APPENDIX 15: DESCRIPTION OF RESULTS BY THEMES FOR RQ 2.1: VIEWS AND EXPERIENCES OF PROVIDERS AND COMMISSIONERS

This appendix reports direct quotes coded as barriers or facilitators under relevant themes and sub themes for each included study. The section numbering and heading mirrors the headings in section 5 of the main report.

Barnes & Rudge (2003) [+]

5.3 Assessment and identification of service user needs

5.3.1 Assessment tools

Barriers

None reported

Facilitators

"MH nurses brought elements of AOD assessment into their clinical assessment"

“As a service [mental health] we got together and pulled elements of the D & A [drugs and alcohol] screening process. You know where it doesn’t just ask about whether you use alcohol - it actually goes into how much alcohol do you use, what’s its effects and who do you drink or smoke with - or whatever. It asks have you used D & A in the past and what was your pattern of use then - so we see them [the clients] more broadly - it’s part of our assessment. To be fair though, we didn’t just stop with D & A. We asked if they had a history of abuse or violence, because they can have an impact on your mental health. What we tried to do was get an overlap in the services through a weekly triage where we all met (D & A, women’s health, Aboriginal Health). What this has meant is that no one service does mental health. The mental state examination has moved into all assessments so we get intervention early. We haven’t got it perfect. Still some people fall through the gaps, but they are now more the exception rather than the rule. We even provide a caretaker role for each other, when we are away or they are on leave, we hand over clients we are concerned about to each other.”

5.5 Availability of resources

5.5.1 Lack of resources

Barriers

“A team leader in rural mental health service stated that DASC was ’stretched to the maximum, practically transparent’.”

Facilitators

None reported

5.6 Care co-ordination and effective inter-agency working

5.6.1 Co-ordinating care

Barriers

None reported

Facilitators

"To solve problems such as sharing care, the most practical way was to share the load. For this to happen she acknowledged that services that are not under the one organisational system have to become 'one' service through a process of referral, active communication (...) and (the provision of) mutual support".

“A guiding principle seems to be that the responsibility for care is considered as not residing in one nurse or service provider and the nurses (MH and AOD) position themselves as co-responsible for the outcomes for the client in the different fields of their expertise. (3) In practice we found that some nurses are dually educated and that led to the treatment being integrated in an individual nurse.”

“An AOD nurse provided an example of a process of co-case management of one client with complex needs that demonstrates the position of ‘pulling together”

"I had assessed this one client who had come to me for drug and alcohol issues. […] So what we did was, I referred him to the mental health team at the weekly triage as someone who needed their assistance for his depression, and that I would help him to deal with his smoking issues. So they worked with his depression, and I worked with him to reduce his smoking - last time I saw him he was only having two cones to help him sleep at night - and the mental health team said that his depression and life was now much easier to deal with and work through - I think that all worked well because we co-managed him and talked regularly at case management meetings about his progress... I think it works well because we deal with each other [as health professionals] in respectful ways - respectful of each other’s expertise.”

5.8 Pathways through the care system

5.8.1 Service access criteria

Barriers

"A point of view put forward by participants as absolutely essential to the co-managing of people with complex issues (…) was pulling the separated services together through a variety of practices at the local level."

A team leader in rural mental health service described her experience of 'hand-balling' clients backwards and forwards between services: "No we can't deal with you, you have a drug and alcohol problem - no we can't deal with you, you have a mental health problem".

Facilitators

None reported

5.9 Policy, structure and location of services

5.9.1 Co-location of services

Barriers

None reported

Facilitators

"What pulled the treatment together was a mix of formal and informal processes. Co-location of multiple service providers in the same building helped the process as did the closeness of other health facilities and non-government organisations. Policies provided a formalised arena of interaction while informal processes continued through corridor contact. The AOD nurse thought that despite the geographical spread of their clinical responsibilities throughout a rural health region, it was possible that the size of country towns and the closeness of health units within them worked in their favour. In another case, a man with depression was able to get rapid admission to the hospital. This was because he could walk down the road to the General Practitioner, then down the road to the hospital, passing by the AOD office to tell the nurse of his admission. The AOD nurse could then check the next day to see that the mental health nurse now knew about him and would be looking after him following his discharge from hospital. The nurses then shared information through formal and informal channels to manage his care."

Brown et al. (2002) [+]

5.9 Policy, structure and location of services

5.9.3 Cultural differences[1]

Barriers

“Staff working in the programs that treat dually diagnosed patients frequently encounter what they call "attitudes" among other staff members at both substance abuse and mental health treatment agencies. These attitudes can be generally characterised as resistance to the approach and/or questioning the knowledge of providers in the other type of agency.”

“A dual diagnosis coordinator explained that resistant attitudes, more than a lack of material resources, often impede the improvement of care for the dually diagnosed: I don't know if it's the dollars. I think it's more the attitudes and the people buying into this. Staff are feeling that they have competencies to serve this population and there are still very resistant attitudes. [Question: From both mental health providers as well as substance abuse?] I think it's more mental health.”

“One SA [substance abuse] treatment provider expressed her frustration with MH providers who do not respect her knowledge gained from working with dually diagnosed clients: You know, one of the things that I find so frustrating for me is, okay, I'm a drugs and alcohol professional- I'm not an MFCC, I'm not an MSW, I'm not an LCSW, I'm not an M.D., I'm not a Ph.D., I'm not a Psy.D. - I'm none of that, and I live with these people day in and day out and, excuse me, the [expletive] M.D. won't listen to me.”

Facilitators

None reported

5.10 Staff support, supervision and training needs

5.10.2 Training needs

Barriers

The implications […] are that expertise does, in fact, make delivery of services "better" and that traditionally delivered services are not good enough. Furthermore there is the suggestion of "sharing information," but with information "from above", i.e., where the expertise lies.

[1] Cultural differences here refer to the conceptualisations of drug and alcohol problems that services have and the implications for approaches to service delivery that follow from these differences

"Well, when I meet with the staff, essentially I'm very simple. I mean we do different things, but we just want to do it better. I mean that's what the bottom line is, to deliver these services and do it better. The clinicians have been doing it for years and have a lot of experience, but few of them have expertise. To begin to do it better, we need expertise in various ways, by coming together, sharing information, training, giving them all the information from above..."

"A provider who has achieved specialized and formally recognized training may not have as much interest in "staying down" in substance abuse treatment."

"Those people that we developed a relationship and rapport with, did the education and the training, they're gone to mental health now. You know, they get the training and the education and they move on and they move up. Training doesn't stick because of large turnover."

"One MH provider pointed out that even with a formal background, further training is needed for the people "on the floor", i.e. staff who directly deal with patients: I'd start with the lowest common denominator in terms of people that are on the floor with the clients, the mental health workers. And, I's start with training them. I'd take the lowest paid, the ones with the least amount [of] training coming in and I'd give them a lot of training. [...] On what is substance abuse, what is universal precautions, what are boundaries [...]."

Facilitators

None reported

Carey et al. (2000) [++]

5.4 Attitudes to service users with a dual diagnosis

5.4.1 Stigma and negative attitudes towards people with a dual diagnosis

Barriers

"In one group, two people voiced opinions that dually diagnosed patients may be treated too harshly or unfairly. One clinician spoke at length about the need to stop the prohibition and criminalization of drug use, and about the benefits of a European experimental program for chronic drug abusers that involved legalisation, intensive outreach programming."

Facilitators

"Harm reduction tactics were also stressed in two groups."

"One clinician reflected, "you really need to suspend your own values and judgments when things aren't working . . . you know, I also will let people use marijuana if they can lay off the crack.""

5.4.2 Relationship between practitioner and service user

Barriers

None reported

Facilitators

"All four groups (n=5) included at least one person who emphasized the need to be flexible and to adjust therapeutic actions to the patient's current concerns or level of functioning."

"One of the things I really try to do with people is find out where they are. If they want to deal with psychiatric stuff, if they want to work with other stuff, I go to wherever they are because [the issues] intertwine so easily. . . ."

"Client-centered or humanistic themes were mentioned in two groups (n=5). This included emphasis on listening to patients (n=4), and connecting with the patient as an individual (n=2). Similarly, clinicians commented on the importance of treating patients with dignity and acceptance."

"One clinician represented patients' sentiments as follows: 'Don't fix me, listen to me first'."

5.5 Availability of resources

5.5.1 Lack of resources

Barriers

"Two groups included members (n=4) that expressed frustration about lack of integrated psychiatric and substance use treatment, and patients falling into the gap between the two services. Clinicians reported that they sometimes find themselves in a bind regarding hospitalization, because a client may not fit agency parameters for either psychiatric or substance use treatment."

"Two groups voiced the need for more programs and/or training. These included additional treatment facilities, such as rehabilitation programs, residential programs, units dedicated to patients dually diagnosed with substance use and psychiatric disorders, and more dual diagnosis on existing units."

Facilitators

None reported

5.8 Pathways through the care system

5.8.1 Service access criteria

Barriers

"Two groups included members (n=4) that expressed frustration about lack of integrated psychiatric and substance use treatment, and patients falling into the gap between the two services. Clinicians reported that they sometimes find themselves in a bind regarding hospitalization, because a client may not fit agency parameters for either psychiatric or substance use treatment."

"we're not a substance abuse treatment center so that when we're doing this work, it's over and above the mental health treatment. And [it involves] resource stretching . . . Oh, yeah, let's add this other layer of treatment that we're not licensed for, we don't get paid for. . . . That makes it tough

Facilitators

None reported

5.10 Staff support, supervision and training needs

5.10.1 Staff support and supervision

Barriers

"Improved supervision was mentioned twice, as it is currently mandated but not done by people experienced in dual diagnosis."

Facilitators

None reported

5.10.2 Training needs

Barriers

"Two of these individuals raised the need for more training for professionals who work with this client group."

Facilitators

None reported

Coombes & Wratten (2007) [++]

5.4 Attitudes to service users with a dual diagnosis

5.4.1 Stigma and negative attitudes towards people with a dual diagnosis

Barriers

"Coping with the assumptions, prejudices and negative attitudes of colleagues was felt by the community mental health nurses to be as hard as working with clients. They were shocked by the judgemental responses of some members of the mental health team who saw people with a dual diagnosis as a waste of time and a low priority. This problem was particularly prevalent in the primary care setting."

"Mental illness is never greeted with open arms but if there is drugs or alcohol as well it's even worse."

"Consultant psychiatrists were often singled out as being distant from the world of dually diagnosed clients and of being moralistic about their client's lifestyles."

"You still have consultants who come from obviously different backgrounds who have a sort of authoritarian approach to drug use – we need to get away from telling people off for taking drugs because it doesn't work."

"Frequently the reputations of dual diagnosis clients meant that agencies and organizations were reluctant to provide necessary resources. Housing was a particular problem."

"You go into his house and there's bottles and piles of rubbish everywhere, the house is beyond the pale, he lives in absolute squalor, but doesn't want it changed."

Facilitators

None reported

5.4.2 Relationship between practitioner and service user

Barriers

"Dually diagnosed people required long-term commitment in order to build trusting relationships and to establish enough contact with them over time. Community mental health nurses felt that they never had enough time to achieve their goals of care."

"It's a long-term problem when you are dealing with people with complex needs like dual diagnosis, the need long-term input - you are looking at two to three years that they are going to be on your caseload."

“Community mental health nurses reported working with unpredictable, mentally disturbed and sexually inappropriate clients in situations that often felt unsafe.”

“He was worse when he smoked marijuana and in the end I couldn’t work with him – he was very unpleasant towards me and left me very frightened. It was the worst situation.”

Facilitators

None reported

5.5 Availability of resources

5.5.1 Lack of resources

Barriers

“In addition to the reluctance of services to be involved in the care of dual diagnosis clients, often the resources needed to provide quality care were not available.”

Facilitators

None reported

5.6 Care co-ordination and effective inter-agency working

5.6.1 Co-ordinating care

Barriers

“Coordinating care for clients was frustrating. There was lack of an agreed approach to dealing with clients who have a dual diagnosis. […] The community mental health professionals felt that they spent a lot of time chasing around for information and services to meet the needs of clients with a dual diagnosis, but most of this was unproductive.”

“She found that the team was pulling in different directions regarding the care of the client.”

“She found it frustrating that often care was not based on the needs of the client but on the needs of the mental health team (418).”

“In her experience working with colleagues is harder than working with clients with a dual diagnosis (323).”

“In her experience there is often disagreement in mental health teams about whether they should work with dual diagnosis clients (318).”

Facilitators

None reported

5.9 Policy, structure and location of services

5.9.3 Cultural difference

Barriers

"In her experience drug and alcohol workers have a different approach and it is not always clear what the rationale for interventions is."

Facilitators

None reported

5.10 Staff support, supervision and training needs

5.10.1 Staff support and supervision

Barriers

"There was an acute awareness among the community mental health nurses of the increased need for information and training about dual diagnosis."

"I find that as a professional dual diagnosis is very frustrating because it highlights my lack of skills – I need to get skilled up."

Facilitators

None reported

5.10.2 Training needs

Barriers

"Without clinical support and supervision the community mental health professionals felt isolated and vulnerable. They felt that they might unwittingly contribute to their client's problems through lack of knowledge, experience or insight."

Facilitators

None reported

Deans & Soar (2005) [+]

5.4 Attitudes to service users with a dual diagnosis

5.4.1 Stigma and negative attitudes towards people with a dual diagnosis

Barriers

"I think that there is a small percentage of GPs who understand people with a combined mental illness and drug and alcohol problem. The majority are less tolerant or they don't have the interest in it."

Facilitators

None reported

5.6 Care co-ordination and effective inter-agency working

5.6.2 Challenges with the service user group

Barriers

"Frustration was the dominant emotion expressed throughout interviews. Examples of this frustration were the description of working with clients who were slow to respond to treatments."

"I felt frustrated because you find it is very slow progress. Any goals that you set between yourself and your patient are very slow to achieve. There are a lot of setbacks because they are sabotaged because of the drugs."

"It's not like you are treating a person with paranoid schizophrenic where you get them stabilised and everything is okay. With dual diagnosis patients you've always have the difficulty of them using drugs, especially when they think it's helping their symptoms."

"Visiting unpredictable clients at home to render care and treatment was highlighted as increasing the risk factor to professionals. Health professionals do not know what state they are going to find the client in, given that drug/s can mask the illness"

"I mean it's really difficult to deal with someone when you go around to visit; they are drunk or high on drugs. You wonder if they going to be violent towards you, have they got hepatitis from using drugs? You might walk in to visit someone when they have got four people sitting around abusing drugs. You don't know if they are going to turn on you"

Facilitators

None reported

5.8 Pathways through the care system

5.8.1 Service access criteria

Barriers

"I think they're the most complex clients. I found them the most challenging and difficult and they tend to slip through all the service systems because health workers hand ball them all over the place."

Facilitators

None reported

5.10 Staff support, supervision and training needs

5.10.2 Training needs

Barriers

"Participants from all disciplines believe that their initial training was limited in regard to dual diagnosis."

"I don't think I was that prepared at all especially being young in psychiatry . . . it was quite daunting to work with people who had a dual diagnosis . . . Only maybe a lecture or two at University and then a lecture in a tutorial that was geared to the postgraduate as well so nothing really extensive."

Facilitators

None reported

Fonseca et al. (2012) [-]

5.8 Pathways through the care system

5.8.2 Organisation and continuity of care

Barriers

"The absence of other types of services was considered a barrier to co-ordinate care; 'the lack of long stay resources in our area and detoxification units'."

Facilitators

None reported

5.9 Policy, structure and location of services

5.9.1 Co-location of services

Barriers

"In rural areas, distances to the centres and a poor network of public transport were highlighted as barriers to treatment. Also, the absence of other types of services was considered a barrier to co-ordinate care; 'the lack of long stay resources in our area and detoxification units'"

"However, the co-location of services in the same center (i.e. centres that combine CAP, CAS and/or CSMA) was seen as a potential barrier for some patients (mainly alcohol users), due to the potential stigma that being recognised by family and friends while attending the addiction service might cause."

Facilitators

"Some patients and staff appreciated the location of addiction centres in general hospitals and also the location of CSMA [out-patient general psychiatry centres], CAP [primary care centres] and CAS [out-patient addiction centres] in the same location because it was easier to receive and coordinate care."

5.9.2 Integrating services

Barriers

None reported

Facilitators

"Many staff thought that integrating mental health and addiction sectors would improve access for patients with alcohol and drug problems"

"I think that (addiction) services should be integrated into the mental health network, because addiction is a mental disorder and should be seen as such by patients and staff."

5.10 Staff support, supervision and training needs

5.10.2 Training needs

Barriers

None reported

Facilitators

"'Better trained staff would improve patient's retention in treatment […] The need to improve detection' and 'improve drug addiction training in primary care professionals' was highlighted."

"'More training for staff in mental health and addiction sectors' would 'normalize these problems, at social and health levels'."

Hodges et al. (2006) [-]

5.3 Assessment and identification of service user needs

5.3.2 Health and well-being

Barriers

"Attention needed to be paid to the wider health and psych-social needs of the individual […]."

Facilitators

None reported

5.4 Attitudes to service users with a dual diagnosis

5.4.1 Stigma and negative attitudes towards people with a dual diagnosis

Barriers

"The law was seen as interfering with the flexibility need to deal with complex co-morbid problems. Substance misuse often prevented people from gaining access to mental health provision."

Facilitators

None reported

5.5 Availability of resources

5.5.1 Lack of resources

Barriers

"All services were perceived as being overstretched […]."

"[…] community care and addiction services were under-funded."

"More resources needed to be assigned to catering for those with severe needs."

“Financial constraints were seen as a potential barrier to appropriate service provision.”

Facilitators

None reported

5.5.2 Non-statutory sector

Barriers

“Attention needed to be paid to [...] and further development of voluntary services.”

The voluntary sector had limited capacity to cope with alcohol related problems. Different statutory services tended to concentrate on uniform problems which had led to an inefficient and disparate way of dealing with service users. Investment in the non-statutory sector was considered to be essential for the development of specific projects and services that the statutory sector was not able to provide on its own.”

Facilitators

None reported

5.6 Care co-ordination and effective inter-agency working

5.6.1 Co-ordinating care

Barriers

“GAP did not display a consistent approach in dealing with co-morbidity and there was a lack of uniformity in terms of service response and procedures. For example there were few case conferences and these patients were often not included in the Care Programme Approach (CPA).”

“Agencies viewed each other as competitors for finite resources and were reluctant to 'lose' their clients by referring them on.”

Facilitators

None reported

5.7 Involvement of, and support for, family and carers

5.7.1 Lack of carer support

Barriers

"Carer support was identified as a gap in service provision. Specific examples included children who informally care for one or both of their parents with either a substance misuse of mental health problem(s) or both."

Facilitators

None reported

5.8 Pathways through the care system

5.8.1 Service access criteria

Barriers

"General Adult Psychiatry (GAP) was reluctant to deal with patients who had drug or alcohol issues and might discharge them from their caseloads, even when an on-going and severe mental health problem existed. Specific psychological services were essentially non-existent for patients with addictions."

"[…] and situations arose where neither substance misuse nor mental health sectors took responsibility for these service users."

"Service users tended to be passed between services and inter-agency working did not always function efficiently."

Facilitators

None reported

5.8.2 Organisation and continuity of care

Barriers

"There was little attention paid to the care pathways of patients with co-morbidity. Although the NHS general psychiatry service and substance misuse services were normally part of the same directorate, they had traditionally been run as separate services."

"There was no specific integrated care pathway for co-morbid service users […]."

"Grampian's rural nature made the delivery and integration of certain services demanding."

Facilitators

"*A medical training position had been developed to provide some provision for co-morbid people who were also homeless. The development of direct links between psychology provisions and homeless services had helped to reduce waiting times and service bottlenecks*."

"Locality clinics, led by community mental health services, provided a one-stop shop for multi-professional advice, assessment and referral. These were helping to reduce waiting times and provide access to appropriate support and treatment interventions."

5.9 Policy, structure and location of services

5.9.2 Integrating services

Barriers

"The statutory and non-statutory sectors found working together challenging, especially when it involved sharing of budgets or contributions from different budgets. This was highlighted as a significant barrier to working out an appropriate strategy that actually targeted people's needs."

"Other views centred on the notion that a 'one size fits all' approach would be unlikely to favour all service users and might be unsuitable in certain areas, resulting in either limited benefits or no benefits at all. Commissioners with a wide remit of services were concerned about the complexity of integrated service provision and the potential for chaos and confusion as opposed to smooth and seamless functioning."

"A note of caution was expressed by commissioners who understood 'integrated' as 'holistic' care with all services coming together to address pertinent and wider needs. One commissioner raised the possibility that such an approach might have the unintended consequence of service users falling through the net because of a perceived threat to their daily life, such as the fear of child protection involvement. This showed a lack of awareness of the availability of published guidance and advice on Integrated Care Pathways and Managed Care Networks."

Facilitators

*“Integration as a concept, at the very least at a structural level, was viewed by the majority of commissioners as essential to effective and efficient service delivery, not only to co-morbid service users but to all service users with complex needs. […] Others explored the idea that sharing budgets on a needs-led and consumer-focused basis might lead to lowered conflict between services that currently have very different remits and might ring-fence resources to satisfy those responsibilities.”*5.9.3 Cultural differences

Barriers

“Differences in practice criteria and professional culture, especially between mental health and substance misuse services, required to be overcome.”

“Although partnership working was viewed positively, there were still outstanding cultural and attitudinal barriers, which were not helped by current financial strictures on health budgets.”

Facilitators

None reported

5.10 Staff support, supervision and training needs

5.10.2 Training needs

Barriers

"Attention needed to be paid to the wider health and psych-social needs of the individual, the need for increased training for staff and the further development of voluntary services. There was a dearth of diploma-qualified social workers, particularly in the core substance misuse and mental health teams."

“Traditional ways of working coupled with a lack of knowledge regarding co-morbid mental health and substance misuse issues further constrained the degree to which people receive or are referred to appropriate services.”

Facilitators

None reported

Holt & Treloar (2008) [-]

5.4 Attitudes to service users with a dual diagnosis

5.4.2 Relationship between practitioner and service user

Barriers

“So if you try and talk to somebody about the fact that you’re experiencing mental health problems, they’re more likely to say ‘Look, I don’t want to know about this; just leave me alone’. So people learn very quickly not to talk about it because nobody wants to know. The consequences of that are often that they [consumers] don’t develop the language, they don’t develop a positive and lucid way of talking about their mental health experiences because of this cut-off and not being allowed to.’”

Facilitators

“Providers from drug treatment and mental health services often said that they tried to avoid using clinical terminology with clients and emphasised the use of lay or client centred language.”

"‘When I’m talking to people, I tend to talk as much as possible in their own language… I think generally you hear people use comorbidity or dual diagnosis as a clinical term; it’s not necessarily something that’s used when you’re talking to people."

“Among service providers, there was a recognised need for drug treatment clients to develop ‘positive and lucid’ ways of talking about mental health to improve treatment outcomes”

Maslin et al. (2001) [-]

5.6 Care co-ordination and effective inter-agency working

5.6.1 Co-ordinating care

Barriers

“Overall, it was found that the main needs identified by staff were […] improved links between services.”

Facilitators

None reported

5.10 Staff support, supervision and training needs

5.10.1 Staff support and supervision

Barriers

“[...] the respondents felt that they needed additional support to enable them to work with clients experiencing combined severe mental health and substance use problems. Examples of the kind of support staff specifically identified included: [...] access to expert advice and support, supervision.”

Facilitators

None reported

5.10.2 Training needs

Barriers

“Overall, it was found that the main needs identified by staff were: information (about combined severe mental health and substance use issues and about non-specialist area, i.e. drug/alcohol use for mental health workers and mental health for substance misuse workers) [...].”

“Overall, it was found that the main needs identified by staff were [...] skills training to work with the client group, […], training in combined severe mental health and substance use problems.”

“The kind of information requested frequently focused on drug and alcohol awareness training.”

‘a greater understanding of what drugs actually look and feel like and what symptoms people are likely to present if they have taken drugs'

Facilitators

None reported

McLaughlin et al. (2008) [-]

5.3 Assessment and identification of service user needs

5.3.1 Assessment tools

Barriers

None reported

Facilitators

"The findings demonstrated that all of the DDWs would like to use an assessment tool that amalgamated criteria to assess both mental health and alcohol/drug use issues."

"I don't know if there's one tool specifically for the assessment of dual diagnosis. Everything that comes along is either a mental health tool or it's an addiction one. Perhaps they just need to be amalgamated."

5.6 Care co-ordination and effective inter-agency working

5.6.2 Challenges with the service user group

Barriers

"Fear because I've always received referrals for people that nobody else wants to work with. The chances of showing improvement would then be limited because we would be working with people resistant to change. We'll be working with people perhaps who have lost faith in themselves and the service."

Facilitators

None reported

5.8 Pathways through the care system

5.8.2 Organisation and continuity of care

Barriers

"Findings demonstrated that the participants were unsure of whom they could accept referrals from and what protocols were required for accepting referrals."

"Initially we [the peer group] thought that only consultant psychiatrists should make referrals, but we think that's too limited. Now we're suggesting that any key worker can refer to us. That means anybody who's in contact with a psychiatrist or has a client with a dual diagnosis."

"There isn't a policy on referrals in my area. So, we'll wait and see."

Facilitators

None reported

5.9 Policy, structure and location of services

5.9.2 Integrating services

Barriers

None reported

Facilitators

"Overall, the findings showed that all of the respondents were aware that there were two distinct treatment services providing care for people with a dual diagnosis. Mixed views were held on where their service should be located."

"When I went to the first meeting one of the managers wanted to know who I was working with and when I told her I was a dual diagnosis worker and I was based in 'addictions' her immediate reaction was 'well you shouldn't be there, you should be with us in mental health', so I think it will eventually go down the line of going into the mental health service."

"I think we should be sitting independently between the two, but having the ability to bring the two teams together rather than this separation."

"I feel protected as the dual diagnosis worker placed within the addictions service."

5.10 Staff support, supervision and training needs

5.10.1 Staff support and supervision

Barriers

Facilitators

"I get a lot of support from other dual diagnosis workers. They're the best people to bounce ideas off, particularly around clinical or complex issues. I've changed some of my ideas and practice after listening to my peer group. When I'm talking to my peer group we discuss the skills component of our job and how to improve practice."

"Clinical supervision is important because I'm on my own, being the only one employed in the Trust. I need it as I'll be working with a very difficult client group."

5.10.2 Training needs

Barriers

None reported

Facilitators

"The hope for further education and training was illustrated by another interviewee: 'I'm hoping that there could be some kind of team building in the service. Currently there is a lack of training for staff. Sometimes I'm not sure how to handle something so I tend to back away and say 'well that's someone else's problem'. So, we all need more training to build confidence in staff'."

Mericle et al. (2007) [+]

5.4 Attitudes to service users with a dual diagnosis

5.4.1 Stigma and negative attitudes towards people with a dual diagnosis

Barriers

"[clients] feared being stigmatized in substance abuse treatment because of their mental disorders."

Facilitators

None reported

5.5 Availability of resources

5.5.1 Lack of resources

Barriers

"With respect to improving treatment, providers in one focus group frequently mentioned lengthening treatment stays and creating more residential treatment facilities."

"Very long term residential treatment is what most of these patients need."

Facilitators

None reported

5.6 Care co-ordination and effective inter-agency working

5.6.2 Challenges with the service user group

Barriers

"Client-level barriers included barriers intrinsic to the clients that prevented them from directly confronting their substance use problems. The most frequently cited client-level barriers pertained to denial of substance use problems and to a lack of motivation to deal with these problems. With respect to denial, one participant

remarked: 'unfortunately, they are in denial, I mean, they even lie. I know they are using when I see that their lips are all burned from the pipe of crack but they insist they are not using'."

Facilitators

None reported

5.8 Pathways through the care system

5.8.2 Organisation and continuity of care

Barriers

"The majority of participants (82%) mentioned system-level barriers that pertained to how the current system of care was organized (or not organized) to treat seriously mentally ill clients with substance use problems."

"I find myself having to actually wait until the client is hospitalized before they can get into a program . . . The waiting list is too long. It's too complicated a process to get them in, so lots of times, they won't even get in until they're 5150'd [involuntary mental health detention in California]."

"Limited treatment options for individuals with co-occurring disorders and lack of continuity in care were also frequently cited."

"Some of the detox programs have helped our clients to the point of stopping for a short period of time . . . but the next step, there's usually a big gap, so they fall right back in."

Facilitators

None reported

5.10 Staff support, supervision and training needs

5.10.1 Staff support and supervision

Barriers

"A participant in the other focus group mentioned needing to discuss his client's substance abuse problems with his supervisor because he felt that he was not 'very strong' in that area."

Facilitators

None reported

5.10.2 Training needs

Barriers

"The most frequently cited provider-level barriers included the need to address competing treatment demands and a lack of training in substance abuse treatment."

"I don't know whether it's because I'm not skilled at it or really haven't focused on it but, I don't find that I use motivational interviewing. I mean I think about it sometimes and try to put it in but, I don't. I guess maybe I don't feel really comfortable or really have a sense of how to take that in a way that could seem to get somewhere."

Facilitators

None reported

Perryman et al. (2011) [+]

5.8 Pathways through the care system

5.8.1 Service access criteria

Barriers

"A large number of the respondents (38%) felt that clients with complex needs were poorly served by the treatment agencies. "Complex needs" encompassed clients that had additional problems including dual diagnosis, [...], or any client that was judged to be a "complex" case that may require more specialist care. Half of the residential agency staff reported this category as an issue for their services, and a third of community agency staff felt clients with complex needs were poorly served. People with dual diagnosis (mental health & alcohol) are often left untreated as neither types of service have the resources to treat the other."

Facilitators

None reported

Roberts & Darryl (2014) [+]

5.4 Attitudes to service users with a dual diagnosis

5.4.1 Stigma and negative attitudes towards people with a dual diagnosis

Barriers

"For many mental health clinicians, asking a patient about substance use was still felt to be taboo and inappropriate, something to be avoided as far as possible."

Facilitators

None reported

5.5 Availability of resources

5.5.1 Lack of resources

Barriers

“There was no consideration to the differences in the service systems and the capacity of the different service systems to be responsive. I thought it was some sort of weird joke. The intention is absolutely fine, but both service systems are probably under-resourced, and AOD more so.”

"Drug and alcohol has had virtually no new money for the last decade!. . .I think the VDDI was a good idea but it’s very small and so you’re really sending a boy on a man’s errand if you think it’s going to change rapidly"

Facilitators

None reported

5.6 Care co-ordination and effective inter-agency working

5.6.1 Co-ordinating care

Barriers

“A contrasting view pointed to undetected psychoses in the community and to the over-specialisation of MH services on people experiencing psychosis: there was a clear need to collaborate, as ‘mental health services don’t provide a service to a lot of people who need it’ (KI 5).”

“A lack of coordination was seen as a factor causing some delay and confusion, particularly in the matter of choice of screening tools and in the coexistence of state and national initiatives: ‘You had the national initiative and the state initiatives run out at the same time and there’s confusion between the two. . . different labels, different tools, agendas, staffing. I don’t think that helped’.”

Facilitators

None reported

5.9 Policy, structure and location of services

5.9.3 Cultural differences

Barriers

“One element of the cultural clash, according to key informants, is that the clinical mental health workforce tends to have a disparaging attitude toward the expertise of the substance use services workforce. They noted therapeutic pessimism about the value of substance use screening, assessment, and treatment and, moreover, an underlying sense of medical cultural superiority.”

“I think there is still a sense in mental health that we’re all skilled and trained and we’re one of the Big Five—nurse, doctor, social worker, psychologist, occupational therapist, whatever—and that the others [in alcohol and other drug and other sectors] are not . . . rather than that it’s a different model and different people are required for it. I think that’ll be a maturing when we all kind of work that out.”

“The second strong cultural difference identified in the interviews was between mental health practitioners' tendency toward paternalism and substance use practitioners' favoring of client autonomy.”

“As one informant put it, the mental health workforce was still adjusting (post-deinstitutionalization) to clients having more autonomy and being able to 'live their lives messily in the community'.”

“Third, attitudes toward use of medication in a given case can differ widely.”

“In psych, they’ll medicate for behavior. If someone’s behaving badly they’ll give them some medication to shut them up. In drug and alcohol you don’t medicate for behavior—it goes back to ‘you don’t treat a drug problem with a drug’.”

“Informants discussed the role of cultural attitudes toward substance use services and problems. Enduring barriers included ideology, policy, language, and client-related factors.”

“The cultures of the staff that do those jobs now in the public sector are a long way apart. . . . They are talking different languages, different conceptualizations of condition or problem. . . .The cultural differences between clinical mental health, psych disability support, drug and alcohol, and intellectual disability are significant. And I think that’s at the heart of it.”

“Informants, however, emphasised underlying attitudes: fear of ‘‘the other’’, social stigma and protectiveness of professional status. One noted that attitudes in MH were ‘based on myths and assumptions without really understanding the perspective of a substance user and hearing their story. . . Fear and ignorance are huge psychological factors in any health profession’ (KI 14). On status, there were

references to 'professional snobbery' on the part of MH clinicians (KI 11) and a need for a 'maturing' of interprofessional relationships (KI 12)."

Facilitators

None reported

Siddiqui et al. (2009) [+]

5.5 Availability of resources

5.5.1 Lack of resources

Barriers

None reported

Facilitators

"Staff unanimously stated that the expanded social work services…. [was] one of the most positive and beneficial aspects of the program for clients."

"The one thing that makes the biggest difference is that every client has a social worker. That's rare in therapeutic communities that every client has a social worker to see so I think that makes a big difference."

"Now everyone all of them have assigned social workers, they see them weekly or biweekly and that also helps them to go through the treatment process. So they get more attention that's what I want to say. More attention from staff."

5.6 Care co-ordination and effective inter-agency working

5.6.1 Co-ordinating care

Barriers

None reported

Facilitators

"Most of the study sample also indicated the existence of more collaboration and cohesion among staff within the MTC modality."

"In the past, the social workers and the case managers would rarely interface because each of their workloads was just so overwhelming. Now since we have like three more social workers, there's more interaction, there's more collaboration, and there's more opportunities for cross-fertilization of skills."

5.9 Policy, structure and location of services

5.9.2 Integrating services

Barriers

None reported

Facilitators

"One major theme that emerged consistently throughout the interviews was the comprehensive nature of the treatment provided at the facility. The staff's overall impression of the treatment provided within the MTC modality was positive, with many study participants indicating that the services are holistic, '…we've tried to create more of those specialized clinical groups to target those special populations. The more we have those small groups, I think it's also better'. As one staff member stated, 'Clients receive a lot of services … [the facility] is addressing the population of dual diagnosis well'. Another staff member elaborated on this sentiment and felt that 'the thing that makes us unique is that we have so many social workers and we have a vocational staff and we have the housing specialist'."

"Two staff members in this study also felt that services provided within an MTC and specifically at this facility were unique and cutting edge while also noting that the program service to fill a gap in treatment for a very specific subset of substance abusers that has for far too long been ignored in the clinical setting [...]."

"[…] I'm in the community all the time at professional meetings and stuff and there's just a desperate need for specialized services for those with co-occurring disorders and um I hope that … [co-occurring programming] expands because um I mean as they say this is the future, well the future is here as far as this is it, this is our population."

St Mungo's Broadway (2015) [-]

5.4 Attitudes to service users with a dual diagnosis

5.4.1 Stigma and negative attitudes towards people with a dual diagnosis

Barriers

"Instead, staff reported that mental health professionals were 'very quick at discharging 'unwilling to engage' clients with a severe and enduring diagnosis, rather than taking a look at what could be changed in their own practices (less prejudice, more creativeness, better joint work) that could improve engagement'."

"According to staff, attitudes to substance use among some mental health professionals remain poor. Despite evidence of a strong link between mental health

issues and substance use, the latter is still seen as a 'lifestyle choice' by many mental health workers."

Facilitators

None reported

5.6 Care co-ordination and effective inter-agency working

5.6.1 Co-ordinating care

Barriers

"joint work is a massive facilitator when it exists from early on, but very often the lack of it is a barrier to providing appropriate services and to making sure that service users have their needs met".

Facilitators

"Working with a range of services together can help early detection of deteriorating mental health, allowing early intervention and reducing the need of more costly interventions such as mental health in-patient treatment, or more traumatic interventions such as sectioning."

5.8 Pathways through the care system

5.8.1 Service access criteria

Barriers

"many people will not receive a service because mental health services will insist on the individual having detoxed from the various substances before they can diagnose, so therefore a good portion of our clients suffer by not receiving the service they need. The impact on others around them—fellow residents, family, friends, local community and staff—can be considerable."

"Where clients are diagnosed appropriately, staff indicate that a 'blanket' requirement that patients are abstinent during treatment is a significant barrier for people whose substance use issues are caused or exacerbated by mental ill health"

Facilitators

None reported

5.8.2 Organisation and continuity of care

Barriers

"When clients are denied access to or discharged from services at multiple points during their lives, continuity of assessment and care is often poor. In the experience of staff, this disjointed patient experience may lead to issues being missed, as clients are reluctant to engage with similar services after negative experiences. [...] Lack of continuity can exacerbate client engagement problems and lead to poor care plans and care quality."

Facilitators

None reported

5.10 Staff support, supervision and training needs

5.10.2 Training needs

Barriers

"Better training for mental health professionals on substance use is crucial to make services accessible and to improve understanding and empathy with clients."

"whilst plenty of studies indicate that dual diagnosis should be seen as the norm and not the exception, resources in terms of training and clear guidelines about strong liaison with physical health services are more often than not still lacking."

Facilitators

None reported

Sylvain & Lamothe (2012) [+]

5.4 Attitudes to service users with a dual diagnosis

5.4.1 Stigma and negative attitudes towards people with a dual diagnosis

Barriers

None reported

Facilitators

"All professionals considered the establishment of a relationship of trust – an "alliance" – with each patient as essential [...]. The result was that professionals spent more time in individual follow-up for these patients in order to encourage and support their participation in group treatment."

“Our goal is not so much that they change, but that they become involved and commit. The first step is to create an alliance.”

5.6 Care co-ordination and effective inter-agency working

5.6.1 Co-ordinating care

Barriers

“The sustained involvement of partners, with whom team members never managed to cooperate fully despite their considerable efforts, came to be considered as potentially detrimental and something to be restricted in order to prevent patients from ‘falling between the cracks’.”

Facilitators

“The dynamics of this particular team was influenced by importance given to co-therapy and team discussions. These occasions for interactions enabled a sharing of knowledge and experience, and favored the obtaining and maintaining of consensuses.”

5.9 Policy, structure and location of services

5.9.3 Cultural differences

Barriers

“The integration project tented to focus on the coordination of all clinical practices, including those of partners. However, coordinating actions with these partners was not obvious because of differences in treatment approaches.”

“Of course we are careful to make sure the person doesn’t get into a dangerous situation, but if the person consumes and this has no impact on his environment, we are not necessarily going to report him and get him hospitalized. But some partners see things differently: they will sometimes prevent the patient from going out because he consumed, and this includes going out for treatment [in our program]. So we have a patient who is trying to work on his problems but is punished for having consumed and then is cut off from services.”

Facilitators

None reported

Tiderington et al. (2013) [+]

5.4 Attitudes to service users with a dual diagnosis

5.4.2 Relationship between practitioner and service user

Barriers

“Where consumers were not open about drug use, this often became a barrier to good communication between the providers and consumers, although providers understood this to be influenced in part by consumers' previous experience with abstinence based programs.”

“I think that whole [harm reduction] model… everything about that falls apart if they are actively concealing something from us like using. Like, if there's walls there, then there's something that we can do to get through that. But there's this sense of being on edge and anxiety of… that I think compromises relationship….”

Facilitators

“*the openness of communication between consumer and provider served to reinforce a positive relationship. This open communication then presented greater possibilities for harm reduction conversations and practices to take place. When consumers were open about their use, providers experienced this as a willingness to at least discuss the possibility of reducing use.”*

“So once they bring it up or they talk about using then I'll go in and I'll be like, okay, you know, you're talking about—maybe they'll say, you know, ‘I want to stop.’ Okay, well since you want to stop I can help you with that. But I don't come out and say, ‘You need to stop.’ I don't want them to feel as though I'm trying to control them in any way. I don't want them to shut down on me.”

"When the consumer and provider did directly discuss a consumer's use, these discussions were often preceded by time spent building the relationship rather than an immediate focus on a consumer's substance use."

"And so typically when discussions about like using drugs comes up it's usually, you know, after so much time, after getting to know them, and we kind of begin to establish kind of a, you know, a trusting relationship and they feel comfortable talking about their drug and alcohol use. It's kind of like they just—you know, it's them bringing it up to me."

“Some providers described the impact a positive alliance could have on consumers' willingness to engage with substance abuse services and how providing a non-confrontational, supportive environment could facilitate communication.”