services (HSE Social Inclusion)														
Number of referrals from CMHTs for Adults														
Number of referrals from Perinatal Psychiatry														
Number of Hospital Consultation referrals (choose from below)														
Consultation referrals from inpatient psychiatric units														
Consultation referrals from Liaison Psychiatry														
Number of referrals from other sources (if any)														
Number of referrals accepted														
Number of referrals not accepted														
Number of referrals assessed within 8 weeks														

Number of referrals which required working in partnership with another service such as a HSE organisation and/or voluntary body after assessment														
Outcome after assessment (choose from one below)														
Intervention completed by Dual Diagnosis service														
Did not follow up with the Dual Diagnosis service and discharged														
Referred back to HSE Drug and Alcohol services/CMHTs/ Perinatal Psychiatry														
Referred to others (such as GPs, medical teams)														
Number of inpatient admissions under Dual Diagnosis service in the last one month														
Average (mean) length of stay of inpatient-non rehabilitation admissions (to be collected on a 3-monthly basis)														
Number of admissions to inpatient rehabilitation services														

Recovery & Engagement And Role Of The Family



19 Recovery and Engagement and the Role of the Family

19.1 Mental Health Recovery and Engagement

HSE Mental Health Recovery and Engagement, in partnership with the Recovery Academy of Ireland, supported the development of the Model of Care by engaging with the National Working Group subgroup on Recovery Engagement and Capacity Building (RECB). This group – consisting of HSE Mental Health Recovery and Engagement, the Recovery Academy of Ireland and the DCU Recovery College – has already been working in a collaborative way across the mental health and addiction recovery and engagement forums.

The purpose of the Mental Health Engagement and Recovery element of the RECB subgroup was to support the NWG in developing and driving core service improvement programmes to develop recovery-oriented services for individuals with a Dual Diagnosis.

The Recovery Academy of Ireland (RAI) is a voluntary organisation made up of people in recovery, supporters, advocates, researchers and professionals who want to promote and champion the concept of recovery. International research shows that people can move from dependence on addiction services to a life of fulfilment, wellbeing and full participation in society. The purpose of the RAI on the RECB subgroup is to ensure that addiction recovery and mental health recovery work together to develop a whole-of-system mechanism to support dual recovery.

Furthermore, the Dublin North, North East Recovery College works to support local communities to reframe mental health in the direction of inclusion through providing mental health recovery education and community development programmes, which are open to everyone. Its work includes:

- Promoting engagement between the National Clinical Programme (NCP) and individuals with lived experience, ensuring that the programme is developed and delivered in line with the principles of co-production.
- Identifying training needs from a recovery perspective for both professionals and service users/family members/carers and identify appropriate training providers.
- Supporting the development of links across the HSE between the NCP and local leads in Recovery and Engagement.
- Supporting NCP in developing links with Recovery Colleges, the Recovery Academy of Ireland and the Recovery College network.

The recovery and engagement element will promote and support the benefits of peer support. This will be realised by supported peer workers working as a team across the Mental Health division, including the Dual Diagnosis specialist team (HSE), building and maintaining a community of advocates for recovery across the spectrum of Mental Health and Addiction services. This includes statutory, voluntary and academic partners. HSE Recovery and Engagement will also provide training to service providers and individuals with lived experience, in line with its strategic objectives.

19.2 Role of the Family

When an individual has a mental health problem, substance-use issue or both, it affects not only them individually, but can have an effect on the whole family: their relationships; physical health and daily lives. It is useful to contextualise the role of families in two ways:

1. *As an agent of change* – the family in some cases can provide a support network for the individual and often be an integral part of the care and recovery process.
2. *As service users in their own right* – because of the stress and strain associated with their loved one's challenges.

The family may have a unique insight into the difficulties that their loved one is facing, and so can be a valuable source of support if services work collaboratively with them. Families may experience high levels of stress, and may come up against issues such as confidentiality when trying to be a part of the care, their loved one is receiving. They may need information and skills to help them understand and cope better with the disorder and what their family is experiencing.

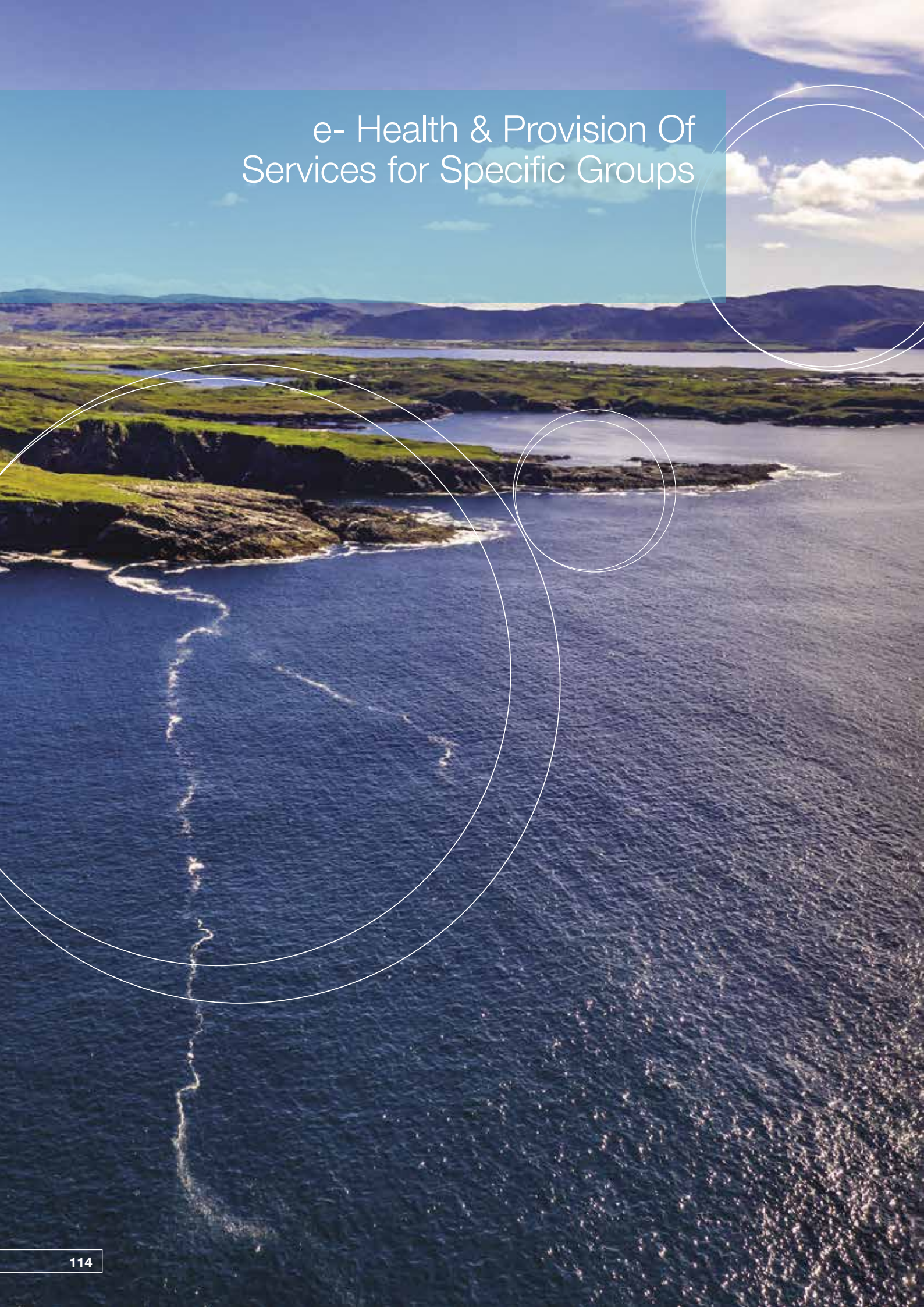
Research has shown that behavioural family therapy (BFT) is effective in reducing stress for people who experience mental health difficulties and their families. Behavioural Family Therapy is a way of working with families when a member of the family is experiencing a mental health or substance-use issue, or both. It aims to improve their relationships and help them identify solutions to problems. Therapy usually takes place in the family home unless the family prefers to meet somewhere else. This therapy can also be provided remotely.

The aim of the programme is to ensure that families have access to family-sensitive services and evidence-based interventions. The aim is to help improve communication within the family, enhance problem-solving skills and provide a comprehensive education on illness, treatment and relapse-prevention strategies. BFT is provided by an experienced team member of the Mental Health team. This therapist will have undergone specialist training and gets specialist supervision.

While the specialist DD team may not be able to provide the BFT interventions itself, it will make referrals, and provide support, advice and consultation to the community service supporting the family. The specialist team will ensure that the family remains linked in with the care being provided (with the consent of the individual in their care) and will provide necessary updates to the family support agencies.

As part of the individual's care plan, the specialist team will work with the supporting agencies to assist with addressing issues within the family, with and on behalf of the individual in their care. The team will ensure that a supportive non-judgemental partnership of support is provided to the individual in their care, their family and other related service providers, in line with best practice and with consent.

e- Health & Provision Of Services for Specific Groups



20 e-Health

In alignment with *Sláintecare,* e-health will play an important role in the Dual Diagnosis services. In the case of the Adolescent DD services, professionals in the spokes (i.e. CNS and Addiction Counsellor) will be using electronic means (HSE-approved video interfaces) to communicate with the hubs, particularly when supervision for clinical scenarios is required. It is expected that the professionals in the spokes in the Adolescent DD teams will be using HSE-approved e-health interfaces to communicate with service users (subject to consent by parents of the service users and the adolescent) when it is not possible for them to access the Adolescent DD services. In addition, it is envisaged that service users can link in with the spoke professionals and use their video interfaces for review by other members of the MDT in the Adolescent DD team hubs. The professionals in the hubs and spokes can also use the e-health system to provide consultations to inpatient adolescent units or join meetings in such units, and also liaise with inpatient rehabilitation centres as needed.

In the Adult DD services, e-health will be used to review service users (subject to their consent) as a way of outreach, particularly in scenarios where a DD team is covering a wide geographical area. It is important to emphasise, however, that face-to-face assessments and reviews are the preferred method, particularly in complex presentations. In addition, feedback from service providers and users relating to experience during the pandemic indicates that not all adolescents prefer remote consultations.

The video interfaces will also be used to conduct monthly and bimonthly multidisciplinary and multi-agency meetings when face-to-face meetings are not possible. In addition, there are plans to develop focused modules for DD service users on HSE-approved online platforms similar to online counselling services for depression and anxiety, provided free of cost by HSE at present. A major focus in these modules will also be on providing online self-support for substance-use disorders, including alcohol and behavioural addictions. In each DD service, the team members will be encouraged to use e-health to provide support groups for service users (subject to the consent of the service user) when face-to-face meetings are not feasible.

21 Provision of Services for Specific Groups

21.1 Services for Traveller/Roma community, homeless people, ethnic minorities, refugees, asylum-seekers and vulnerable women

The National Working Group recognises the high rates of mental health and substance-use disorders co-morbidity among Travellers/Roma community, ethnic minorities, refugees, asylum-seekers, vulnerable women (such as those in refuges and victims of domestic abuse) in addition to those suffering from homelessness.

The Dual Diagnosis services will offer the same level of access to these groups similar to all other service users, in conjunction with the Mental Health and Addiction services. The Dual Diagnosis Clinical Programme will take into account the needs of the above and other marginalised populations of Ireland. No barriers are envisaged in accessing these services through the pathways described in this Model of Care. The DD teams when established will be expected to work in collaboration with associated Section 39 agencies and voluntary bodies associated with the above marginalised groups.

21.2 Providing Services in Prisons

In the Irish Prison Service (IPS), medical services are largely provided by professional staff employed by the IPS. In the Dublin and Portlaoise/Midland prisons, mental health services are provided through in-reach (inside prisons) by services led by a Consultant Forensic Psychiatrist associated with the HSE National Forensic Mental Health Services based in Dublin. However, this varies across the country, particularly outside Dublin; some prisons have access to an in-reach mental health service only for part of the week, in addition to such forensic mental health teams being limited in resources. These services are often under the Clinical Governance of the HSE Mental Health Services in their respective Community Health Organisation (CHO).

Provision of addiction services in prisons also varies widely across the country, particularly in prisons outside Dublin. HSE Addiction services provide in-reach to the prison population in most of the Dublin prisons. However, outside Dublin, addiction services are provided in a limited manner by those professionals employed by the Irish Prison Service and/or by staff from Section 39 agencies. This variation in services creates a challenge in meeting the needs of those with DD, since the Dual Diagnosis Clinical Programme is envisaged as a tertiary service within the Dual Diagnosis Model of Care. As a tertiary service, the provision of DD services will largely depend on the existing service provision by the Mental Health and Addiction services, and the Clinical Programme when established is not envisaged to manage the gaps in such services as a tertiary service, due to the limited resources.

Hence, any consideration of DD service provision in prisons needs to be preceded by adequate mental health and addiction services being delivered in advance of such services being provided in the individual prisons. The Clinical Programme will be expected to engage with the Irish Prison Services in order to progress the issue of DD treatment provision in prisons in the future in line with the recommendations as below.

Considering the variation in clinical governance and varying service providers across the Irish prisons in the provision of mental health and addiction services, in addition to the resources involved, the National Working Group recommends that an interdepartmental group, involving the Departments of Justice and Health and other stakeholders, be set up to further explore the options of establishing Dual Diagnosis services in Irish prisons and a pathway for this. The Dual Diagnosis Clinical Programme recognises the challenges in managing DD in prisons and the need for collaboration between various services. For those attending probation services, no barriers are envisaged; they will have access to the DD services (when established) in their local regions similar to others in the same catchment area through the pathways described in this Model of Care.

Integrated Alcohol Services & Dual Diagnosis

22 Integrated Alcohol Services and Dual Diagnosis

Integrated Alcohol Services (IAS) are community alcohol services providing psychosocial and therapeutic interventions and family support, in addition to developing integrated care pathways between acute, primary care and addiction services. In Cork and Limerick, they are being established under the *Sláintecare Healthy Communities Programme*, which is led by HSE Health and Wellbeing, and is expected to expand to other regions over the coming years, subject to funding. Apart from these services, there have been separate funding sources for community-based alcohol services in Galway city and North Dublin. The community-based IAS teams consist of one Senior Addiction Counsellor, two Addiction Counsellors, one Dual Qualified Mental Health Staff Nurse/ Senior Staff Nurse, one Project Worker, and one Grade III Clerical Officer. Clinical governance for the service is provided at the CHO level by a clinical lead for Addiction Services in HSE Social Inclusion.

Pathways of care will be established between the Integrated Alcohol Services and Dual Diagnosis services at the local CHO level, in line with the referral pathway flowcharts 1 and 2 in the DD Model of Care. The detail of these pathways will be worked out at local level, depending on the available services. The learning identified through the evaluations of the delivery of both services will inform how these services integrate into the future. At a national level, the Dual Diagnosis Clinical Programme and HSE Integrated Alcohol Programme will collaborate on developing joint initiatives such as e-health, including digital interventions.

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Glossary of Terms and Acronyms

CMHT – Community Mental Health Team in the Health Service Executive

D & A services –- Drug and Alcohol services

DD – Dual Diagnosis

DSM – Diagnostic and Statistical Manual of Mental Disorders

ED – Emergency Department

EMCDDA – European Monitoring Centre for Drug and Drug Addiction

HSE – Health Service Executive

ICD – International Classification of Diseases

MDT – multidisciplinary team

MH practitioner – mental health service staff member

MH service – any mental health service

MoC – Model of Care

PPI – Personal and Public Involvement

SMART – specific, measurable, achievable, results-focused, time- bound

SUD – Substance-use disorder

WTE – whole-time equivalent

Appendices

Appendix A: Feedback Survey of Service Users Attending/Attended a Dual Diagnosis (DD) service

Please check the appropriate box before continuing the survey below

Currently attending the DD service ☐ **Attended the DD service in the past** ☐

1. I had no difficulty in being referred to the Dual Diagnosis service

Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐

2. I felt that my views were taken in to account in providing the appropriate management plan

Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐

3. I felt the views of my next of kin were taken in to account when providing the appropriate management plan

Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐ Not Applicable ☐

4. I was easily able to access the Dual Diagnosis service after the initial assessment

Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐

5. I felt that Dual Diagnosis service worked with other service providers such as the mental health teams, drug services or voluntary bodies to provide me the appropriate service

Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐

6. I felt that my social and occupational needs such as housing, social welfare, support for employment, studies were taken in to account when providing me with the appropriate service

Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐ Not Applicable ☐

7. I felt my psychological needs such as counselling for past difficulties such as childhood trauma were addressed when providing an appropriate service

Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐

8. I was able to access an inpatient bed as part of my management plan

Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐ Not Applicable ☐

9. I do not see the need for a specialist Dual Diagnosis service as it can be provided by other existing services such as the mental health teams, drug services, hospitals and voluntary bodies

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
☐	☐	☐	☐	☐

10. Overall I am happy with the service provided by the Dual Diagnosis team

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
☐	☐	☐	☐	☐

Any other comments/suggestions

Appendix B: Pre-commencement Survey of the Dual Diagnosis service for service providers

1. How confident are you about what is included in diagnosing someone with a Dual Diagnosis?

Not at all confident	Slightly confident	Confident	More confident	Very confident
☐	☐	☐	☐	☐

2. How confident are you in screening/assessing someone with Dual Diagnosis?

Not at all confident	Slightly confident	Confident	More confident	Very confident
☐	☐	☐	☐	☐

3. I am able to refer those with addiction and mental health issues to the appropriate service

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
☐	☐	☐	☐	☐

4. I am aware of the pathways for referral when someone presents with addiction and mental health issues

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
☐	☐	☐	☐	☐

5. I am satisfied with the outcome when I refer someone with addiction and mental health issues to an appropriate service

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
☐	☐	☐	☐	☐

6. The various service providers work in partnership and in an integrated manner to address the needs of those with addiction and mental health issues

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
☐	☐	☐	☐	☐

7. There is no difficulty in accessing inpatient beds for those presenting with addiction and mental health issues

Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐

8. I have no difficulty in accessing services for pregnant women when they present with addiction and mental health issues

Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐

9. I feel supported by the my service when dealing with issues such as any adverse incidents when dealing with those with addiction and mental health issues

Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐

10. Existing services can cater to the needs of those with addiction and mental health issues and there is no need for a specialist Dual Diagnosis Team

Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐

Appendix C: Post-commencement Survey of the Dual Diagnosis service for service providers

1. How confident are you about what is included in diagnosing someone with a Dual Diagnosis?

Not at all confident ☐ Slightly confident ☐ Confident ☐ More confident ☐ Very confident ☐

2. How confident are you in screening/assessing someone with Dual Diagnosis?

Not at all confident ☐ Slightly confident ☐ Confident ☐ More confident ☐ Very confident ☐

3. I am able to refer those with addiction and mental health issues to the appropriate service

Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐

4. I am aware of the pathways for referral when someone presents with addiction and mental health issues

Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐

5. I am satisfied with the outcome when I refer someone with addiction and mental health issues to an appropriate service

Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐

6. The various service providers work in partnership and in an integrated manner to address the needs of those with addiction and mental health issues

Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐

7. There is no difficulty in accessing inpatient beds for those presenting with addiction and mental health issues

Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐

8. I have no difficulty in accessing services for pregnant women when they present with addiction a nd mental health issues

Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐

9. I feel supported by the my service when dealing with issues such as any adverse incidents when dealing with those with addiction and mental health issues

Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐

10. Existing services can cater to the needs of those with addiction and mental health issues and there is no need for a specialist Dual Diagnosis Team

Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree ☐

Appendix D: Referral form for HSE Dual Diagnosis Services

Name	Date of Birth	Gender

Address:

Contact number	Allergies (if known)

Date of discussion of the referral with the service user (in case of adolescents, with their parent/guardian):

General Practitioner, address & phone number:

General Practitioner prescribing methadone/suboxone, address and phone number (if relevant and different to above):

Reason for referral (to include current substances of misuse including new psychoactive substances, alcohol, street tablets, prescribed medication misuse, behavioural addictions if any and the age of onset, duration and quantity/frequency of each)

Current medications including psychiatric medications, if any and dose of suboxone/methadone (if on them) including number of days attendance in a week in the community drug and alcohol service and number of take-aways per week (if relevant)

Urine drug screening results (to include last one month result(s) & indicate current or recent alcohol misuse if any)

Previous history of inpatient treatment for addiction disorder including private rehab placements/ inpatient treatment for mental illness and outcomes (if completed, left or relapsed later)

Initial presentation to the Community Mental Health Services for Adults/ CAMHS (in adolescents)/ Perinatal Mental Health Services/Liaison Psychiatry services (only for Consultations) and/or Community Drug & Alcohol services (to include substance misuse & mental health history if any) and progress while attending these services and duration of attendance with those services

Medical History (any relevant known history like heart problems and viral screen status if known)

Family history (relevant history of family history of addiction disorder and/or mental illness only)

Personal history (relevant history only)

Relationship history

Current place of living (homeless, supported housing, etc.)

Employment status

History of childhood adversities (history of abuse, childhood trauma, childhood stressful life events, etc.)

Number of children if any and any known child welfare concerns

Forensic history (including prison sentences, convictions and/or current pending charges and engagement with probation services as relevant)

Any other risk issues including behavioural issues (such as a history of violence, aggression) if any after/ while attending the referring services or other services if any.

Other services involved including inpatient private rehabilitation centres (if any)

Diagnosis after assessment:

Mental Illness diagnosis:

Addiction diagnosis:

Yours sincerely,

_____

Signature

If manually completed, please print name in capital letters below

Name of the referrer:

Designation:

Organisation:

Date of referral:

P.S. Please note that the lead care of this service user will remain with the referring team until stated otherwise in writing by the Dual Diagnosis team.

Appendix E: List of Contributors and Local DATF Involved in Service User Feedback

List of contributors:

The group would like to thank the following individuals for supporting the many conversations with people with a lived experience of a Dual Diagnosis and their family members who informed this important preliminary chapter.

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Local research was submitted by the following task forces:

Ballyfermot Local DATF	*Rapid Assessment and Community Response to suicide and suspected suicide in Dublin South (hse.ie)* *Microsoft Word - ABS_JI__FINAL__DRAFT_SWAAT__POST Luanch_June_25th_2021_ PRINTER_VERSION_.docx (ballyfermotldatf.ie)*
Finglas Cabra Local DATF	*https://www.drugsandalcohol.ie/31370/1/DCU-Dual-Diagnosis-A-Community-Perspective-2019.pd*

Appendix F: Competencies for Advanced Nurse Practitioners

Advanced Practice (Nursing), NMBI (2017)

Domain 1: Professional Values and Conduct of the Registered Advanced Nurse Practitioner (RANP)

Standard 1

The registered Advanced Nurse Practitioner will apply ethically sound solutions to complex issues related to individuals and populations.

Cues TO BE COMPLETED

Domain 2: Clinical Decision Making Competencies

Standard 2

Cues To be completed

Domain 3: Knowledge and Cognitive Competencies

To be completed

Domain 4: Communication and Interpersonal Competencies

TBC

Domain 5: Management and Team Competencies

TBC

Domain 6: Leadership and Professional Scholarship Competencies

TBC

For broad guide to indicative content within these domains, see Advanced Practice (Nursing) Standards and Requirements, https://www.nmbi.ie

Appendix G: Core Competencies and Associated Competencies

Core Concepts	Associated Competencies Components
Clinical Focus	· Articulates and demonstrates the concept of nursing and midwifery specialist practice within the framework of relevant legislation, *Scope of Nursing and Midwifery Practice Framework* (An Board Altranais 2000 a), *The code of professional conduct* (An Board Altranais 2000c) and Guidelines or Midwives (An Board Altranais 2001). · Possesses specially focused knowledge and skill in a defined area of nursing or midwifery practice at a higher level than that of a staff nurse/ midwife. · Performs a nursing/midwifery assessment, plans, and initiates care and treatment modalities within agreed interdisciplinary protocols to achieve patient/client-centred outcomes, and evaluates their effectiveness. · Identifies health promotion priorities in the area of specialist practice. · Implements health promotion strategies for patient/client groups in accordance with public health agenda.
Patient Advocacy	· Enables service users/service users, families and communities to participate in decisions about their health needs. · Articulates and represents patient/client interests in collaboration with the interdisciplinary team. · Implements change in healthcare services in response to patient/client need and service demand.
Education & Training	· Provides mentorship, preceptorship, teaching, facilitation and professional supervisory skills for nurses and midwives and other healthcare workers. · Educates patient/service users, families and communities in relation to their healthcare needs in the specialist practice. · Identifies own Continuing Professional Development (CPD) needs and engages accordingly.
Audit & Research	· Identifies, critically analyses, disseminates and integrates nursing/ midwifery and other evidence in to the area of specialist practice.
Consultancy	· Provide leadership in clinical practice and acts as a resource and role model for specialist practice. · Generates and contributes to the development of clinical standards and guidelines. · Uses specialist knowledge to support and enhance generalist nursing midwifery practice.

NOTES:

Dual Diagnosis

NATIONAL CLINICAL PROGRAMME

Clinical Design & Innovation

Person-centred, co-ordinated care

HSE Mental Health Services

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