Severe mental illness and substance misuse (dual diagnosis): community health and social care services

Draft Review 2: Service user, family and carer, provider and commissioner views and experiences of health and social care services for people with a severe mental illness who also misuse substances

A systematic review

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1 EXECUTIVE SUMMARY

Dual diagnosis refers to people with a severe mental illness (including schizophrenia, schizotypal and delusional disorders, bipolar affective disorder and severe depressive episodes with or without psychotic episodes) combined with misuse of substances (the use of legal or illicit drugs, including alcohol and medicine, in a way that causes mental or physical damage). For people with a dual diagnosis, a good experience of health and social care is of particular importance not only because mental health outcomes are generally poorer than for people with either diagnosis alone but so are physical health outcomes as well as an increased demand on other services such as social care and the criminal justice system.

Different treatment philosophies, both within mental health services and between mental health and substance misuse services, can present barriers to the delivery of effective services. In addition, many substance misuse services expect some level of readiness to change, which may not be possible for some people with severe mental illness. Different service configurations (mental health and substance misuse are rarely co-located and are often managed through different agencies) may also militate against integrated provision. This can be further exacerbated by different funding streams underpinned by different objectives for the services and different budget priorities.

The National Collaborating Centre for Mental Health (NCCMH) was commissioned by NICE Centre for Public Health to conduct four evidence reviews to help inform the development of a guideline aimed at optimising service organisation and delivery of community health and social care services for adults and young people with coexisting severe mental illness and substance misuse. This systematic review is the second of these four evidence reviews and focuses on the views and experiences of health and social care community services for people with a severe mental illness who also misuse substances from the perspective of service users, their families or carers, providers and commissioners.

This review was conducted in accordance with *Developing NICE Guidelines: The Manual* (NICE, 2014). A systematic search was conducted in 16 electronic databases (for studies published from 2000 onwards) and 58 websites. This review considered data from qualitative studies such as face-to-face interviews, focus groups and surveys in order to address the following review questions:

- RQ 2.1: What are the facilitators and barriers for commissioners or practitioners in their commissioning or delivery of health and social care community services for people with a severe mental illness who also misuse substances?
- RQ 2.2: What are the facilitators and barriers to accessing and using health and social care community services, and to satisfaction with those services, for people with coexisting severe mental illness and substance misuse and their family or carers?

Qualitative data synthesis was guided by a “best fit” framework synthesis approach (Carroll et al. 2011). For review question 2.2, the thematic framework identified and

developed by the *Service User Experience in Adult Mental Health* guidance (NICE 2011; NCCMH 2012) was used as a starting point to systematically index and organise all relevant themes and sub-themes. For review question 2.1 this framework was adapted so that themes were relevant to a commissioner and practitioner perspective.

Overall, 35 studies met the inclusion criteria; 15 for RQ 2.1,18 for RQ 2.2 and 2 which met criteria for both RQ2.1 and RQ 2.2. The Critical Appraisal Skills Programme (CASP) checklist was used to assess the quality of qualitative studies included. Of the 17 studies identified for RQ 2.1, 2 studies were rated as high quality (++), 9 studies were rated as moderate quality (+) and the remaining 6 studies were rated as poor quality (-). Of the 20 studies identified for RQ 2.2, 2 studies were rated as high quality (++), 13 studies were rated as moderate quality (+) and 5 studies were rated as poor quality (-). The key findings from these studies are summarised below in evidence statements, ordered by key theme and sub-theme.

Review question 2.1: Views and experiences of providers and commissioners on the delivery or commissioning of health and social care services

Assessment and identification of service user needs

Evidence statement 2.1.1: Assessment tools

Two studies provided evidence of facilitators associated with assessment tools.

One Australian study (1[+][1]) and 1[-][2] UK study conducted in mental health and substance misuse services provided a consistent view that the incorporation of mental health and substance misuse assessment tools into a single assessment would facilitate the delivery of mental health and social care. This would make assessments more timely and efficient and reduce the likelihood of service users having restricted access to particular assessments because of their dual diagnosis.

Applicability to UK:
Although only 1 of the 2 studies was conducted in the UK, this evidence is directly applicable to the delivery of care in the UK.

[1]Barnes & Rudge (2003) [+]
[2]McLaughlin et al. (2008) [-]

Evidence statement 2.1.2: Health and wellbeing

One Scottish study 1[-][1] involving commissioners found evidence to suggest that the health and wellbeing of service users with a dual diagnosis needed to be addressed. No facilitators were identified.

Applicability to UK:
This evidence is directly applicable to the delivery of care in the UK because it is from a study based in Scotland.

[1]Hodges et al. (2006) [-]

Attitudes to service users with a dual diagnosis

Evidence statement 2.1.3: Stigma and negative attitudes towards people with a dual diagnosis

Seven studies provided evidence of barriers related to stigma and negative attitudes towards people with a dual diagnosis. No facilitators were identified.

Two UK studies (1[++][2] and 1[-][7]) conducted in community settings and the voluntary sector, 2 US studies (1[++][1] and 1[+][5]) conducted in mental health services and an intensive case management programme and 2[+][3,6] Australian studies conducted in a mental health service and other non-specified settings provided a consistent view that stigma and negative attitudes towards service users with a dual diagnosis may act as a barrier to the effective delivery of care. This prejudice was reported across the care pathway, within primary and secondary services, including community settings and was mainly reported as a negative attitude towards substance misuse within mental health settings, although 1[+][5] US study reported negative attitudes towards mental health diagnoses within a substance misuse service. One Australian study 1[+][6] also highlighted that stigma associated with substance misuse meant that some practitioners felt unable to talk about the use of drugs with service users.

One Scottish study (1[-][4]) of commissioners also found a consistent view that stigma and negative attitudes towards service users, as well as laws against substance misuse may act as a barrier to the effective delivery of care.

Applicability to UK:
Although only 2 out of the 7 studies were conducted in the UK, this evidence is directly applicable to practitioners or commissioners in the UK as societal attitudes towards mental health and substance misuse are broadly similar in Australia and Spain and to a slightly lesser extent in the US compared with those in the UK.

[1]Carey et al. (2000) [++]
[2]Coombes & Wratten (2007) [++]
[3]Deans & Soar (2005) [+]
[4]Hodges et al. (2006) [-]
[5]Mericle et al. (2007) [+]
[6]Roberts & Darryl (2014) [+]
[7]St Mungo's Broadway (2015) [-]

Evidence statement 2.1.4: Relationship between the practitioner and service user

Five studies provided evidence of barriers or facilitators related to the relationship between the practitioner and service user.

One UK study (1[++][2]) of community mental health nurses found that the misuse of drugs could have a negative impact on the relationship between practitioner and service user acting as a barrier to the effective delivery of care.

One UK study (1[++][2]) conducted in community settings, 2 US studies (1[++][1] and 1[+][5]) conducted in mental health services and an assertive community treatment service, 1[+][4] Canadian study and 1[-][3] Australian study conducted in mental health and substance misuse services provided a consistent view that good relationship between practitioner and service user could act as a facilitator to the effective delivery of health and social care. Factors that were deemed most important were having a person centred approach, using appropriate language and building a positive and open relationship. These elements were viewed as important facilitators for improving outcomes, engaging service users and effectively reducing the usage of drugs.

Applicability to UK:
Although only 1 out of the 5 studies was conducted in the UK, this evidence is directly applicable to practitioners in the UK as the nature of the relationship between practitioner and service user is likely to have a similar effect on the delivery of health and social care in Australia, Canada and the US.

[1]Carey et al. (2000) [++]
[2]Coombes & Wratten (2007) [++]
[3]Holt & Treloar (2008) [-]
[4]Sylvain & Lamothe (2012) [+]
[5]Tiderington et al. (2013) [+]

Availability of resources

Evidence statement 2.1.5: Lack of resources

Seven studies provided evidence of barriers or facilitators related to a need for additional resources.

Two US studies (1[++][2] and 1[+][5]) conducted in mental health services and intensive case management programmes, 2[+][1,6] Australian studies conducted in mental health and substance misuse services and a range of unspecified settings and 1[++][3] UK study conducted in community settings provided a consistent view that a lack of resources acted as a barrier to the effective delivery of health and social care. This was also found to compromise the quality of delivered care. One US study 1[++][2] outlined the need for more services specifically tailored to service users with a dual diagnosis.

One US based study (1[+][7]) involving practitioners from a dual diagnosis service for homeless reported that the provision of additional social workers could improve treatment outcomes for service users with a dual diagnosis.

One UK study (1[-][4]) of commissioners found consistent views whereby existing services were seen as stretched and that a lack of funding was seen as a barrier to the adequate provision of health and social care. In particular, additional resources were seen as necessary for service users with less severe needs.

Applicability to UK:
This evidence is partially applicable to practitioners and commissioners in the UK as only 2 out of the 7 studies were conducted in the UK and the remaining were in Australia and US. There is however a consistent picture across a range of healthcare settings of perceived under-resourcing of services for service users with dual diagnosis.

[1]Barnes & Rudge (2003) [+]
[2]Carey et al. (2000) [++]
[3]Coombes & Wratten (2007) [++]
[4]Hodges et al. (2006) [-]
[5]Mericle et al. (2007) [+]
[6]Roberts & Darryl (2014) [+]
[7]Siddiqui et al. (2009) [+]

Evidence statement 2.1.6: Non-statutory sector

One study provided evidence of a barrier and a facilitator associated with the non-statutory sector.

One Scottish study (1[-][1]) of commissioners found evidence that a lack of funding in voluntary services acted as a barrier to the provision of health and social care. However, investment in the non-statutory sector could facilitate the provision of integrated services when these were not provided in the statutory sector.

Applicability to UK:
This evidence is directly applicable because the included study was conducted in Scotland but needs to be considered in light of a significant shift to the provision of drug and alcohol services by non-statutory services in England in the last 10 years.

[1]Hodges et al. (2006) [-]

Care co-ordination and effective inter-agency working

Evidence statement 2.1.7: Co-ordinating care

Eight studies provided evidence of barriers or facilitators associated with the management of cases with members of the same team and across different health and social care agencies.

Three UK studies (1[++][2] and 2[-][4,8]) conducted in community settings, mental health and substance misuse services and a homelessness charity, 1[+][5] Australian study conducted in a range of unspecified settings and 1[+][7] Canadian study conducted in mental health and substance misuse services reported a consistent view that difficulties in the co-management of cases could act as a barrier to the provision of effective health and social care. This was attributed as being due to a lack of a shared approach in dealing with service users with a dual diagnosis which resulted in an inability to work collaboratively both within a team and across treatment agencies.

One UK study 1[-][3] involving commissioners found a consistent view that differences in practitioners' approach to dual diagnosis could act as a barrier to the delivery of health and social care.

One Australian study 1[+][1] conducted in rural mental health and substance misuse settings, 1[+][6] US study conducted in a dual diagnosis service for homeless service users and 1[+][7] Canadian study conducted in mental health and substance misuse services reported that the effective management of cases both within the same team and with practitioners from other agencies could act as a facilitator to the provision of health and social care. Aspects such as organising case-management meetings, sharing responsibilities and regular communication were seen as essential to the provision of health and social care for service users with a dual diagnosis. One UK study 1[-][8] conducted in a homelessness charity reported that the effective management of cases between agencies could help the early detection of mental health problems preventing the potential need for costly inpatient treatment or sectioning should symptoms deteriorate.

Applicability to UK:
Although only 4 of the 8 studies were conducted in the UK, this evidence is directly applicable to the delivery of care in the UK because issues regarding the co-ordination of care are not likely to differ in a significant way across countries.

[1]Barnes & Rudge (2003) [+]
[2]Coombes & Wratten (2007) [++]
[3]Hodges et al. (2006) [-]
[4]Maslin et al. (2001) [-]
[5]Roberts & Darryl (2014) [+]
[6]Siddiqui et al. (2009) [+]
[7]Sylvain & Lamothe (2012) [+]
[8]St Mungo's Broadway (2015) [-]

Evidence statement 2.1.8: Challenges with the service user group

Three studies provided evidence of barriers associated with the challenging nature of the service user group. No facilitators were identified.

One Australian study (1[+][1]) conducted in mental health services, 1[+][3] US study conducted in an intensive case management programme and 1[-][2] UK study conducted in mental health and substance misuse services consistently reported that the challenge of engaging with and co-ordinating care for service users with a dual diagnosis could act as a barrier to the provision of adequate health and social care. The main aspects of dual diagnosis which were deemed challenging were the current misuse of drugs and alcohol, which was found to interfere with the treatment of the mental health disorder, the complexity and long-enduring nature of the comorbid substance-use disorder, as well as service users' frequent denial of drug and alcohol problems or resistance to change.

Applicability to UK:
Although 2 out the 3 studies were conducted outside of the UK, this evidence is directly applicable to the delivery of care in the UK because the nature of the problems presented by service users with a dual diagnosis is not likely to differ between countries.

[1]Deans & Soar (2005) [+]
[2]McLaughlin et al. (2008) [-]
[3]Mericle et al. (2007) [+]

Involvement of, and support for, family and carers

Evidence statement 2.1.9: Lack of carer support

One study provided evidence of barriers associated with lack of support for carers of people with a dual diagnosis. No facilitators were identified.

One Scottish study (1[-][1]) involving commissioners found evidence that a lack of support for carers could represent a gap in the provision of services for people with a dual diagnosis. Children who informally care for one or both of their parents were singled out as requiring support.

Applicability to UK:
This evidence is directly applicable because the study was conducted in the UK.

[1]Hodges et al. (2006) [-]

Pathways through the care system

Evidence statement 2.1.10: Service access criteria

Six studies provided evidence of barriers associated with service access criteria. No facilitators were identified.

Two Australian studies (2[+][1,3]) conducted in mental health and substance misuse services, 2 UK studies (1[+][5] and 1[-][6]) set in community and residential alcohol services and a homelessness charity and 1[++][2] US study conducted in mental health services consistently reported that mental health and substance misuse services failed to take responsibility for service users with a dual diagnosis. This resulted in service users being denied access to mental health and substance misuse services and potentially being unable to receive appropriate physical or social care. This was found to negatively impact friends, family and the local community as well as the individual with a dual diagnosis.

One Scottish study (1[-][4]) of commissioners found consistent views that that mental health and substance misuse services failed to take responsibility for service users with a dual diagnosis.

Applicability to UK:
Although only 3 out of 6 studies were conducted in the UK, this evidence is directly applicable to the delivery of care in the UK. This is because issues regarding the movement of service users along the care pathway are influenced by the same factors, such as restrictive entry criteria, which hinders the uptake of service users with a dual diagnosis.

[1]Barnes & Rudge (2003) [+]
[2]Carey et al. (2000) [++]
[3]Deans & Soar (2005) [+]
[4]Hodges et al. (2006) [-]
[5]Perryman et al. (2011) [+]
[6]St Mungo's Broadway (2015) [-]

Evidence statement 2.1.11: Organisation and continuity of care

Five studies provided evidence of barriers or facilitators associated with a lack of organisation and continuity of care for service users with a dual diagnosis.

One Spanish study (1[-][1]) conducted in primary care, mental health and substance misuse services, 2[-][3,5] UK studies conducted in mental health and substance misuse services and a homelessness charity, and 1[+][4] US study conducted in intensive case management programmes reported a consistent view that barriers associated with the organisation of care for service users with a dual diagnosis. Issues were mainly regarding which practitioners should make referrals and the lack of long term continuing care for service users.

One Scottish study (1[-][2]) of commissioners found consistent views that pathways for service users with a dual diagnosis were deemed to be inadequately planned and supported. However, commissioners from one area also provided an example of good practice, whereby good links between mental health and homeless services were reported to reduce waiting times and improve the delivery of care to service users with a dual diagnosis.

Applicability to UK:
Although only 3 out of the 5 studies were conducted in the UK, this evidence is directly applicable to the delivery of care in the UK.

[1]Fonseca et al. (2012) [-]
[2]Hodges et al. (2006) [-]
[3]McLaughlin et al. (2008) [-]
[4]Mericle et al. (2007) [+]
[5]St Mungo's Broadway (2015) [-]

Policy, structure and location of services

Evidence statement 2.1.12: Co-location of services

Two studies provided evidence of barriers or facilitators associated with location of mental health and substance misuse services.

One Spanish study (1[-][2]), found mixed views on the co-location of services. While difficulties accessing multiple services, due to poor transport systems in rural areas, was seen as a barrier, the close proximity of services was also seen as an issue. More specifically the location of substance misuse services within the same building as primary care services, was seen as barrier. This was due to the stigma associated with being seen using substance misuse services by friends and family attending primary care services.

One Australian study (1[+][1]) conducted in mental health and substance misuse services and 1[-][2] Spanish study conducted in primary care, mental health and substance misuse services reported that co-location or close proximity of mental health and substance misuse services could act as a facilitator to the access of healthcare for service users with a dual diagnosis.

Applicability to UK:
Although none of the studies were conducted in the UK, this evidence is partially applicable to the delivery of care in the UK because issues regarding the co-location of services are unlikely to differ across countries.

[1]Barnes & Rudge (2003) [+]
[2]Fonseca et al. (2012) [-]

Evidence statement 2.1.13: Integrating services

Four studies provided evidence of barriers or facilitators associated with the integration of mental health and substance misuse services.

One Scottish study (1[-][2]) of commissioners found evidence of barriers and facilitators associated with the integration of services. Complexities in achieving a seamless integrated service were highlighted. There was also confusion about the perceived function of an integrated service, with some commissioners viewing it as a holistic service which would address wider social care needs, such as child protection. Despite such barriers the authors stated that the majority of commissioners felt that integrating services would be essential for the effective and efficient delivery of care for service users with complex needs. Additionally, some commissioners noted that relationships between different services could be expected to improve if they were required to share budgets and resources.

One Spanish study (1[-][1]) conducted in primary care, mental health and substance misuse services and 1[+][4] US study conducted in a dual diagnosis service for homeless service users reported on the need for integrated services to improve access to health and social care for service users with a dual diagnosis. In 1 UK study (1[-][3]), dual diagnosis workers had mixed views regarding the way in which integrated services should be structured. Some favoured a separate dual diagnosis services, whilst others preferred being based in a mental health service or a substance misuse service.

Applicability to UK:
Although only 2 out of the 4 studies were conducted in the UK this evidence is partially applicable to the delivery of care in the UK because issues associated with the increased integration of services are likely to be similar between countries.

[1]Fonseca et al. (2012) [-]
[2]Hodges et al. (2006) [-]
[3]McLaughlin et al. (2008) [-]
[4]Siddiqui et al. (2009) [+]

Evidence statement 2.1.14: Cultural differences

Five studies provided evidence of barriers associated with cultural differences[1] between services in terms of their approaches to dual diagnosis. No facilitators were identified.

One UK study (1[++][2]) conducted in community settings, 1[+][1] US study conducted in mental health and substance misuse services, 1[+][4] Australian study conducted in a range of unspecified settings and 1[+][5] Canadian study conducted in mental health and substance misuse services reported a consistent view that different conceptualisations and the consequent approach adopted to the delivery of care between mental health and substance misuse services acted as a barrier to the provision of care. These differences were also found to strain working relationships between staff from mental health and substance misuse services. This was particularly reported as a problem experienced by substance misuse practitioners who felt their views or expertise was often ignored by mental health professionals.

One Scottish study (1[-][3]) involving commissioners found a consistent view that cultural differences may jeopardise partnerships between services.

Applicability to UK:
As only 2 out of the 5 studies were conducted in the UK this evidence is only partially applicable to practitioners, commissioners and the delivery of care in the UK.

[1]Brown et al. (2002) [+]
[2]Coombes & Wratten (2007) [++]
[3]Hodges et al. (2006) [-]
[4]Roberts & Darryl (2014) [+]
[5]Sylvain & Lamothe (2012) [+]

[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

Staff support, supervision and training

Evidence statement 2.1.15: Staff support and supervision

Five studies provided evidence of barriers or facilitators for the effective delivery of health and social care related to staff support and supervision.

Three UK studies (1[++][2] and 2[-][3,4]) and 2 US studies (1[++][1] and 1[+][5]) conducted in mental health services, substance misuse services, community settings and an intensive case management programme provided a consistent view that a lack of adequate support and clinical supervision acted as a barrier to the delivery of effective treatment. Examples of support included access to expert consultation and advice.

In 1[-][4] UK study which interviewed recently appointed dual diagnosis practitioners, the receipt of support from other practitioners was seen as a facilitator to the delivery of care.

Applicability to UK:
Although only 3 of the 5 studies were conducted in the UK, this evidence is directly applicable to practitioners in the UK because issues regarding staff support and supervision are not likely to differ across countries.

[1]Carey et al. (2000) [++]
[2]Coombes & Wratten (2007) [++]
[3]Maslin et al. (2001) [-]
[4]McLaughlin et al. (2008) [-]
[5]Mericle et al. (2007) [+]

Evidence statement 2.1.16: Training needs

Ten studies reported that a lack of training may act as a barrier to the effective delivery of care for service users with a dual diagnosis. No facilitators were identified.

Four UK studies (1[++][3] and 3[-][7,8,10]) conducted in community settings, mental health and substance misuse services and a homelessness charity, 3 US studies (1[++][2] and 2[+][1,9]) conducted in mental health services and an intensive case management programme, 1[+][4] Australian study conducted in a mental health service and 1[-][5] Spanish study conducted in primary care, general psychiatry and specialised addiction centres provided a consistent view that a lack of adequate training and education acted as a barrier to the delivery of effective services and care. Examples include more specific training in substance misuse, dual diagnosis and about how to improve links with physical health services.

One Scottish study 1[-][6] of commissioners also found a consistent view that a lack of training could act as a barrier to the effective delivery of services.

One 1[+][1] US based study additionally found that delivering extra training to staff in substance misuse services may result in the loss of staff to mental health services.

Applicability to UK:
Although only 5 out of the10 studies were conducted in the UK, this evidence is directly applicable to practitioners or commissioners in the UK because issues regarding training are not likely to differ across countries.

[1]Brown et al. (2002) [+]
[2]Carey et al. (2000) [++]
[3]Coombes & Wratten (2007) [++]
[4]Deans & Soar (2005) [+]
[5]Fonseca et al. (2012) [-]
[6]Hodges et al. (2006) [-]
[7]Maslin et al. (2001) [-]
[8]McLaughlin et al. (2008) [-]
[9]Mericle et al. (2007) [+]
[10]St Mungo's Broadway (2015) [-]

Review question 2.2: Views and experiences of service users, their family and carers of health and social care services

Attention to physical and environmental needs

Evidence statement 2.2.1: Housing issues

Evidence from 6 studies showed that people with a dual diagnosis face a number of barriers or facilitators when seeking to access social care services, particularly housing support.

Two US studies (2[++][3,6]) and 1 Swedish study (1[+])[1] reported consistent evidence suggesting that a failure to provide an adequate level of housing support or a suitable living environment for people with a dual diagnosis could have a negative impact on service users with the potential to trigger a relapse. One US study (1[++][3]) provided evidence to suggest that the lack of transitional support back into the community, as well as the social stigma associated with seeking assistance, were both factors that constituted barriers to accessing housing. The latter point was also reflected in another US study (1[+][5]), which in the context of seeking independent housing, also described how financial constraints and previous criminal convictions could act as barriers to accessing accommodation, and how long waiting lists were prohibitive when seeking access to supervised housing. This study also described a lack of choice of housing options for service users.

Views of supported housing were mixed. One US study (1[++][6]) and 1[+][1] Swedish study suggested that supported housing was often inadequate with reports of high levels of crime and unkempt facilities which had a detrimental impact on service users' health. Yet the same Swedish study ([+][1]) also suggested that 'special housing' could have a positive impact on service users, enhancing feelings of independence.

One Scottish study (1[-][2]) reported that voluntary services may facilitate access to accommodation for people with a dual diagnosis.

Applicability to UK:
Only 1 of the 6 studies was conducted in the UK (in Scotland), while the rest were conducted in either the US or Sweden. Despite the fact that most of these studies were not UK based, general themes such as the impact of poor transitional care, social stigma in regards to seeking support, and the deleterious effect of poor housing on both physical and mental health are likely to be directly applicable to most healthcare settings irrespective of geographical location.

Comments made relating to transitional care emerged in the specific context of women transitioning back to the community from prison. Nevertheless, these themes are still directly applicable to other transitional contexts (for example, when service users transition from inpatient care to community settings).
Some of the financial barriers to accessing housing support are only likely to be partially applicable to a UK setting. For example, whilst a landlord accepting

federal rental subsidy housing vouchers is US specific[5], a UK landlord discriminating against individuals in receipt of UK social security benefits is analogous.

[1]Cruce, Öjehagen & Nordström (2012) [+]
[2]Hodges et al. (2006) [-]
[3]Johnson et al. (2013) [++]
[4] Penn, Brooks & Worsham (2002) [+]
[5] Tsai et al. (2010) [+]
[6] Villena & Chesla (2010) [++]

Evidence statement 2.2.2: Employment issues

Evidence from 3 studies showed that individuals with a dual diagnosis face a number of barriers or facilitators when seeking to access support in regards to gaining employment.

Evidence from 1[++][1] US study described how service users with a dual diagnosis face difficult obstacles when seeking to access social care services, particularly employment support. This study also provided evidence to suggest that possessing a criminal record had a negative impact on re-entry into the community and employment prospects. One US based study (1[+][3]) similarly described a lack of support for people who wish to return to work, which acted as a barrier to gaining employment.

In contrast, 1[+][2] Canadian study outlined that services offering vocational support facilitated engagement with young people with a dual diagnosis.

Applicability to UK:
None of the studies reporting on this theme were conducted in the UK. Despite this, the importance of providing employment support for members of this population is a theme that is directly applicable to most job seeking individuals within this population, irrespective of geographical location.

[1]Johnson et al. (2013) [++]
[2]Kozloff et al. (2013) [+]
[3]Penn, Brooks & Worsham (2002) [+]

Clear, comprehensible information and support for self-care

Evidence statement 2.2.3: The provision of information/ training

Two studies reported on barriers or facilitators associated with access to clear and comprehensible information and support for self-care.

Evidence from 1[-][2] UK study revealed that a failure to signpost support services resulted in a barrier to accessing information in relation to community groups. In particular, GPs were described as being unaware of local community groups which service users could access for support.

Evidence from 1[+][1] Swedish study described how the provision of self-care skills training facilitated activities of daily living, such as housework, road safety and occupational support. Undertaking such activities was viewed as an essential part of the recovery process which could help prevent relapse.

Applicability to UK:
Although only 1 of the 2 studies was conducted in the UK, the views expressed are broadly transferable across geographical locations and are therefore directly applicable within the UK context.

[1]Cruce, Öjehagen & Nordström (2012) [+]
[2]Rethink (2015) [-]

Continuity of care and smooth transitions

Evidence statement 2.2.4: Fragmented care

Evidence from 7 studies outlined barriers or facilitators associated with the impact of fragmented care provision on continuity of care for people with a dual diagnosis.

Two US studies (1[++][6] and 1[+][1]), 1[-][3] Scottish study and 1[-][7] UK study reported a consistent view that fragmented care provision could have a negative impact on service users' experience of care and willingness to engage with services. The common thread running through these service user accounts was that they felt that high staff turnover rates, coupled with inconsistent care provision, eliminated the possibility of building trusting relationships. This resulted in a negative perception of staff, apathetic responses to treatment and an unwillingness to engage.

One US study (1[++][4]) and 1[+][5] Canadian study revealed a consistent view that transitional care from prison back into the community was particularly fragmented. In the 1[++][4] US study, female ex-offenders described how their relapse was in part due to an inability to access services. In the 1[+][5] Canadian study young people described difficulties in accessing addiction counselling when moving back into the community, even when these were conditions of their bail order.

One Swedish study (1[+][2]) revealed the benefits of consistent care, which in turn facilitated engagement. Service users described an enhanced sense of trust in healthcare professionals, and this was said to positively impact the recovery process. In 1[-][7] UK study, good after-care was viewed as an important aspect for preventing relapse.

Applicability to UK:
Of these 7 studies, 2 were conducted in the UK and are therefore directly applicable. The rest of the evidence came from studies conducted in the US, Canada and Sweden, however the barriers to engagement identified are directly applicable to the UK setting.

[1]Brooks et al. (2007) [+]
[2]Cruce, Öjehagen & Nordström (2012) [+]
[3] Hodges et al. (2006) [-]
[4]Johnson et al. (2013) [++]
[5]Kozloff et al. (2013) [+]
[6]Villena & Chesla (2010) [++]
[7]VoiceAbility 2014 [-]

Effective care delivered by trusted professionals

Evidence statement 2.2.5: Care environment

Evidence from 9 studies revealed that people with a dual diagnosis face numerous barriers and facilitators when seeking access to effective care delivered by trusted professionals. These included issues related to an appreciation of cultural sensitivities, the role of stigma, and issues pertaining to staff/financial resource that impact the delivery of care. Facilitators included the role of the non-statutory sector and good relationships with staff.

Overall, 9 studies reported on barriers associated with access to effective care by trusted professionals. Of these, 1[++][8] US study, 1[+][1] Norwegian study and 1[+][7] Finnish study provided consistent evidence to suggest that service users' mistrust of health and social care professionals was a common reason for poor engagement with services. One UK study (1[+][9]), 1[+][5] US study and 1[-][3] Scottish study provided evidence to suggest that a lack of adequate staffing resources appeared to impair the ability of service users to access effective care. The UK study (1[+][9]) also suggested that a failure to recognise the cultural differences of black and minority ethnic individuals was a barrier to accessing care. There were consistent views from 2[-][2,6] UK studies, 1[++][8] US study and 1[-][4] Australian study suggesting that stigma acted as a barrier to access. The US study (1[++][8]) found that negative stereotyping by healthcare professionals hindered access to treatment for physical health problems. The Australian study (1[+][4]) and 1[-][6] UK study described how having a dual diagnosis had a particularly negative connotation. In the 1[-][6] UK study a service user with mental health problems described how they did not access care for drugs and alcohol specifically to avoid being labelled as having problems with both mental health and addiction.

One Norwegian study (1[+][1]), 1[+][5] US study and 1 [-][2] UK study described factors which facilitated access to care for people with a dual diagnosis. In 1[+][1] Norwegian study evidence was provided to support the use of outreach services to facilitate access to effective care, as did good service user and healthcare practitioner relationships. The UK study (1[-][2]) outlined that service users were likely to report positive experiences of voluntary service provision, including quick access to services and good relationships with staff. In 1[+][5] US study the provision of childcare was also regarded as a means for facilitating engagement with services.

Applicability to the UK:
Four of the 9 studies were based in the UK and are therefore directly applicable. The rest were based in the US, Europe and Australia. Irrespective of the fact that the majority of the data were drawn from non-UK based studies, the findings are highly salient within a UK context. Themes pertaining to service user mistrust and failure to engage due to poor provision appear broadly transferable across multiple settings or geographical location. However, generalisability of some findings may be limited in some instances. For example, impeded access to healthcare services due to a lack of child care support only affects those with children.

[1]Edland-Gryt & Skatvedt (2013) [+]

[2]Fraser et al. (2003) [-]
[3]Hodges (2006) [-]
[4]Holt & Treloar (2008) [-]
[5]Kuo et al. (2013) [+]
[6]Rethink (2015) [-]
[7]Sorsa & Åstedt-Kurki (2013) [+]
[8]Villena & Chesla (2010) [++]
[9]Warfa et al. (2006) [+]

Evidence statement 2.2.6 Integrated approach to care

Evidence from 9 studies outlined barriers or facilitators associated with an integrated approach to care.

Two US studies (1[++][4] and 1[+][1]) and 2[-][8,9] UK studies outlined barriers faced by service users when accessing effective care. These studies found that a failure to integrate care impeded access to effective treatment, resulting in some service user needs being overlooked.

Evidence from 5 US studies (1[++][4] and 4[+][1,3,6,7]), 1[+][2] Swedish study, 1[+][5] Canadian study and 2[-][8,9] UK studies provided consistent evidence to suggest that people with a dual diagnosis derived benefit from an integrated approach to care that addressed their multiple needs. The benefits of this approach included increased access to medical, social or psychological care, and increased engagement resulting in positive changes in health, functioning and psychological wellbeing.

Applicability to UK:
Two of the 9 studies were conducted in the UK and are therefore directly applicable. Though the remaining studies were not UK based, this theme is transferable across geographical locations, and as a result, it is directly applicable within the UK context.

[1]Brooks et al. (2007) [+]
[2]Cruce, Öjehagen & Nordström (2012) [+]
[3]Edward & Robins (2012) [+]
[4]Johnson et al. (2013) [++]
[5]Kozloff et al. (2013) [+]
[6]Kuo et al. (2003) [+]
[7]Luciano & Carpenter-Song (2014) [+]
[8]Rethink 2015 [-]
[9]VoiceAbility (2014) [-]

Emotional support, empathy and respect

Evidence statement 2.2.7: Relationships with healthcare professionals

Evidence from 8 studies suggested that the nature of relationships between healthcare professionals and service users can act as either a barrier or facilitator to the receipt of empathic, respectful and emotionally supportive healthcare.

Three US studies (1[++][7] and 2[+][2,4]), 1[-][3] Scottish study and 1[-][8] UK study consistently described how service user and practitioner relationships that are characterised by a lack of empathic understanding and emotional support can act as a barrier to service user engagement with healthcare and support services. Additionally, 1[++][4] US study also found that women released from prison regard some community treatment programmes as being overly punishing and judgmental, which can result in a disinclination to engage with support.

Evidence from 1[+][1] Swedish study, 1[+][5] Canadian study, 1[-][3] Scottish study and 1[-][6] UK study suggested that the ability of healthcare practitioners to confer a sense of respect and act empathically enhanced feelings of self-worth and promoted engagement with services.

Applicability to UK:
Three of the 8 studies were conducted in the UK, while the rest were from Sweden, the US and Canada. All studies are considered to be directly applicable within the UK healthcare system because the importance of good relationships based on empathic understanding is a theme unlikely to be limited by geographical context.

[1]Cruce, Öjehagen & Nordström (2012) [+]
[2]Green et al. (2015) [+]
[3]Hodges et al. (2006) [-]
[4]Johnson et al. (2013) [++]
[5]Kozloff et al. (2013) [+]
[6]Rethink (2015) [-]
[7]Villena & Chesla (2010) [++]
[8]VoiceAbility (2014) [-]

Fast access to reliable health advice

Evidence statement 2.2.8: Service structure

Evidence from 6 studies revealed that service users with a dual diagnosis face numerous barriers when seeking fast access to reliable health advice. There were few facilitators.

Two US studies (1[++][6] and 1[+][1]), 1[+][4] Canadian study and 1[-][3] Scottish study consistently identified service structure as the overriding reason prohibiting fast access to healthcare for people with a dual diagnosis. Evidence from 1[+][4] Canadian study, 1[-][3] Scottish study and 1[-][2] UK study specifically described how long waiting lists acted as a barrier to the receipt of expedient care. One UK study (1[-][5]) also described how the failure to address mental health issues promptly could result in service users using drugs or alcohol as a coping strategy to deal with untreated mental health symptoms.

To overcome the issue of long waiting lists, 1[-][3] study based in Scotland indicated that direct referrals by alcohol and addictions teams could act as a facilitator, speeding up service user access to reliable health advice.

Applicability to UK:
Three of the 6 studies were conducted in the UK and are therefore directly applicable. The rest were based in the US, Canada and Finland. Owing to the differences in the UK and US healthcare systems (for example, health insurance considerations in regards to eligibility for service access), 1 US study[6] is not applicable to the UK context.

[1]Brooks et al. (2007) [+]
[2]Fraser et al. (2003) [-]
[3]Hodges et al. (2006) [-]
[4]Kozloff et al. (2013) [+]
[5]Rethink (2015) [-]
[6]Villena & Chesla (2010) [++]

Involvement in decisions and respect for preferences

Evidence statement 2.2.9: Service user focused approach

Evidence from 3 studies outlined the barriers or facilitators encountered by people with a dual diagnosis being involved in making decisions about their treatment, and receiving care that respects their preferences. Evidence suggested that a service user focused approach can have a significant impact on the provision of healthcare to this population.

One US study (1[+][1]) revealed an unmet need for service user focused services. One Finnish study (1[+][3]) found that in some instances service users felt coerced into participating in treatment that did not reflect their preferences.

One Scottish study (1[-][2]) suggested that giving service users the ability to shape their own care plans facilitated access to care that was shaped around service user preference.

Applicability to UK:
One of the 3 studies was based in Scotland and it is therefore directly applicable to a UK context. The other 2 studies were based in the US and Finland. Nevertheless, the general theme of a service user focused approach is relevant in healthcare settings irrespective of their geographical location. As such, these studies are directly applicable within the UK context.

[1]Brooks et al. (2007) [+]
[2]Hodges et al. (2006) [-]
[3]Sorsa & Åstedt-Kurki (2013) [+]

Involvement of, and support for, family and carers

Evidence statement 2.2.10: Failure to provide information to family/carers

Evidence from 2 studies outlined the barriers faced by the families and carers of people with a dual diagnosis in relation to receiving support for themselves. No facilitators were identified.

One US study (1[+][1]) and 1[-][2] UK study described a consistent view on the barriers faced by families and carers when seeking support. These included a lack of information about how to contact family support groups, and difficulties in gaining assistance for caring for a relative with a dual diagnosis.

Applicability to UK:
One out of the 2 studies contributing to this theme was based in the UK and is therefore directly applicable. Although 1 study was based in the US, the views expressed appear broadly transferable across geographical locations and are therefore directly applicable within the UK context.

[1]EnglandKennedy & Horton (2011) [+]
[2]Rethink (2015) [-]

2 GLOSSARY AND ABBREVIATIONS

AOD: Alcohol and drugs

Axis I: Clinical Disorders - this is the top-level of the DSM multiaxial system of diagnosis. It represents acute symptoms that need treatment; Axis I diagnoses are the most familiar and widely recognised (e.g., major depressive episode, schizophrenic episode, panic attack).

CAP: Primary Care Centres (NB: Acronym originally in Spanish)

CAS: Out-patient addiction centres (NB: Acronym originally in Spanish)

CCA: Constant comparative approach

CSMA: Out-patient General Psychiatry Centres (NB: Acronym originally in Spanish)

COD: co-occurring disorders

Content analysis: a technique for systematically describing written, spoken or visual communication. It provides a quantitative (numerical) description and is useful for deriving themes within data.

DA: discourse analysis

D&A: drugs and alcohol

DASC: Drug and Alcohol Services Council in Australia

DD: dual diagnosis

DDW: dual diagnosis worker

DSM-III: Diagnostic & Statistical Manual of Mental Disorders, 3rd Edition Revised; a classification system for mental illnesses developed by the American Psychiatric Association

DSM-IV: Diagnostic & Statistical Manual of Mental Disorders, 4th Edition

Focus group (FG): a group of people asked about their perceptions, opinions, beliefs, and attitudes towards a service, intervention, etc.

Framework analysis: A qualitative method which was developed by researchers at the UK National Centre for Social Research. The approach creates a hierarchical thematic framework that is used to organise data according to key themes, concepts and emergent categories. The framework identifies a series of main themes subdivided by a succession of related subtopics. Once judged to be comprehensive

each main theme is charted by completing a matrix or table where each case has its own row and columns represent the subtopics. Cells contain relevant summaries from the data set. These charts are used to examine the data for patterns and connections.

GAP: general adult psychiatry

Grounded theory (GT): a research method which aims to conceptualise latent social patterns and structures in an area of interest through the process of constant comparison. An inductive approach is used primarily to generate codes from data, and will inform a developing theory suggesting whether additional data should be collected and which more-focused questions should be asked.

Interpretative phenomenological analysis (IPA): the aim of interpretative phenomenological analysis is to explore in detail how participants are making sense of their personal and social world, and the main currency for an IPA study is the meanings particular experiences, events and states hold for participants.

IPT: interpersonal therapy

MDD: major depressive disorder

MTC: modified therapeutic community

NR: not reported

Phenomenological method: a phenomenological research study is a study that attempts to understand people's perceptions, perspectives and understandings of a particular situation (or phenomenon).

PTSD: post-traumatic stress disorder

SD: substance dependence

SMI: serious/severe mental illness

Survey (for qualitative study): a research method in which a relatively large group of participants are asked a set of open-ended questions. Responses are then analysed using a qualitative method.

Thematic analysis (TA): a qualitative method which focuses on identifying patterned meaning across a dataset. Patterns are identified through a rigorous process of data familiarisation, data coding, and theme development and revision.

3 INTRODUCTION

The National Institute for Health and Care Excellence (NICE) has been asked by the Department of Health to develop a guideline on effective multi-agency working to improve access to community health and social care services for people with severe mental illness and substance misuse (referred to as a dual diagnosis). This review is the second of four reviews to inform the guideline.

- Review 1 considers the epidemiology and current configuration of UK health and social care community services for people with a dual diagnosis.
- Review 2 considers the views and experiences of service users, their families and carers, and providers and commissioners of health and social care community services for people with a dual diagnosis.
- Review 3 considers the effectiveness and efficiency of service delivery models.
- Review 4 considers the cost-effectiveness of service delivery models.

3.1 CONTEXT IN WHICH THE REVIEW IS SET

Ensuring that people have a good experience of healthcare is a central objective of NHS England's Outcome Framework, along with the related theme of treating people in a safe environment and protecting them from harm (Department of Health, 2013). For people with a dual diagnosis of a severe mental illness (which for the purposes of this guideline includes schizophrenia, schizotypal and delusional disorders, bipolar affective disorder and severe depressive episodes with or without psychotic episodes) and substance misuse (which refers to the use of legal or illicit drugs including alcohol and medicine, in a way that causes mental or physical damage) this is of particular importance because of concerns about the quality of care provided (Schizophrenia Commission, 2012; UKDPC, 2012). Not only are mental health outcomes for people with a dual diagnosis generally poorer than for people with either diagnosis alone but so are physical health outcomes and there is increased demand on other services such as social care and the criminal justice system (Mitchell et al., 2009; Crome et al., 2009).

In 2002 the Department of Health produced the *Dual Diagnosis Good Practice Guide,* which promoted an integrated model of care, based on a type of service delivery developed in the US. This guide supported the 'mainstreaming' of dual diagnosis services so that mental health services should deliver care for both the mental health problem and the substance misuse problem, with substance misuse services providing support, advice and joint working, based on the rationale that substance misuse is common rather than exceptional in people with severe mental illness. A number of services adopted this model immediately before and after the publication of the Good Practice Guide; examples of these services are described in a report by Turning Point (Turning Point, 2007).

The integrated approach to dual diagnosis was supported by the *Psychosis with Coexisting Substance Misuse* NICE guideline (CG120). The guideline's review of qualitative evidence suggested that dual diagnosis has an impact on a person's

ability to both access and engage in services and treatment for both conditions. Different treatment philosophies, both within mental health services and between mental health and substance misuse services, can present barriers to the delivery of effective care. In addition, many substance misuse services expect some level of readiness to change, which may not be possible for some people with severe mental illness. Different service configurations (mental health and substance misuse are rarely co-located and often managed through different agencies) may also militate against integrated provision. This can be further exacerbated by different funding streams underpinned by different objectives for the services and different budget priorities.

The *Service User Experience in Adult Mental Health* NICE guideline (CG136) was explicitly concerned with service user experience and had a particular focus on severe mental illness including the experience of inpatient care. Although not directly concerned with substance misuse, the guideline set out a number of general principles characterising high quality care and which have direct relevance to this guideline. These include being treated in an atmosphere of optimism, involvement in decision making about treatment, prompt access to treatment and continuity of care. The guideline also developed a framework for the analysis of qualitative data in mental health services, which has been adopted for review question 2.2 and adapted for review question 2.1. An examination of the views and experiences of commissioning, delivering and receiving care is important as it raises implications for the evaluation of service delivery models.

3.2 AIMS AND OBJECTIVES OF THE REVIEW

To review the views and experiences of health and social care community services for people with a severe mental illness who also misuse substances from the perspective of service users, their families or carers, providers and commissioners

3.3 REVIEW QUESTIONS AND PROTOCOL

The review protocol summary, including the review question and the eligibility criteria used for this review, can be found in Table 1. The full protocol is available here.

Table 1: Review protocol summary for evidence review 2 (service user, family and carer, provider and commissioner views and experiences of health and social care services for people with a severe mental illness who also misuse substances)

Component	Description
Review question(s)	RQ 2.1: What are the facilitators and barriers for commissioners or practitioners in their commissioning or delivery of health and social care community services for people with a severe mental illness who also misuse substances? RQ 2.2: What are the facilitators and barriers to accessing and using health and social care community services, and to satisfaction with those services, for people with coexisting severe mental illness and substance misuse and their family or carers?

Component	Description
Condition or domain being studied	'Dual diagnosis' was defined as a severe mental illness combined with misuse of substances. Severe mental illness includes a clinical diagnosis of: • schizophrenia, schizotypal and delusional disorders • bipolar affective disorder • severe depressive episode(s) with or without psychotic episodes Substance misuse refers to the use of legal or illicit drugs including alcohol and medicine, in a way that causes mental or physical damage (this may include low levels of substance use that would not usually be considered harmful or problematic, but may have a significant effect on the mental health of people with a mental illness such as psychosis)
Context	Included: Community settings (including a range of services provided by the NHS, social care and schools, as well as the community and voluntary sectors) Studies from any OECD member country will be included. However, applicability to the UK service setting will be considered during data analysis and synthesis Excluded: • non-OECD studies • prisons and other custodial settings • young offenders units • forensic secure mental health settings
Perspective	Included: Service users, their family or carers, providers and commissioners Excluded: • children (aged under 14 years old) • people with a severe mental illness but no evidence of substance misuse • people who misuse substances who have not been diagnosed with a severe mental illness • people with a severe mental illness who smoke or use tobacco but do not misuse any other substances • people who have a severe mental illness and misuse substances, but who are not living in the community
Phenomenon of interest	• Factors or attributes (at the individual-, practitioner-, commissioner- or service- level) that can enhance or inhibit access to services • Factors or attributes (at the individual-, practitioner-, commissioner- or service- level) that can enhance or inhibit delivery of services • Factors or attributes (at the individual-, practitioner-, commissioner- or service- level) that can enhance or inhibit uptake of and engagement with intervention and services • Actions by services that could improve or diminish the experience of care for example:-

Component	Description
	○ Form, frequency, and content of interactions with service users, families or carers ○ Sharing information with and receiving information from service users, families or carers ○ Planning of care with service users, families or carers • Experience of specific recognition or assessment tools, or specific interventions, from the perspective of practitioners, commissioners, service users, family or carers Excluded: The provision of financial support (for example direct payments) is outside the scope of this guideline and will not be included.
Evaluation	Experience and views of services. This includes experience/views of: • assessment received/delivered/commissioned • care received/delivered/commissioned • access to care • engagement with care • care planning and coordination • content and configuration of services • satisfaction with services • resource needs • awareness, knowledge and use of wider services • a service delivery model change/intervention Excluded: • Experiences of coexisting severe mental illness and substance misuse with no explicit implications for management, planning and/or delivery of care
Study design	Included: Primary qualitative research, surveys, case studies, autobiographical accounts Excluded: Commentaries, editorials, vignettes, books, policy and guidance, and non-empirical research

3.4 IDENTIFICATION OF POSSIBLE EQUALITY AND EQUITY ISSUES

The following equality issues were identified through scoping and the NICE equality impact assessment[2] and where possible, consideration was given to the specific needs of:

- older people
- people with a learning disability
- teenage parents
- people from black and minority ethnic groups
- travellers
- asylum seekers or refugees
- women
- lesbian, gay, bisexual, transsexual or transgender people
- people who are homeless or in insecure accommodation
- people from a low-income family or on a low income
- people who are socially isolated
- ex-offenders
- sex workers
- people who are, or have a history of being, 'looked after' or adopted
- adults who have a history of experiencing, or witnessing or perpetrating violence or abuse
- young people who have experienced abuse or witnessed domestic violence and abuse
- young people who are excluded from school
- young people whose parents have mental health or substance misuse problems

[2] Available at: http://www.nice.org.uk/guidance/gid-phg87/documents/severe-mental-illness-and-substance-misuse-dual-diagnosis-community-health-and-social-care-services-equality-impact-assessment-scoping2

4 METHODOLOGY

4.1 LITERATURE SEARCH AND ABSTRACT APPRAISAL

Based on the scope, a systematic search strategy was developed to identify relevant evidence published from 2000 to April 2015. The balance between sensitivity (the power to identify all studies on a particular topic) and specificity (the ability to exclude irrelevant studies from the results) was carefully considered, and a decision made to utilise a systematic and exhaustive approach to the searches to maximise the retrieval of evidence. Searches were conducted in the following databases:

- ASSIA
- CINAHL
- Cochrane Database of Reviews of Effect (DARE)
- Cochrane Database of Systematic Reviews (CDSR)
- Embase
- EPPI Centre databases - Bibliomap and DOPHer
- HMIC
- IBSS
- Medline and Medline in Process
- PsycEXTRA
- PsycINFO
- Social Care Online
- Social Policy & Practice
- Social Science Citation Index
- Social Service Abstracts
- Sociological Abstracts

The search strategies were initially developed for Medline before being translated for use in other databases/interfaces. Strategies were built up through a number of test searches and discussions of the results of the searches with the project team to ensure that all relevant search terms were covered. In order to assure comprehensive coverage, search terms for dual diagnosis were kept purposefully broad to help counter dissimilarities in database indexing practices and thesaurus terms, and imprecise reporting of study populations by authors in the titles and abstracts of records. The search terms for the Medline search are set out in full in Appendix 1.

Search restrictions included the following:

- Date (publication limit 2000-current)
- Language (English-language studies) limits.
- Animal studies, letters, editorials and other non-relevant publication types
- Searching Embase using only major Emtree headings
- Qualitative studies adapted from filters developed by the Health Information Research Unit, McMaster University

The following websites were also searched:

- Addaction www.addaction.org.uk/
- Alcohol Concern www.alcoholconcern.org.uk/
- Alcohol Research UK www.alcoholresearchuk.org/
- Audit Commission www.gov.uk/government/organisations/audit-commission
- British Medical Association www.bma.org.uk/
- Care Quality Commission www.cqc.org.uk/
- Centre for Mental Health www.centreformentalhealth.org.uk/
- Changes.org.uk
- Department of Health www.gov.uk/government/organisations/department-of-health
- DrugScope www.drugscope.org.uk/
- European Monitoring Centre for Drug & Drug addiction www.emcdda.europa.eu/
- European Observatory on Healthcare Systems and Policies www.euro.who.int/en/about-us/partners/observatory
- Google UK (for identification of case studies and other web sites of relevance to the topic area)
- Health and Social Care Information Centre www.hscic.gov.uk/
- Health Services Management Centre www.birmingham.ac.uk/schools/social-policy/departments/health-services-management-centre/index.aspx
- Healthcare Improvement Scotland www.healthcareimprovementscotland.org/
- Healthcare Quality Improvement Partnership www.hqip.org.uk/
- Healthtalkonline www.healthtalk.org/
- Hearing Voices Network www.hearing-voices.org/
- Institute for Public Policy Research www.ippr.org/
- Joseph Rowntree Foundation www.jrf.org.uk/
- Kings Fund www.kingsfund.org.uk/
- Mental Health Research UK www.mhruk.org/
- Mental Healthcare www.mentalhealthcare.org.uk/
- MIND www.mind.org.uk/
- National Audit Office www.nao.org.uk/
- National Survivor User Network www.nsun.org.uk/
- NHS England www.england.nhs.uk/
- NHS Improving Quality www.nhsiq.nhs.uk/
- NICE (guidelines and Evidence Search – including QIPP) www.nice.org.uk/
- NIHR Health Services & Delivery Research Programme www.nets.nihr.ac.uk/programmes/hsdr
- Nuffield Trust www.nuffieldtrust.org.uk/Health-Care
- Office for National Statistics www.ons.gov.uk/
- OpenGrey www.opengrey.eu/
- Patient UK www.patient.info/
- Public Health England (including National Treatment Agency for Substance Misuse) www.gov.uk/government/organisations/public-health-england
- Public Health Observatory www.apho.org.uk/
- Public Health Wales www.publichealthwales.wales.nhs.uk/

- Race Equality Foundation www.raceequalityfoundation.org.uk/
- Rethink Mental Illness www.rethink.org/
- Royal College of Emergency Medicine www.rcem.ac.uk/
- Royal College of General Practitioners www.rcgp.org.uk/
- Royal College of Nursing www.rcn.org.uk/
- Royal College of Obstetricians and Gynaecologists www.rcog.org.uk/
- Royal College of Paediatrics and Child Health www.rcpch.ac.uk/
- Royal College of Physicians /www.rcplondon.ac.uk/
- Royal College of Psychiatrists www.rcpsych.ac.uk/
- Royal College of Surgeons www.rcseng.ac.uk/
- Sane www.sane.org.uk/
- Scottish Government www.gov.scot/
- Scottish Public Health Network www.scotphn.net/
- SIGN www.sign.ac.uk/
- South Asian Health Foundation www.sahf.org.uk/
- Turning Point www.turning-point.co.uk/
- US National Guidelines Clearinghouse www.guideline.gov/
- Welsh Government www.gov.wales/?lang=en
- World Health Organisation www.who.int/
- Youthtalkonline www.healthtalk.org/young-peoples-experiences

Citations from each search were downloaded into EndNote software and duplicates removed. Records were then screened against the eligibility criteria of the review before being appraised for methodological quality (see below). The unfiltered search results were saved and retained for future potential re-analysis to help keep the process both replicable and transparent.

NICE issued a call for evidence to stakeholders between January and February 2015. From this call for evidence 3 reports were identified for these review questions. The NICE project team also carried out an informal search for relevant case studies using Google. Out of 27 identified case studies, 2 were included in this review.

4.2 RETRIEVAL OF DATA AND FULL PAPER APPRAISAL

Titles and abstracts of identified studies were screened for inclusion against agreed criteria. Two reviewers independently screened 10% of references (selected randomly). Although the overall inter-rater reliability was very good (percentage agreement of 98%), when considering the inter-rater reliability only for the proportion of studies which were included, it was deemed too low (percentage agreement of 27%). A further 10% of references (selected randomly) were screened independently by two reviewers. Again, despite good overall inter-rater reliability (percentage agreement of 98%), inter-rater reliability for included studies was poor (percentage agreement of 31%). The recurrent poor agreement with regards to included studies was due to the low hit rate, which meant that discrepancies in inclusions had an inflated effect on the percentage agreement. The review team decided to conduct a further hand search on the remaining 80% of references, erring on the side of inclusion, following testing of a text mining method, which did not identify the majority of studies that might be relevant, as expected (see Appendix 12 for further details).

All primary-level studies included after the first scan of citations were acquired in full and re-evaluated for eligibility at the time they were entered into a study database (standardised template created in Microsoft Excel). The full text papers were screened by two reviewers using the inclusion criteria for reference. Any disagreements regarding inclusion/exclusion were resolved by discussion with a third reviewer. Two researchers extracted data into the study database, comparing a sample of each other's work (10%) for reliability. Discrepancies or difficulties with coding were resolved through discussion between reviewers. Study characteristics, aspects of methodological quality, and outcome data were extracted from all eligible studies using an Excel-based form.

4.3 QUALITY ASSESSMENT AND APPLICABILITY APPRAISING

The Critical Appraisal Skills Programme (CASP) checklist (CASP, 2013) was completed for each study. Each study was rated ++, + or - to denote its quality, where:

- ++ indicates that all or most of the checklist criteria have been fulfilled (and where they have not been fulfilled the conclusions are very unlikely to alter),
- + indicates that some of the checklist criteria have been fulfilled (and where they have not been fulfilled, or not adequately described, the conclusions are unlikely to alter) and,
- – indicates that few or no checklist criteria have been fulfilled (and the conclusions are likely or very likely to alter)

See Appendix 2 and 3 for example completed quality checklists. The review team also considered the applicability of individual studies to the review question.

4.4 METHODS OF DATA EXTRACTION, SYNTHESIS AND PRESENTATION

Data extraction

The data extracted (where available) were as follows:

- Study characteristics: RQ addressed, geographical region, N, inclusion/exclusion criteria, severe mental illness (for carer/family/practitioner/commissioner this was based on service user demographics where applicable), substance misuse (for carer/family/practitioner/commissioner this was based on service user demographics where applicable), demographics of service user and family/carer/practitioner/commissioner (age, sex, ethnicity, SES, other characteristics), service/setting details, data collection method, data analysis method, limitations identified by author, limitations identified by review team, funding
- For thematic meta-synthesis: RQ addressed, population (commissioner, practitioner, service user, family member, carer), point on care pathway, overarching theme from each matrix (seeTable 2 and Table 3), intervention/service, type of experience, emotional valence of experience (positive/negative/mixed/neutral), themes, sub-themes, author quotes to support themes, participant quotes to support themes

Data synthesis

Qualitative data synthesis

Qualitative data synthesis was guided by a “best fit” framework synthesis approach (Carroll et al., 2011). The distinguishing characteristic of this type of approach, and the aspect in which it differs from other methods of qualitative synthesis such as meta-ethnography (Campbell et al., 2003) is that it is primarily deductive. This means that a pre-existing thematic framework was selected *a priori* rather than using data to primarily guide the development of the thematic framework. For review question 2.2, the thematic framework identified and developed by the *Service User Experience in Adult Mental Health* guideline (NICE, 2011; NCCMH, 2012) was used as a starting point to systematically index and organise all relevant themes and sub-themes within an Excel-based spreadsheet (see Table 2). A matrix was formed by creating a table with eight themes down the vertical axis and key points of a pathway of care across the horizontal axis. For review question 2.1, the thematic framework developed by the *Service User Experience in Adult Mental Health* guideline (NICE, 2011; NCCMH, 2012), was adapted so that the themes were relevant to a commissioner and practitioner perspective (seeTable 3). Where possible the review team developed themes which mirrored those in the originally agreed framework. Data from included studies were extracted into an Excel-based spreadsheet and organised within each cell of the matrix (see Table 5 and Table 23). A secondary thematic analysis was then used to inductively identify additional themes and sub-themes in cyclical stages (Carroll et al., 2011).

Table 2: Matrix of service user experience (adopted from the NICE Service User Experience in Adult Mental Health guideline)

Experience of care	***Key points on the pathway of care***		***Themes that apply to all points on the pathway***
Attention to physical and environmental needs			
Clear, comprehensible information and support for self-care			
Continuity of care and smooth transitions			
Effective treatment delivered by trusted professionals			
Emotional support, empathy and respect			
Fast access to reliable health advice			
Involvement in decisions and respect for preferences			
Involvement of, and support for, family and carers			

Table 3: Matrix of commissioner and practitioner experience (adapted from the *Service User Experience in Adult Mental Health* guideline)

Experience of services	***Key points on the pathway of care***		
			Themes that apply to all points on the pathway
Assessment and identification of service user needs			
Attitudes to service users with a dual diagnosis			
Availability of resources			
Care co-ordination and effective inter-agency working			
Involvement of, and support for, family and carers			
Pathways through the care system			
Policy, structure and location of services			
Staff support, supervision and training needs			

5 REVIEW QUESTION 2.1: What are the facilitators and barriers for commissioners or practitioners in their commissioning or delivery of health and social care community services for people with a severe mental illness who also misuse substances?

5.1 STUDIES CONSIDERED FOR REVIEW QUESTION 2.1

The electronic database search identified 13,796 records. Of these, full-text appraisal was conducted for 148 records (and 13,648 were excluded on the basis of title and abstract). After a full-text review of 148 papers, 15 studies were included (reported across 16 papers). Two additional reports were included; one from the call for evidence and one from a set of case studies identified by the NICE project team. See Appendix 6 for PRISMA diagram, Appendix 8 for a bibliography of included studies and Appendix 9 for a bibliography of excluded studies with reasons for exclusion.

5.2 SUMMARY OF THE EVIDENCE FOR REVIEW QUESTION 2.1

5.2.1 Overview of included studies

Included studies mainly used a primary qualitative research design (N=13) and focused their research on the experience and/or views of care delivered and/or commissioned (N=10). Data was mostly collected using interviews (N=11) with sample sizes ranging from 7 to 214 (mean: 40). Six of the 17 included studies were conducted in the UK. Most of the studies (N=13) only included practitioners. Studies were conducted in a range of settings. To improve the comparability of studies in the summary of findings, the generic term ‘mental health services’ was used to describe settings such as psychiatric services and psychotic disorders programme and the term ‘substance misuse services’ was used to describe settings such as addiction and alcohol treatment agencies. See Appendix 13 for full evidence tables for RQ2.1 which include detailed study information. Supporting information containing quotes coded as barriers or facilitators for each study can be found in Appendix 15.

Table 4: Study information table of included studies for RQ2.1

	Qualitative studies included
Included studies	N=17
Sample size	7-214 (mean: 40)
Study design	Primary qualitative research (N=13); mixed - primary qualitative research and survey data (N=1); surveys (N=2); case studies (N=1)
Focus of study	Experience and/or views of care delivered and/or commissioned (N=10); experience and/or views of the content and configuration of service (N=3); experience and/or views of resource needs (N=2); experience and/or views of a service delivery model change (N=1); experience and/or views of access to care (N=1)
Target population	Practitioners (N=14), practitioners and service users (N=2), commissioners and service users (N=1)
Data collection	Face-to-face interview (N=4); telephone interview (N=1); interview (multiple methods; N=2); interview (format not reported; N=3); focus group (N=2); questionnaire (open-ended) (N=2); face-to-face interview and observations (N=1); not reported (N=2)
Data collection setting	Community (N=3); workplace (N=3); telephone (N=1); not reported (N=10)
Country	UK (N=6); US (N=5); Australia (N=4); Canada (N=1); Spain (N=1)
Geographical location	Mixed settings (N=9); urban setting (N=5); rural setting (N=2); not reported (N=1)

5.2.2 Quality assessment

The general quality of included studies was judged to be low to moderate. Out of 17 studies, 2 were rated [++], 9 were rated [+] and 6 were rated [-].This indicates that the evidence described in this section may be subject to bias, potentially influencing the views expressed. In most studies there was insufficient information on qualitative methods to adequately assess biases, reducing overall quality ratings. Common limitations included a lack of a justification for the research design and data collection methods, no explanation for the recruitment strategy and the absence of descriptions of how themes were derived from the data. Across all studies there was a consistent absence of discussion about how the researcher's views may have biased or influenced those of the participant.

Table 5: Matrix of qualitative evidence for RQ 2.1								
Experience of services	**Key Points on the pathway of care**							
	Access	**Assessment**	**Secondary Mental Health Services**	**Substance Misuse Services**	**Specialist Dual Diagnosis Services**	**Social Care**	**Voluntary Services**	**Themes that apply to all points on the pathway**
Assessment and identification of service user needs		Barnes & Rudge (2003) [+]; Hodges et al. (2006) [-]	Barnes & Rudge (2003) [+]; Hodges et al. (2006) [-]	McLaughlin et al. (2008) [-]				
Attitudes to service users with a dual diagnosis		Carey et al. (2000) [++]; Coombes & Wratten (2007) [++]; Deans & Soar (2005) [+]; Hodges et al. (2006) [-]; Holt & Treloar (2008) [-]; Roberts & Darryl (2014) [+]	Hodges et al. (2006) [-]; Roberts & Darryl (2014) [+]	Mericle et al. (2007) [+]; Sylvain & Lamothe (2012) [+]; Tiderington et al. (2013) [+]			St Mungo's Broadway (2015) [-]	
Availability of resources		Barnes & Rudge (2003) [+]; Carey et al. (2000) [++]; Coombes & Wratten (2007) [++]; Hodges et al. (2006) [-]; Roberts & Darryl (2014) [+]	Barnes & Rudge (2003) [+]; Hodges et al. (2006) [-]; Roberts & Darryl (2014) [+]	Mericle et al. (2007) [+]; Siddiqui et al. (2009) [+];		Hodges et al. (2006) [-]	Hodges et al. (2006) [-]	
Care co-ordination and effective inter-agency working		Barnes & Rudge (2003) [+]; Coombes & Wratten (2007) [++]; Deans & Soar (2005) [+]; Hodges et al. (2006) [-]; Maslin	Barnes & Rudge (2003) [+]; Hodges et al. (2006) [-]; Roberts & Darryl (2014) [+]	McLaughlin et al. (2008) [-]; Mericle et al. (2007) [+]; Siddiqui et al. (2009) [+]; Sylvain & Lamothe (2012) [+]			St Mungo's Broadway (2015) [-]	

Table 5: Matrix of qualitative evidence for RQ 2.1

Experience of services	Key Points on the pathway of care							
	Access	**Assessment**	**Secondary Mental Health Services**	**Substance Misuse Services**	**Specialist Dual Diagnosis Services**	**Social Care**	**Voluntary Services**	**Themes that apply to all points on the pathway**
		et al. (2001) [-]; Roberts & Darryl (2014) [+]						
Involvement of, and support for, family and carers					Hodges et al. (2006) [-]			
Pathways through the care system	Fonseca et al. (2012) [-]	Barnes & Rudge (2003) [+]; Carey et al. (2000) [++]; Deans & Soar (2005) [+]; Hodges et al. (2006) [-]	Barnes & Rudge (2003) [+]; Fonseca et al. (2012) [-]; Hodges et al. (2006) [-]; Maslin et al. (2001) [-]; Perryman et al. (2011) [+]	McLaughlin et al. (2008) [-]; Mericle et al. (2007) [+]		Hodges et al. (2006) [-]	Hodges et al. (2006) [-]; St Mungo's Broadway (2015) [-]	
Policy, structure and location of services	Fonseca et al. (2012) [-]	Barnes & Rudge (2003) [+]; Coombes & Wratten (2007) [++]; Hodges et al. (2006) [-]; Roberts & Darryl (2014) [+]	Barnes & Rudge (2003) [+]; Hodges et al. (2006) [-]; Roberts & Darryl (2014) [+]	Brown et al. (2002) [+]; McLaughlin et al. (2008) [-]; Siddiqui et al. (2009) [+]; Sylvain & Lamothe (2012) [+]		Hodges et al. (2006) [-]	Fonseca et al. (2012) [-]; Hodges et al. (2006) [-]; Roberts & Darryl (2014) [+]	
Staff support, supervision and training needs		Carey et al. (2000) [++]; Coombes & Wratten (2007) [++]; Deans & Soar (2005) [+];Fonseca et al. (2012) [-]; Hodges et	Fonseca et al. (2012) [-]; Maslin et al. (2001) [-]; Hodges et al. (2006) [-];	Brown et al. (2002) [+]; McLaughlin et al. (2008) [-]; Mericle et al. (2007) [+]			St Mungo's Broadway (2015) [-]	

Table 5: Matrix of qualitative evidence for RQ 2.1								
Experience of services	**Key Points on the pathway of care**							
	Access	**Assessment**	**Secondary Mental Health Services**	**Substance Misuse Services**	**Specialist Dual Diagnosis Services**	**Social Care**	**Voluntary Services**	**Themes that apply to all points on the pathway**
		al. (2006) [-]; Maslin et al. (2001) [-];						

5.3 ASSESSMENT AND IDENTIFICATION OF SERVICE USER NEEDS

This conceptual category contains the following themes:

- **Assessment tools**
- **Health and wellbeing**

5.3.1 Assessment tools

Table 6: Summary of characteristics of studies contributing to the theme: assessment tools

Author (year) [quality] Data collection method	Country	Target population	Geographical location	Service setting
Barnes & Rudge (2003) [+] Interview (telephone)	Australia	Registered nurses (NR)	Rural	Mental health and substance misuse services
McLaughlin et al. (2008) [-] Interview (face-to-face)	UK	Recently appointed dual diagnosis practitioners (n=8)	Mixed	Mental health and substance misuse services

Narrative summary

Two studies provided evidence of facilitators associated with the effective use of assessment tools. No barriers were identified. Key characteristics of the contributing studies are summarised in Table 6.

Facilitators

Two studies (Barnes & Rudge (2003) [+], McLaughlin et al. (2008) [-]) indicated that practitioners felt it would be useful to incorporate aspects of mental health and substance misuse within a single assessment for service users with a dual diagnosis:

"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." (McLaughlin et al., 2008)

One practitioner in Barnes & Rudge (2003) outlined how this could minimise the time between assessment and treatment and ensure service users are not turned away because of their dual diagnosis:

"As a service [mental health] we got together and pulled elements of the D & A [drugs and alcohol] screening process. […] 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 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"

Evidence statement 2.1.1: Assessment tools

Two studies provided evidence of facilitators associated with assessment tools.

One Australian study (1[+][1]) and 1[-][2] UK study conducted in mental health and substance misuse services provided a consistent view that the incorporation of mental health and substance misuse assessment tools into a single assessment would facilitate the delivery of mental health and social care. This would make assessments more timely and efficient and reduce the likelihood of service users having restricted access to particular assessments because of their dual diagnosis.

Applicability to UK:
Although only 1 of the 2 studies was conducted in the UK, this evidence is directly applicable to the delivery of care in the UK.

[1]Barnes & Rudge (2003) [+]
[2]McLaughlin et al. (2008) [-]

5.3.2 Health and wellbeing

Table 7: Summary of characteristics of studies contributing to the theme: health and wellbeing

Author (year) [quality] Data collection method	Country	Target population	Geographical location	Service setting
Hodges et al. (2006) [-] Interview (multiple methods)	Scotland	Commissioners (n=26), including representatives of Local Authorities, NHS services, directors of Social Services, Public Health Physicians, Drug and Alcohol Team (DAAT) co-ordinators and Lead Officers for Mental Health	Mixed	NR

Narrative summary
One study provided evidence on barriers associated with the health and well-being of service users with a dual diagnosis. No facilitators were reported. Key characteristics of the contributing studies are summarised in Table 7.

Barriers

One study based in Scotland that involved commissioners (Hodges et al. (2006) [-]) provided evidence that the health and wellbeing of service users with a dual diagnosis needed to be addressed:

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

Evidence statement 2.1.2: Health and wellbeing

One Scottish study 1[-][1] involving commissioners found evidence to suggest that the health and wellbeing of service users with a dual diagnosis needed to be addressed. No facilitators were identified.

Applicability to UK:
This evidence is directly applicable to the delivery of care in the UK because it is from a study based in Scotland.

[1]Hodges et al. (2006) [-]

5.4 ATTITUDES TO SERVICE USERS WITH A DUAL DIAGNOSIS

This conceptual category contains the following themes:

- **Stigma and negative attitudes towards people with a dual diagnosis**
- **Relationship between practitioner and service user**

5.4.1 Stigma and negative attitudes towards people with a dual diagnosis

Table 8: Summary of characteristics of studies contributing to the theme: stigma and negative attitudes towards people with a dual diagnosis

Author (year) [quality] Data collection method	Country	Target population	Geographical location	Service setting
Carey et al. (2000) [++] Focus group	US	Practitioners (n=12)	NR	Mental health services
Coombes & Wratten (2007) [++] Interview (face-to-face)	UK	Mental health nurses (n=7)	Mixed	Community setting (not specified)
Deans & Soar (2005) [+] Interview (face-to-face)	Australia	Mental health practitioners (n=13)	Rural	Mental health services
Hodges et al. (2006) [-] Interview (multiple methods)	Scotland	Commissioners (n=26)	Mixed	NR
Mericle et al. (2007) [+] Interview (face-to-face)	US	Dual diagnosis practitioners (n=17)	Urban	Intensive case management programmes
Roberts & Darryl (2014) [+]	Australia	Key informants (senior policy executives, service providers, and consumer	Mixed	Range of settings (not specified)

Interview (format NR)		researchers with expert knowledge in the field of dual diagnosis) (n=19)		
St Mungo's Broadway (2015) [-] NR	UK	Practitioners (NR)	Mixed	Homelessness charity and housing association

Narrative summary

Six studies provided evidence of barriers related to stigma and negative attitudes towards people with a dual diagnosis. No facilitators were identified. Key characteristics of the contributing studies are summarised in Table 8.

Barriers

Six studies (Carey et al. (2000) [++], Coombes & Wratten (2007) [++], Deans & Soar (2005) [+], Mericle et al. (2007) [+], Roberts & Darryl (2014) [+], St Mungo's Broadway (2015) [-]) reported that practitioners had witnessed prejudice and negative attitudes from other members of staff towards service users with a dual diagnosis. This is described by a mental health nurse in Coombes & Wratten (2007):

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

Coombes & Wratten (2007) also outlined how such prejudice could act as a barrier to the provision of health and social care:

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

Prejudice (directed to service users) could also have a negative effect on practitioners:

"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."

Negative attitudes were directed particularly towards the misuse of drugs. Such attitudes are likely to be influenced by factors such as the criminalisation of drug use and a wider public prejudice against drug as opposed to alcohol misuse. In 1 study involving commissioners from 7 areas across Scotland, those from South West Edinburgh singled out the law against drug use as barrier to the provision of care (Hodges et al. (2006) [-]):

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

This view was echoed in Carey et al. (2000), a US-based study, where the relaxation of laws with regards to substance misuse was viewed as a way of improving the provision of care:

"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."

The stigma associated with substance misuse had a far reaching impact, to the extent that some clinicians felt unable to talk about the use of drugs with service users as reported in Roberts & Darryl (2014):

"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."

While negative attitudes were mostly focused on substance misuse, dual diagnosis practitioners in 1 US-based study (Mericle et al. 2007) reported that service users felt their mental health problem might be viewed negatively in substance misuse services:

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

Evidence statement 2.1.3: Stigma and negative attitudes towards people with a dual diagnosis

Seven studies provided evidence of barriers related to stigma and negative attitudes towards people with a dual diagnosis. No facilitators were identified.

Two UK studies (1[++][2] and 1[-][7]) conducted in community settings and the voluntary sector, 2 US studies (1[++][1] and 1[+][5]) conducted in mental health services and an intensive case management programme and 2[+][3,6] Australian studies conducted in a mental health service and other non-specified settings provided a consistent view that stigma and negative attitudes towards service users with a dual diagnosis may act as a barrier to the effective delivery of care. This prejudice was reported across the care pathway, within primary and secondary services, including community settings and was mainly reported as a negative attitude towards substance misuse within mental health settings, although 1[+][5] US study reported negative attitudes towards mental health diagnoses within a substance misuse service. One Australian study 1[+][6] also highlighted that stigma associated with substance misuse meant that some practitioners felt unable to talk about the use of drugs with service users.

One Scottish study (1[-][4]) of commissioners also found a consistent view that stigma and negative attitudes towards service users, as well as laws against substance misuse may act as a barrier to the effective delivery of care.

Applicability to UK:
Although only 2 out of the 7 studies were conducted in the UK, this evidence is directly applicable to practitioners or commissioners in the UK as societal attitudes towards mental health and substance misuse are broadly similar in Australia and Spain and to a slightly lesser extent in the US compared with those in the UK.

[1]Carey et al. (2000) [++]
[2]Coombes & Wratten (2007) [++]
[3]Deans & Soar (2005) [+]
[4]Hodges et al. (2006) [-]
[5]Mericle et al. (2007) [+]
[6]Roberts & Darryl (2014) [+]
[7]St Mungo's Broadway (2015) [-]

5.4.2 Relationship between practitioner and service user

Table 9: Summary of characteristics of studies contributing to the theme: relationship between practitioner and service user

Author (year) [quality] Data collection method	Country	Target population	Geographical location	Service setting
Carey et al. (2000) [++] Focus group	US	Practitioners (n=12)	NR	Mental health services
Coombes & Wratten (2007) [++] Interview (face-to-face)	UK	Mental health nurses (n=7)	Mixed	Community setting (not specified)
Holt & Treloar (2008) [-] Interview (multiple methods)	Australia	Practitioners (n=18)	Mixed	Mental health and substance misuse services
Sylvain & Lamothe (2012) [+]	Canada	Practitioners involved in integrating mental health and substance abuse	Urban	Mental health and substance misuse services

Author (year) [quality] Data collection method	Country	Target population	Geographical location	Service setting
Interviews, participant observation and analysis of documents		services (n=23)		
Tiderington et al. (2013) [+] Interview (face-to-face)	US	Assertive community treatment case managers (n=24)	Urban	Assertive community treatment service

Narrative summary

Five studies provided evidence of barriers or facilitators relating to the nature of the relationship between the practitioner and service user. Key characteristics of the contributing studies are summarised in Table 9.

Barriers

One UK-based study (Coombes & Wratten (2007) [++]) of community mental health nurses described how the influence of drug use on a service user could have a negative impact on the relationship between practitioner and service user and thus act as a barrier to the provision of care:

"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

Four studies (Carey et al. (2000) [++], Holt & Treloar (2008) [-], Sylvain & Lamothe (2012) [+], Tiderington et al. (2013) [+]) reported that the nature of the relationship between practitioners and service users could act as a facilitator to the delivery of effective care. As noted in Sylvain & Lamothe (2012):

"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."

In Carey et al. (2000), practitioners from mental health services based in the US stressed the importance of having a person-centred approach to working with dual diagnosis service users:

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

Practitioners in Holt & Treloar (2008) highlighted the need to use appropriate language, particularly with reference to mental health:

"*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*".

"*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*".

In Tiderington et al. (2013), assertive community treatment case managers stressed that building a positive and open relationship with service users takes time but would eventually facilitate communication resulting in the possibility of reducing drug usage:

"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".

Evidence statement 2.1.4: Relationship between practitioner and service user

Five studies provided evidence of barriers or facilitators related to the relationship between the practitioner and service user.

One UK study (1[++][2]) of community mental health nurses found that the misuse of drugs could have a negative impact on the relationship between practitioner and service user acting as a barrier to the effective delivery of care.

One UK study (1[++][2]) conducted in community settings, 2 US studies (1[++][1] and 1[+][5]) conducted in mental health services and an assertive community treatment service, 1[+][4] Canadian study and 1[-][3] Australian study conducted in mental health and substance misuse services provided a consistent view that good relationship between practitioner and service user could act as a facilitator to the effective delivery of health and social care. Factors that were deemed most important were having a person centred approach, using appropriate language and building a positive and open relationship. These elements were viewed as important facilitators for improving outcomes, engaging service users and effectively reducing the usage of drugs.

Applicability to UK:
Although only 1 out of the 5 studies was conducted in the UK, this evidence is

directly applicable to practitioners in the UK as the nature of the relationship between practitioner and service user is likely to have a similar effect on the delivery of health and social care in Australia, Canada and the US.

[1]Carey et al. (2000) [++]
[2]Coombes & Wratten (2007) [++]
[3]Holt & Treloar (2008) [-]
[4]Sylvain & Lamothe (2012) [+]
[5]Tiderington et al. (2013) [+]

5.5 AVAILABILITY OF RESOURCES

This conceptual category contains the following themes:

- **Lack of resources**
- **Non-statutory sector**

5.5.1 Lack of resources

Table 10: Summary of characteristics of studies contributing to the theme: lack of resources

Author (year) [quality] Data collection method	Country	Target population (n)	Geographical location	Service setting
Barnes & Rudge (2003) [+] Interview (telephone)	Australia	Registered nurses (NR)	Rural	Mental health and substance misuse services
Carey et al. (2000) [++] Focus group	US	Practitioners (n=12)	NR	Mental health services
Coombes & Wratten (2007) [++] Interview (face-to-face)	UK	Mental health nurses (n=7)	Mixed	Community setting (not specified)
Hodges et al. (2006) [-] Interview (multiple methods)	Scotland	Commissioners (n=26)	Mixed	NR
Mericle et al. (2007) [+] Interview (face-to-face)	US	Dual diagnosis practitioners (n=17)	Urban	Intensive case management programmes

Author (year) [quality] Data collection method	Country	Target population (n)	Geographical location	Service setting
Roberts & Darryl (2014) [+] Interview (format NR)	Australia	Key informants (senior policy executives, service providers, and consumer researchers with expert knowledge in the field of dual diagnosis) (n=19)	Mixed	Range of settings (not specified)
Siddiqui et al. (2009) [+] Interviews (face-to-face)	US	Staff from the modified therapeutic community (MTC) model (n=7)	Urban	Dual diagnosis service for homeless service users

Narrative summary

Seven studies provided evidence of barriers or facilitators related to a lack of resources. Key characteristics of the contributing studies are summarised in Table 10.

Barriers

Five studies (Barnes & Rudge (2003) [+], Carey et al. (2000) [++], Coombes & Wratten (2007) [++], Mericle et al. (2007) [+], Roberts & Darryl (2014) [+]) reported that a lack of resources presented a barrier to the provision of health and social care. One Australian study based in mental health and substance misuse services reported:

"A team leader in rural mental health service stated that DASC was 'stretched to the maximum, practically transparent'"

In Coombes & Wratten (2007) the unavailability of additional resources was found to have an impact on the quality of care delivered:

"Often the resources needed to provide quality care were not available"

Carey et al. (2000) outlined which additional services were required for service users with a dual diagnosis:

"Two groups voiced the need for more programs [..] 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."

This was echoed by dual diagnosis practitioners in Mericle et al. (2007):

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

One Scottish study involving commissioners (Hodges et al. (2006) [-]) found views consistent with those of practitioners, where additional resources were seen as essential for the provision of adequate health and social care for service users with a dual diagnosis, particularly those with less severe needs:

"All services were perceived as being overstretched and community care and addiction services were under-funded"

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

"Financial constraints were seen as a potential barrier to appropriate service provision"

Facilitators

One US-based study (Siddiqui et al. (2009) [+]), which involved practitioners from a dual diagnosis service for homeless people, reported that the provision of additional resources could act as a facilitator to the quality of care delivered. Specifically, the employment of additional social workers was found to improve treatment outcomes:

"The one thing that makes the biggest difference is that every client has a social worker. […] 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."

Evidence statement 2.1.5: Lack of resources

Seven studies provided evidence of barriers or facilitators related to a need for additional resources.

Two US studies (1[++][2] and 1[+][5]) conducted in mental health services and intensive case management programmes, 2[+][1,6] Australian studies conducted in mental health and substance misuse services and a range of unspecified settings and 1[++][3] UK study conducted in community settings provided a consistent view that a lack of resources acted as a barrier to the effective delivery of health and social care. This was also found to compromise the quality of delivered care. One US study 1[++][2] outlined the need for more services specifically tailored to service users with a dual diagnosis.

One US based study (1[+][7]) involving practitioners from a dual diagnosis service for homeless reported that the provision of additional social workers could improve treatment outcomes for service users with a dual diagnosis.

One UK study (1[-][4]) of commissioners found consistent views whereby existing services were seen as stretched and that a lack of funding was seen as a barrier to the adequate provision of health and social care. In particular, additional resources were seen as necessary for service users with less severe needs.

Applicability to UK:
This evidence is partially applicable to practitioners and commissioners in the UK as only 2 out of the 7 studies were conducted in the UK and the remaining were in Australia and US. There is however a consistent picture across a range of healthcare settings of perceived under-resourcing of services for service users with dual diagnosis.

[1]Barnes & Rudge (2003) [+]
[2]Carey et al. (2000) [++]
[3]Coombes & Wratten (2007) [++]
[4]Hodges et al. (2006) [-]
[5]Mericle et al. (2007) [+]
[6]Roberts & Darryl (2014) [+]
[7]Siddiqui et al. (2009) [+]

5.5.2 Non-statutory sector

Table 11: Summary of characteristics of studies contributing to the theme: non-statutory sectors

Author (year) [quality] Data collection method	Country	Target population (n)	Geographical location	Service setting
Hodges et al. (2006) [-] Interview (multiple methods)	Scotland	Commissioners (n=26)	Mixed	NR

Narrative summary

One study involving commissioners (Hodges et al. (2006) [-]), based in Scotland, found evidence of barriers or facilitators associated with the use of the non-statutory sector for the delivery of wider health or social care needs. Key characteristics of the contributing study are summarised in Table 11.

Barriers

The non-statutory sector was found to be in need of funding and further development:

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

Facilitators

However, the non-statutory sector was also seen as a potential facilitator to the delivery of adequate health and social care through the provision of specialised services for service users with a dual diagnosis where there was a lack of integrated services within the statutory sector:

"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."

Evidence statement 2.1.6: Non-statutory sector

One study provided evidence of a barrier and a facilitator associated with the non-statutory sector.

One Scottish study (1[-][1]) of commissioners found evidence that a lack of funding in voluntary services acted as a barrier to the provision of health and social care. However, investment in the non-statutory sector could facilitate the provision of integrated services when these were not provided in the statutory sector.

Applicability to UK:
This evidence is directly applicable because the included study was conducted in Scotland but needs to be considered in light of a significant shift to the provision of drug and alcohol services by non-statutory services in England in the last 10 years.

[1]Hodges et al. (2006) [-]

5.6 CARE CO-ORDINATION AND EFFECTIVE INTER-AGENCY WORKING

This conceptual category contains the following themes:

- **Co-ordinating care**
- **Challenges with the service user group**

5.6.1 Co-ordinating care

Table 12: Summary of characteristics of studies contributing to the theme: co-ordinating care

Author (year) [quality] Data collection method	Country	Target population (n)	Geographical location	Service setting
Barnes & Rudge (2003) [+] Interview (telephone)	Australia	Registered nurses (NR)	Rural	Mental health and substance misuse services
Coombes & Wratten (2007) [++] Interview (face-to-face)	UK	Mental health nurses (n=7)	Mixed	Community setting (not specified)
Hodges et al. (2006) [-] Interview (face-to-face)	Scotland	Commissioners (n=26)	Mixed	NR
Maslin et al. (2001) [-] Survey (open-ended)	UK	Practitioners (n=136)	Urban	Mental health and substance misuse services
Roberts & Darryl (2014) [+] Interview (format NR)	Australia	Key informants (senior policy executives, service providers, and consumer researchers with expert knowledge in the field of dual diagnosis) (n=19)	Mixed	Range of settings (not specified)

Siddiqui et al. (2009) [+] Interviews (face-to-face)	US	Staff from the modified therapeutic community (MTC) model (n=7)	Urban	Dual diagnosis service for homeless service users
Sylvain & Lamothe (2012) [+] Interviews, participant observation and analysis of documents	Canada	Practitioners involved in integrating mental health and substance abuse services (n=23)	Urban	Mental health and substance misuse services
St Mungo's Broadway (2015) [-] NR	UK	Practitioners (NR)	Mixed	Homelessness charity and housing association

Narrative summary

Eight studies provided evidence of barriers or facilitators associated with the management of cases with members of the same team and across different health and social care agencies. Key characteristics of the contributing studies are summarised in Table 12.

Barriers

Five studies (Coombes & Wratten (2007) [++], Maslin et al. (2001) [-], Roberts & Darryl (2014) [+], Sylvain & Lamothe (2012) [+], St Mungo's Broadway (2015) [-]) reported on barriers associated with the management of cases both within the same team and with practitioners from other agencies. Difficulties in managing cases were described as being due to a lack of a shared approach as well as an inability to work collaboratively. In a UK-based study, Coombes & Wratten (2007), 1 mental health nurse described her frustration in managing service users with a dual diagnosis:

"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"

This sentiment was apparent within a single team:

"She [mental health nurse] found that the team was pulling in different directions regarding the care of the client"

It was also expressed across agencies, as detailed in Sylvain & Lamothe (2012):

"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'."

One study, which involved commissioners based in Scotland (Hodges et al. (2006) [-]), found views that were consistent with those of practitioners, outlining a lack of a shared approach to managing service users with a dual diagnosis:

"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

Four studies (Barnes & Rudge (2003) [+], Siddiqui et al. (2009) [+], Sylvain & Lamothe (2012) [+], St Mungo's Broadway (2015) [-]) reported that the effective management of cases both within the same team and with practitioners from other agencies could act as a facilitator to the improved provision of health and social care. By sharing the responsibility of care, organising regular case management meetings and having discussions, practitioners were able to share knowledge and skills, potentially improving the quality of delivered care, as mentioned by a practitioner in Sylvain & Lamothe (2012):

"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."

In St Mungo's Broadway (2015), staff described how effective co-ordination of care between services may help improve the detection of mental health issues preventing a deterioration in symptoms which could lead to inpatient treatment:

"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."

In Barnes & Rudge (2003) a practitioner described how the management of service users with a dual diagnosis could be improved through sharing responsibilities and regular communication between mental health and substance misuse services:

"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"

This was echoed by another practitioner in Barnes & Rudge (2003) who touched upon the need for an integration of services:

"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".

Evidence statement 2.1.7: Co-ordinating care

Eight studies provided evidence of barriers or facilitators associated with the management of cases with members of the same team and across different health and social care agencies.

Three UK studies (1[++][2] and 2[-][4,8]) conducted in community settings, mental health and substance misuse services and a homelessness charity, 1[+][5] Australian study conducted in a range of unspecified settings and 1[+][7] Canadian study conducted in mental health and substance misuse services reported a consistent view that difficulties in the co-management of cases could act as a barrier to the provision of effective health and social care. This was attributed as being due to a lack of a shared approach in dealing with service users with a dual diagnosis which resulted in an inability to work collaboratively both within a team and across treatment agencies.

One UK study 1[-][3] involving commissioners found a consistent view that differences in practitioners' approach to dual diagnosis could act as a barrier to the delivery of health and social care.

One Australian study 1[+][1] conducted in rural mental health and substance misuse settings, 1[+][6] US study conducted in a dual diagnosis service for homeless service users and 1[+][7] Canadian study conducted in mental health and substance misuse services reported that the effective management of cases both within the same team and with practitioners from other agencies could act as a facilitator to the provision of health and social care. Aspects such as organising case-management meetings, sharing responsibilities and regular communication were seen as essential to the provision of health and social care for service users with a dual diagnosis. One UK study 1[-][8] conducted in a homelessness charity reported that the effective management of cases between agencies could help the early detection of mental health problems preventing the potential need for costly inpatient treatment or sectioning should symptoms deteriorate.

Applicability to UK:
Although only 4 of the 8 studies were conducted in the UK, this evidence is directly applicable to the delivery of care in the UK because issues regarding the co-ordination of care are not likely to differ in a significant way across countries.

[1]Barnes & Rudge (2003) [+]
[2]Coombes & Wratten (2007) [++]
[3]Hodges et al. (2006) [-]
[4]Maslin et al. (2001) [-]
[5]Roberts & Darryl (2014) [+]
[6]Siddiqui et al. (2009) [+]
[7]Sylvain & Lamothe (2012) [+]
[8]St Mungo's Broadway (2015) [-]

5.6.2 Challenges with the service user group

Table 13: Summary of characteristics of studies contributing to the theme: challenges with the service user group

Author (year) [quality] Data collection method	Country	Target population (n)	Geographical location	Service setting
Deans & Soar (2005) [+] Interview (face-to-face)	Australia	Mental health practitioners (n=13)	Rural	Mental health services
McLaughlin et al. (2008) [-] Interview (face-to-face)	UK	Recently appointed dual diagnosis practitioners (n=8)	Mixed	Mental health and substance misuse services
Mericle et al. (2007) [+] Interview (face-to-face)	US	Dual diagnosis practitioners (n=17)	Urban	Intensive case management programmes

Narrative summary

Three studies provided evidence of barriers associated with challenges with the service user group. No facilitators were identified. Key characteristics of the contributing studies are summarised in Table 13.

Barriers

Three studies (Deans & Soar (2005) [+], McLaughlin et al. (2008) [-], Mericle et al. (2007) [+]) described how it was particularly challenging for staff to work with service users with a dual diagnosis. This was mainly due to the impact of current misuse of drugs and alcohol on the service user, which presented a barrier to effective engagement and co-ordination of care. In Deans & Soar (2005) 1 mental health practitioner stated how the misuse of drugs could interfere with treatment goals:

"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."

In McLaughlin et al (2008) a dual diagnosis practitioner expressed the difficulty in working with service users who were resistant to change:

"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."

In Mericle et al (2007), dual diagnosis practitioners described how it was often difficult to engage service users in treatment as some were not honest about their usage of drugs and/or alcohol:

"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'."

Evidence statement 2.1.8: Challenges with the service user group

Three studies provided evidence of barriers associated with the challenging nature of the service user group. No facilitators were identified.

One Australian study (1[+][1]) conducted in mental health services, 1[+][3] US study conducted in an intensive case management programme and 1[-][2] UK study conducted in mental health and substance misuse services consistently reported that the challenge of engaging with and co-ordinating care for service users with a dual diagnosis could act as a barrier to the provision of adequate health and social care. The main aspects of dual diagnosis which were deemed challenging were the current misuse of drugs and alcohol, which was found to interfere with the treatment of the mental health disorder, the complexity and long-enduring nature of the comorbid substance-use disorder, as well as service users' frequent denial of drug and alcohol problems or resistance to change.

Applicability to UK:
Although 2 out the 3 studies were conducted outside of the UK, this evidence is directly applicable to the delivery of care in the UK because the nature of the problems presented by service users with a dual diagnosis is not likely to differ between countries.

[1]Deans & Soar (2005) [+]
[2]McLaughlin et al. (2008) [-]
[3]Mericle et al. (2007) [+]

5.7 INVOLVEMENT OF, AND SUPPORT FOR, FAMILY AND CARERS

This conceptual category contains the following theme:

- **Lack of carer support**

5.7.1 Lack of carer support

Table 14: Summary of characteristics of studies contributing to the theme: lack of carer support

Author (year) [quality] Data collection method	Country	Target population (n)	Geographical location	Service setting
Hodges et al. (2006) [-] Interview (multiple methods)	Scotland	Commissioners (n=26)	Mixed	NR

Narrative summary

One study provided evidence of barriers associated with a lack of carer support. No facilitators were identified. Key characteristics of the contributing study are summarised in Table 14.

Barriers

One Scottish study involving commissioners (Hodges et al. (2006) [-]) found evidence that a lack of support for carers of people with a dual diagnosis was a barrier.

"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."

Evidence statement 2.1.9: Lack of carer support

One study provided evidence of barriers associated with lack of support for carers of people with a dual diagnosis. No facilitators were identified.

One Scottish study (1[-][1]) involving commissioners found evidence that a lack of support for carers could represent a gap in the provision of services for people with a dual diagnosis. Children who informally care for one or both of their parents were singled out as requiring support.

Applicability to UK:
This evidence is directly applicable because the study was conducted in the UK.

[1]Hodges et al. (2006) [-]

5.8 PATHWAYS THROUGH THE CARE SYSTEM

This conceptual category contains the following themes:

- **Service access criteria**
- **Organisation and continuity of care**

5.8.1 Service access criteria

Table 15: Summary of characteristics of studies contributing to the theme: service access criteria

Author (year) [quality] Data collection method	Country	Target population (n)	Geographical location	Service setting
Barnes & Rudge (2003) [+] Interview (telephone)	Australia	Registered nurses (NR)	Rural	Mental health and substance misuse services
Carey et al. (2000) [++] Focus group	US	Practitioners (n=12)	NR	Mental health services
Deans & Soar (2005) [+] Interview (face-to-face)	Australia	Mental health practitioners (n=13)	Rural	Mental health services
Hodges et al. (2006) [-] Interview (multiple methods)	Scotland	Commissioners (n=26)	Mixed	NR
Perryman et al. (2011) [+] Postal survey (3 open-ended questions)	UK	Alcohol treatment service providers	Mixed	Community and residential alcohol agencies

St Mungo's Broadway (2015) [-] NR	UK	Practitioners (NR)	Mixed	Homelessness charity and housing association

Narrative summary

Six studies provided evidence of barriers associated with service access criteria. No facilitators were identified. Key characteristics of the contributing studies are summarised in Table 15.

Barriers

Five studies involving practitioners (Barnes & Rudge (2003) [+], Carey et al. (2000) [++], Deans & Soar (2005) [+], Perryman et al. (2011) [+], St Mungo's Broadway (2015) [-]) described how service users tended to fall in the gap between mental health and substance misuse services because neither service was willing to deal with the comorbid disorder, thus presenting a major barrier to the provision of health and social care. In Barnes & Rudge (2003), a mental health practitioner summarised this by saying:

"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".

In Carey et al. (2000), practitioners described criteria for entry to mental health and substance misuse services as being too stringent and restrictive, resulting in a barrier to the access of care for service users with a dual diagnosis:

"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."

In St Mungo's Broadway (2015), stringent entry criteria for entry to mental health services were seen as having a negative impact of friends and family, as well as the local community:

"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."

In Perryman et al. (2011), a UK-based study of alcohol treatment providers, providers noted that people with a dual diagnosis were poorly served because of a lack of resources:

"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, [...]. 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."

One Scottish study of commissioners (Hodges et al. (2006) [-]) found consistent views whereby no single service was seen to take responsibility for service users with a dual diagnosis:

"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."

Evidence statement 2.1.10: Service access criteria

Six studies provided evidence of barriers associated with service access criteria. No facilitators were identified.

Two Australian studies (2[+][1,3]) conducted in mental health and substance misuse services, 2 UK studies (1[+][5] and 1[-][6]) set in community and residential alcohol services and a homelessness charity and 1[++][2] US study conducted in mental health services consistently reported that mental health and substance misuse services failed to take responsibility for service users with a dual diagnosis. This resulted in service users being denied access to mental health and substance misuse services and potentially being unable to receive appropriate physical or social care. This was found to negatively impact friends, family and the local community as well as the individual with a dual diagnosis.

One Scottish study (1[-][4]) of commissioners found consistent views that that mental health and substance misuse services failed to take responsibility for service users with a dual diagnosis.

Applicability to UK:
Although only 3 out of 6 studies were conducted in the UK, this evidence is directly applicable to the delivery of care in the UK. This is because issues regarding the movement of service users along the care pathway are influenced by the same factors, such as restrictive entry criteria, which hinders the uptake of service users with a dual diagnosis.

[1]Barnes & Rudge (2003) [+]
[2]Carey et al. (2000) [++]
[3]Deans & Soar (2005) [+]
[4]Hodges et al. (2006) [-]
[5]Perryman et al. (2011) [+]
[6]St Mungo's Broadway (2015) [-]

5.8.2 Organisation and continuity of care

Table 16: Summary of characteristics of studies contributing to the theme: organisation and continuity of care

Author (year) [quality] Data collection method	Country	Target population (n)	Geographical location	Service setting
Fonseca et al. (2012) [-] Interview (format NR)	Spain	Practitioners from entry points to treatment for substance misuse (n=214)	Mixed	Primary care, general psychiatry and specialised addiction centres
Hodges et al. (2006) [-] Interview (multiple methods)	Scotland	Commissioners (n=26)	Mixed	NR
McLaughlin et al. (2008) [-] Interview (face-to-face)	UK	Recently appointed dual diagnosis practitioners (n=8)	Mixed	Mental health and substance misuse services
Mericle et al. (2007) [+] Interview (face-to-face)	US	Dual diagnosis practitioners (n=17)	Urban	Intensive case management programmes
St Mungo's Broadway (2015) [-] NR	UK	Practitioners (NR)	Mixed	Homelessness charity and housing association

Narrative summary

Five studies provided evidence of barriers or facilitators associated with a lack of continuity of care for service users with a dual diagnosis. Key characteristics of the contributing studies are summarised in Table 16.

Barriers

Four studies (Fonseca et al. (2012) [-], McLaughlin et al. (2008) [-], Mericle et al. (2007) [+], St Mungo's Broadway (2015) [-]) that involved practitioners highlighted barriers associated with the organisation and delivery of health and social care for service users with a dual diagnosis. This was voiced by a large proportion of participants in Mericle et al. (2007):

"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"

In St Mungo's Broadway (2015), staff described how this could result in poor quality care and problems with future engagement of service users:

"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."

In McLaughlin et al (2008), dual diagnosis workers expressed uncertainties about 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."

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

Other barriers included limited access to long-term care, as described in Fonseca et al. (2012):

"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'."

In Mericle et al. (2007), the lack of long-term care was reported as having the potential to lead to service users relapsing:

"*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."*

One Scottish study (Hodges et al. (2006) [-]) involving commissioners found consistent views that pathways for service users with a dual diagnosis were inadequately planned and supported:

"*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*."

Facilitators

One Scottish study (Hodges et al. (2006) [-]) involving commissioners provided an example from South West Edinburgh of how good links between mental health and social care services could act as a facilitator to the provision of care as well as reducing waiting times:

"*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*."

Evidence statement 2.1.11: Organisation and continuity of care

Five studies provided evidence of barriers or facilitators associated with a lack of organisation and continuity of care for service users with a dual diagnosis.

One Spanish study (1[-][1]) conducted in primary care, mental health and substance misuse services, 2[-][3,5] UK studies conducted in mental health and substance misuse services and a homelessness charity, and 1[+][4] US study conducted in intensive case management programmes reported a consistent view that barriers associated with the organisation of care for service users with a dual diagnosis. Issues were mainly regarding which practitioners should make referrals and the lack of long term continuing care for service users.

One Scottish study (1[-][2]) of commissioners found consistent views that pathways for service users with a dual diagnosis were deemed to be inadequately planned and supported. However, commissioners from one area also provided an example of good practice, whereby good links between mental health and homeless services were reported to reduce waiting times and improve the delivery of care to service users with a dual diagnosis.

Applicability to UK:
Although only 3 out of the 5 studies were conducted in the UK, this evidence is directly applicable to the delivery of care in the UK.

[1]Fonseca et al. (2012) [-]
[2]Hodges et al. (2006) [-]
[3]McLaughlin et al. (2008) [-]
[4]Mericle et al. (2007) [+]
[5]St Mungo's Broadway (2015) [-]

5.9 POLICY, STRUCTURE AND LOCATION OF SERVICES

This conceptual category contains the following themes:

- **Co-location of services**
- **Integrating services**
- **Cultural differences**

5.9.1 Co-location of services

Table 17: Summary of characteristics of studies contributing to the theme: co-location of services

Author (year) [quality] Data collection method	Country	Target population (n)	Geographical location	Service setting
Barnes & Rudge (2003) [+] Interview (telephone)	Australia	Registered nurses (NR)	Rural	Mental health and substance misuse services
Fonseca et al. (2012) [-] Interview (format NR)	Spain	Practitioners from entry points to treatment for substance misuse (n=214)	Mixed	Primary care, general psychiatry and specialised addiction centres

Narrative summary

Two studies provided evidence of barriers and facilitators associated with location of mental health and substance misuse services. Key characteristics of the contributing studies are summarised in Table 17.

Barriers

One study (Fonseca et al. (2012) [-]) reported that the co-location of services could be experienced as a barrier to accessing treatment. This was specifically with regards to the location of substance misuse services within the same building as primary care services:

"The co-location of services in the same centre (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."

In a similar vein, a lack of proximity between services could act as a barrier to the co-ordination of care:

"In rural areas, distances to the centres and a poor network of public transport were highlighted as barriers to treatment."

Facilitators

Two studies (Barnes & Rudge (2003) [+], Fonseca et al. (2012) [-]) reported that the physical location of mental health and substance misuse services could act as a facilitator to the access of healthcare for service users with a dual diagnosis. The close proximity of services meant that service users could easily access a range of services, as described by a nurse from a substance misuse service in Barnes & Rudge (2003):

"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'."

Fonseca et al. (2012) also reported that the co-location of mental health and substance misuse services was well received by service users and practitioners, and helped improve the co-ordination of care:

"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."

Evidence statement 2.1.12: Co-location of services

Two studies provided evidence of barriers or facilitators associated with location of mental health and substance misuse services.

One Spanish study (1[-][2]), found mixed views on the co-location of services. While difficulties accessing multiple services, due to poor transport systems in rural areas, was seen as a barrier, the close proximity of services was also seen as an issue. More specifically the location of substance misuse services within the same building as primary care services, was seen as barrier. This was due to the stigma associated with being seen using substance misuse services by friends and family attending primary care services.

One Australian study (1[+][1]) conducted in mental health and substance misuse services and 1[-][2] Spanish study conducted in primary care, mental health and

substance misuse services reported that co-location or close proximity of mental health and substance misuse services could act as a facilitator to the access of healthcare for service users with a dual diagnosis.

Applicability to UK:
Although none of the studies were conducted in the UK, this evidence is partially applicable to the delivery of care in the UK because issues regarding the co-location of services are unlikely to differ across countries.

[1]Barnes & Rudge (2003) [+]
[2]Fonseca et al. (2012) [-]

5.9.2 Integrating services

Table 18: Summary of characteristics of studies contributing to the theme: integrating services

Author (year) [quality] Data collection method	Country	Target population (n)	Geographical location	Service setting
Fonseca et al. (2012) [-] Interview (format NR)	Spain	Practitioners from entry points to treatment for substance misuse (n=214)	Mixed	Primary care, general psychiatry and specialised addiction centres
Hodges et al. (2006) [-] Interview (multiple methods)	Scotland	Commissioners (n=26)	Mixed	NR
McLaughlin et al. (2008) [-] Interview (face-to-face)	UK	Recently appointed dual diagnosis practitioners (n=8)	Mixed	Mental health and substance misuse services
Siddiqui et al. (2009) [+] Interviews (face-to-face)	US	Staff from the modified therapeutic community (MTC) model (n=7)	Urban	Dual diagnosis service for homeless service users

Narrative summary

Four studies provided evidence of barriers or facilitators associated with increased integration of mental health and substance misuse services. Key characteristics of the contributing studies are summarised inTable 18.

Barriers

One Scottish study of commissioners (Hodges et al. (2006) [-]) highlighted potential barriers associated with the integration of mental health and substance misuse services. These were centred on a perceived difficulty in achieving an integrated service which functioned effectively as well as the possibility that such a service may not be able to meet the needs of all service users:

"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."

There was also a lack of understanding among some commissioners about the remit of an integrated service:

"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

Two studies (Fonseca et al. (2012) [-], Siddiqui et al. (2009) [+]) reported that practitioners felt there was a specific need for an integration of services to provide health and social care for service users with a dual diagnosis:

"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"

The integration of services was highlighted as being particularly important in targeting substance misuse, as described by Fonseca et al. (2012):

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

Although the need for integrated services was clear, 1 UK study (McLaughlin et al. 2008) found mixed views about where dual diagnosis workers should be based, with some practitioners showing a preference to being placed in mental health or substance misuse services:

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

Conversely, other dual diagnosis workers favoured a separate dual diagnosis 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."

Hodges et al. (2006) [-] described how most of the commissioners they interviewed also reported facilitators associated with the integration of services. More specifically, the integration of services was seen as beneficial for the delivery of care for service users with complex needs and the sharing of budgets was seen as a way to improve relationships between services:

"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."

Evidence statement 2.1.13: Integrating services

Four studies provided evidence of barriers or facilitators associated with the integration of mental health and substance misuse services.

One Scottish study (1[-][2]) of commissioners found evidence of barriers and facilitators associated with the integration of services. Complexities in achieving a seamless integrated service were highlighted. There was also confusion about the perceived function of an integrated service, with some commissioners viewing it as a holistic service which would address wider social care needs, such as child protection. Despite such barriers the authors stated that the majority of commissioners felt that integrating services would be essential for the effective and efficient delivery of care for service users with complex needs. Additionally, some commissioners noted that relationships between different services could be expected to improve if they were required to share budgets and resources.

One Spanish study (1[-][1]) conducted in primary care, mental health and substance misuse services and 1[+][4] US study conducted in a dual diagnosis service for

homeless service users reported on the need for integrated services to improve access to health and social care for service users with a dual diagnosis. In 1 UK study (1[-][3]), dual diagnosis workers had mixed views regarding the way in which integrated services should be structured. Some favoured a separate dual diagnosis services, whilst others preferred being based in a mental health service or a substance misuse service.

Applicability to UK:
Although only 2 out of the 4 studies were conducted in the UK this evidence is partially applicable to the delivery of care in the UK because issues associated with the increased integration of services are likely to be similar between countries.

[1]Fonseca et al. (2012) [-]
[2]Hodges et al. (2006) [-]
[3]McLaughlin et al. (2008) [-]
[4]Siddiqui et al. (2009) [+]

5.9.3 Cultural differences

Table 19: Summary of characteristics of studies contributing to the theme: cultural differences

Author (year) [quality] Data collection method	Country	Target population (n)	Geographical location	Service setting
Brown et al. (2002) [+] Focus group	US	Mental health and substance misuse practitioners (n=48)	Mixed	Mental health and substance misuse services
Coombes & Wratten (2007) [++] Interview (face-to-face)	UK	Mental health nurses (n=7)	Mixed	Community setting (not specified)
Hodges et al. (2006) [-] Interview (multiple methods)	Scotland	Commissioners (n=26)	Mixed	NR
	Australia	Key informants (senior policy	Mixed	Range of settings

Roberts & Darryl (2014) [+] Interview (format NR)		executives, service providers, and consumer researchers with expert knowledge in the field of dual diagnosis) (n=19)		(not specified)
Sylvain & Lamothe (2012) [+] Interviews, participant observation and analysis of documents	Canada	Practitioners involved in integrating mental health and substance abuse services (n=23)	Urban	Mental health and substance misuse services

Narrative summary

Five studies provided evidence of barriers associated with cultural differences[3] in the approach to dual diagnosis both within and between services. No facilitators were identified. Key characteristics of the contributing studies are summarised in Table 19.

Barriers

Four studies involving practitioners (Brown et al. (2002) [+], Coombes & Wratten (2007) [++], Roberts & Darryl (2014) [+], Sylvain & Lamothe (2012) [+]) described how mental health and substance misuse services differed in their approach to the delivery of care for service users with a dual diagnosis. This was mentioned by a community mental health nurse in Coombes & Wratten (2007):

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

This was echoed in Roberts & Darryl (2014):

"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."

Cultural differences in practice criteria were found to lead to negative attitudes between practitioners from mental health and substance misuse services, to the extent that practitioners became resistant to the approach of providers in other services and questioned their knowledge. This was particularly felt by practitioners from substance misuse services (Roberts & Darryl., 2014):

[3] 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

“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.”

In Brown et al. (2002), a substance misuse practitioner expressed her frustration with mental health practitioners who questioned her knowledge about service users with a dual diagnosis:

“You know, one of the things that I find so frustrating for me is, okay, I'm a drug 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.”

As well as putting a strain on the working relationships of staff from different services, cultural difference were found to have a negative impact on the delivery of care to service users with a dual diagnosis. An example of this was provided in Sylvain & Lamothe (2012):

“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.”

One Scottish study involving commissioners (Hodges et al. (2006) [-]) reported entrenched views, whereby cultural differences were seen as potentially jeopardising partnerships between services:

“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.”

Evidence statement 2.1.14: Cultural differences

Five studies provided evidence of barriers associated with cultural differences[4] between services in terms of their approaches to dual diagnosis. No facilitators were identified.

One UK study (1[++][2]) conducted in community settings, 1[+][1] US study conducted in mental health and substance misuse services, 1[+][4] Australian study conducted in a range of unspecified settings and 1[+][5] Canadian study conducted in mental health and substance misuse services reported a consistent view that different conceptualisations and the consequent approach adopted to the delivery of care between mental health and substance misuse services acted as a barrier to the provision of care. These differences were also found to strain working relationships between staff from mental health and substance misuse services. This was particularly reported as a problem experienced by substance misuse practitioners who felt their views or expertise was often ignored by mental health professionals.

One Scottish study (1[-][3]) involving commissioners found a consistent view that cultural differences may jeopardise partnerships between services.

Applicability to UK:
As only 2 out of the 5 studies were conducted in the UK this evidence is only partially applicable to practitioners, commissioners and the delivery of care in the UK.

[1]Brown et al. (2002) [+]
[2]Coombes & Wratten (2007) [++]
[3]Hodges et al. (2006) [-]
[4]Roberts & Darryl (2014) [+]
[5]Sylvain & Lamothe (2012) [+]

[4] 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

5.10 STAFF SUPPORT, SUPERVISION AND TRAINING NEEDS

This conceptual category contains the following themes:

- **Staff support and supervision**
- **Training needs**

5.10.1 Staff support and supervision

Table 20: Summary of characteristics of studies contributing to the theme: staff support and supervision

Author (year) [quality] Data collection method	Country	Target population (n)	Geographical location	Service setting
Carey et al. (2000) [++] Focus group	US	Practitioners (n=12)	NR	Mental health services
Coombes & Wratten (2007) [++] Interview (face-to-face)	UK	Mental health nurses (n=7)	Mixed	Community setting (not specified)
Maslin et al. (2001) [-] Survey (open-ended)	UK	Practitioners (n=136)	Urban	Mental health and substance misuse services
McLaughlin et al. (2008) [-] Interview (face-to-face)	UK	Recently appointed dual diagnosis practitioners (n=8)	Mixed	Mental health and substance misuse services
Mericle et al. (2007) [+] Interview (face-to-face)	US	Dual diagnosis practitioners (n=17)	Urban	Intensive case management programmes

Narrative summary

Five studies provided evidence of barriers or facilitators to the effective delivery of health and social care related to staff support and supervision. Key characteristics of the contributing studies are summarised in Table 20.

Barriers

Five studies (Carey et al. (2000) [++], Coombes & Wratten (2007) [++], Maslin et al. (2001) [-], McLaughlin et al. (2008) [-], Mericle et al. (2007) [+]) reported that practitioners required additional support and supervision, such as access to expert consultation and advice, when providing assessments and treatment for service users with a dual diagnosis. This was often understood as arising from the practitioner's lack of knowledge, experience and confidence to deliver care in the area of dual diagnosis, as described by Coombes & Wratten (2007):

"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."

The difficult nature of this group of service users is also a factor, as noted in McLaughlin et al. (2008):

"*Clinical supervision is important […] I need it as I'll be working with a very difficult client group."*

Facilitators

One study (McLaughlin et al. (2008) [-]) outlined how staff support from colleagues could be viewed as a facilitator of an improved quality in the delivery of care for this client group:

"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."

Evidence statement 2.1.15: Staff support and supervision

Five studies provided evidence of barriers or facilitators for the effective delivery of health and social care related to staff support and supervision.

Three UK studies (1[++][2] and 2[-][3,4]) and 2 US studies (1[++][1] and 1[+][5]) conducted in mental health services, substance misuse services, community settings and an intensive case management programme provided a consistent view that a lack of adequate support and clinical supervision acted as a barrier to the delivery of effective treatment. Examples of support included access to expert consultation and advice.

In 1[-][4] UK study which interviewed recently appointed dual diagnosis practitioners, the receipt of support from other practitioners was seen as a facilitator to the delivery of care.

Applicability to UK:
Although only 3 of the 5 studies were conducted in the UK, this evidence is directly applicable to practitioners in the UK because issues regarding staff support and supervision are not likely to differ across countries.

[1]Carey et al. (2000) [++]
[2]Coombes & Wratten (2007) [++]
[3]Maslin et al. (2001) [-]
[4]McLaughlin et al. (2008) [-]
[5]Mericle et al. (2007) [+]

5.10.2 Training needs

Table 21: Summary of characteristics of studies contributing to the theme: training needs

Author (year) [quality] Data collection method	Country	Target population	Geographical location	Service setting
Brown et al. (2002) [+] Focus group	US	Mental health and substance misuse practitioners (n=48)	Mixed	Mental health and substance misuse services
Carey et al. (2000) [++] Focus group	US	Practitioners (n=12)	NR	Mental health services
Coombes & Wratten (2007) [++] Interview (face-to-face)	UK	Mental health nurses (n=7)	Mixed	Community setting (not specified)
Deans & Soar (2005) [+]	Australia	Mental health practitioners (n=13)	Rural	Mental health services

Interview (face-to-face)				
Fonseca et al. (2012) [-] Interview (format NR)	Spain	Practitioners from entry points to treatment for substance misuse (n=214)	Mixed	Primary care, general psychiatry and specialised addiction centres
Hodges et al. (2006) [-] Interview (multiple methods)	Scotland	Commissioners (n=26)	Mixed	NR
Maslin et al. (2001) [-] Survey (open-ended)	UK	Practitioners (n=136)	Urban	Mental health and substance misuse services
McLaughlin et al. (2008) [-] Interview (face-to-face)	UK	Recently appointed dual diagnosis practitioners (n=8)	Mixed	Mental health and substance misuse services
Mericle et al. (2007) [+] Interview (face-to-face)	US	Dual diagnosis practitioners (n=17)	Urban	Intensive case management programmes
St Mungo's Broadway (2015) [-] NR	UK	Practitioners (NR)	Mixed	Homelessness charity and housing association

Narrative summary

Evidence from 10 studies indicated that a lack of training was viewed as a prominent barrier to the effective delivery of care for service users with a dual diagnosis. No facilitators were reported. Key characteristics of the contributing studies are summarised in Table 21.

Barriers

Nine studies (Brown et al. (2002) [+], Carey et al. (2000) [++], Coombes & Wratten (2007) [++], Deans & Soar (2005) [+], Fonseca et al. (2012) [-], Maslin et al. (2001) [-], McLaughlin et al. (2008) [-], Mericle et al. (2007) [+], St Mungo's Broadway (2015) [-]) reported that practitioners required additional training to effectively engage and treat service users with a dual diagnosis.

In particular, practitioners expressed the need for further training in the combined occurrence of serious mental illness and substance misuse. In Deans & Soar (2005), 1 psychiatrist noted limitations in basic training in 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."

Other practitioners working in mental health and dual diagnosis services and a homelessness charity expressed the need for more specific training in substance misuse. In Maslin et al. (2001) 1 mental health clinician requested:

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

In St Mungo's Broadway (2015), staff outlined a need for training and guidelines about how to improve links with physical health services:

"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."

A lack of training was described as having a negative effect on the delivery of care as illustrated in McLaughlin et al. (2008), where a dual diagnosis worker stated that training may also increase staff confidence:

"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."

Staff interviewed in Coombes & Wratten (2007) also acknowledged that a lack of knowledge and experience with regards to dual diagnosis could exacerbate their patients' problems:

"*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."*

Fonseca et al. (2012) described how further training could improve assessments and service user retention in treatment:

"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."

Although all studies consistently viewed a lack of training as a barrier to the delivery of services, 1 US-based study (Brown et al. 2002) found that staff education and training could result in the loss of staff from substance misuse services as they moved over to more specialised mental health services:

"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."

Consistent with the views of practitioners, 1 study based in Scotland (Hodges et al. (2006) [-]) interviewed commissioners and found a lack of knowledge and training as a barrier to the delivery of effective health and social care:

"Attention needed to be paid to […] 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" "[…] 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".

Evidence statement 2.1.16: Training needs

Ten studies reported that a lack of training may act as a barrier to the effective delivery of care for service users with a dual diagnosis. No facilitators were identified.

Four UK studies (1[++][3] and 3[-][7,8,10]) conducted in community settings, mental health and substance misuse services and a homelessness charity, 3 US studies (1[++][2] and 2[+][1,9]) conducted in mental health services and an intensive case management programme, 1[+][4] Australian study conducted in a mental health service and 1[-][5] Spanish study conducted in primary care, general psychiatry and specialised addiction centres provided a consistent view that a lack of adequate training and education acted as a barrier to the delivery of effective services and care. Examples include more specific training in substance misuse, dual diagnosis and about how to improve links with physical health services.

One Scottish study 1[-][6] of commissioners also found a consistent view that a lack of training could act as a barrier to the effective delivery of services.

One 1[+][1] US based study additionally found that delivering extra training to staff in substance misuse services may result in the loss of staff to mental health services.

Applicability to UK:
Although only 5 out of the10 studies were conducted in the UK, this evidence is

directly applicable to practitioners or commissioners in the UK because issues regarding training are not likely to differ across countries.

[1]Brown et al. (2002) [+]
[2]Carey et al. (2000) [++]
[3]Coombes & Wratten (2007) [++]
[4]Deans & Soar (2005) [+]
[5]Fonseca et al. (2012) [-]
[6]Hodges et al. (2006) [-]
[7]Maslin et al. (2001) [-]
[8]McLaughlin et al. (2008) [-]
[9]Mericle et al. (2007) [+]
[10]St Mungo's Broadway (2015) [-]

5.11 DISCUSSION

Overall the review identified evidence that was a good fit with the thematic framework and reflected the context set out in the introduction. Significant barriers or facilitators to the delivery of effective health and social care were adequately captured.

Key issues

Some of the main barriers described by practitioners and commissioners centred on the structural organisation and co-ordination of services. The integration model as a concept was seen as essential to the effective delivery of health and social care, which led to difficulties with regards to referral, assessment, treatment and the ability to engage service users. Service users were often described as 'falling through the cracks' as they failed to meet service access criteria for mental health or substance misuse services. Partnership working between mental health and substance misuse services was seen as challenging due to a lack of a shared approach to dual diagnosis, which resulted in strained working relationships and conflict within and between services. Despite there being support for integrating services, practitioners and commissioners did not provide a clear view of how this could be achieved.

Yet there were examples of facilitators associated with joint working between agencies. These included the co-management of cases, regular communication and the sharing of responsibilities which were voiced as having a positive impact on the delivery of care and detection of mental health problems, aiding early intervention. The close proximity of different services was highlighted as a simple but effective way of improving access for service users with a dual diagnosis. Practitioners also noted that the delivery of mental health and social care could be facilitated by the incorporation of mental health and substance misuse assessment tools into a single assessment. This was viewed as a way to make assessments more efficient and reduce the likelihood of service users having restricted access to particular assessments because of their dual diagnosis.

The need for specific training and support was consistently highlighted by practitioners and commissioners. Many practitioners described a lack of formal training in dual diagnosis, which they felt was required due to the complexity of dealing with both conditions. The nature of dual diagnosis provided an additional barrier to the engagement of service users and co-ordination of care. The impact of current substance misuse on the service user and the often enduring nature of psychotic disorders made it difficult for practitioners to manage and engage service users in treatment. Staff highlighted how building positive and honest relationships with service users was crucial for the effective provision of care, but that this required significant time and resilience in the face of recurrent setbacks during treatment. Adopting a person centred approach and using appropriate language was also stressed as a key facilitator for improving service user engagement and reducing substance misuse.

Having negative attitudes towards service users with a dual diagnosis was seen as a common barrier to the effective delivery of health and social care and was reported across the care pathway. These attitudes were mostly directed towards substance

misuse, reflecting a societal prejudice towards people who misuse drugs and alcohol. This resulted in some practitioners feeling unable to talk about the use of drugs with service users. In both UK and US studies, the authors described how the relaxation of laws regarding substance misuse was described as a way to improve access to care, with a need to view drug and alcohol misuse as a mental health problem rather than a criminal act.

Limitations and gaps in the evidence

Out of 17 included studies only 6 were based in the UK, however this was generally found to only partially affect the applicability of the findings to a UK context. The overall quality of included evidence was low to moderate, with only 2 studies rated [++]. Common limitations included a lack of a justification for the research design and data collection methods, no explanation for the recruitment strategy and the absence of descriptions of how themes were derived from the data. Across all studies there was a consistent absence of discussion about how the researcher's views may have biased or influenced those of the participant. A lack of direct participant quotes reported within studies also meant that findings were often dependent on the interpretation of the author.

Gaps in the evidence included the absence of studies which explored the wider health needs of service users with a dual diagnosis. For example, no studies identified included the perspectives of physical health practitioners, and few studies touched upon views associated with social care. Despite some mention of general practitioners in the views expressed by mental health and substance misuse workers, only 1 study was conducted in a primary care setting. Although consideration was given to the needs of vulnerable groups, as detailed in section 3.4, when identifying studies and extracting data, only two studies which included the views of practitioners who worked with homeless service users were identified.

While the evidence broadly had a good fit with the framework, only 1 study reported findings related to the matrix theme about the 'involvement of, and support for, family and carers'. Only 1 study that included the views of commissioners was identified and while participants represented 7 different regions in Scotland, there was a lack detail in the reporting of findings as well as an absence of direct participant quotes.

In light of these gaps in the evidence, further research involving commissioners, general practitioners, physical health and social care providers is warranted. Additionally, due to considerable changes to service configuration in England post 2002, more recent evidence focusing on the impact of such changes on practitioner and commissioner perspectives is required

6 REVIEW QUESTION 2.2: What are the facilitators and barriers to accessing and using health and social care community services, and to satisfaction with those services, for people with coexisting severe mental illness and substance misuse and their family or carers?

6.1 STUDIES CONSIDERED FOR REVIEW QUESTION 2.2

The electronic database search identified 13,796 records. Of these, full-text appraisal was conducted for 148 records (and 13,648 were excluded on the basis of title and abstract). After a full-text review, 16 studies were included. Four additional reports were included; 2 were identified from the call for evidence, 1 was included from a set of case studies identified by the NICE project team, and 1 was identified during the scoping searches by the NICE project team. See Appendix 7 for PRISMA diagram, Appendix 10 for a bibliography of included studies and Appendix 11 for a bibliography of excluded studies with reasons for exclusion.

6.2 SUMMARY OF THE EVIDENCE FOR REVIEW QUESTION 2.2

6.2.1 Overview of included studies

Included studies mainly used a primary qualitative research design (N=13) and focused their research on the experience and/or views of care received (N=16). The majority of data was collected using interviews (N=13), with sample sizes ranging from 1 to 447 (mean: 46). Five studies were based in the UK. Service users in the included studies were drawn from a broad demographic and included young people, women and ex-offenders. The majority of studies focused exclusively on the experience of service users (N=15). See Appendix 14 for full evidence tables for RQ 2.2 which include detailed study information. Supporting information containing quotes coded as barriers or facilitators for each study can be found in Appendix 16.

Table 22: Study information table of included studies for RQ 2.2

	Qualitative studies included
Included studies	N = 20
Sample size	1 to 190 (mean: 48)
Study design	Primary qualitative research design (N=13); autobiographical account (N=1); mixed – primary qualitative + survey data (N=1); mixed – primary qualitative and observation (N=1); case study (N=4)
Focus of study	The experience and/or views of care received (N=16); experience/views of engagement with care (N=2); experience/views of assessment received (N=1); experience/views of access to care (N=1)
Data collection	Interview (face-to-face) (N=8); focus group (N=4); interview (format not recorded) (N=3); interview (multiple methods) (N=2); focus group and interview (N=1); Internet forum data (N=1); Not reported (N=1).
Data collection setting	Not reported (N=12); community setting (N=3); multiple (home, community settings) (N=2); home (N=2); Internet forum data (N=1)
Country	US (N=10); UK (N=5); Australia (N=1); Sweden (N=1); Norway (N=1); Canada (N=1); Finland (N=1)
Geographical location	Not reported (N=15); Urban (N=3); mixed (N=2)
Population	Service users (N=15); service users and practitioners (N=3); service users and family/carers (N=2).

6.2.2 Quality assessment

The overall quality of included studies was judged to be moderate. Out of 20 studies, 2 were rated [++], 13 were rated [+] and 5 were rated [-]. This indicates that some of the views described in this section may be subject to potential bias. In most cases, the quality ratings were reduced due to insufficient information provided on qualitative methods. Common limitations included a lack of a justification for the research design and the absence of a discussion about how the researcher's views may have biased or influenced the formulation of the research question, the data collection or the views expressed by participants.

Table 23: Matrix of qualitative evidence for RQ2.2

Experience of care	Key points on the care pathway								
	Access	**Assessment**	**Discharge/ transfer of care**	**Secondary Mental Health Services**	**Substance Misuse Services**	**Specialist Dual Diagnosis Services**	**Social Care**	**Voluntary Services**	**Themes that apply to all points on the pathway**
Attention to physical and environmental needs			Johnson et al. (2013) [++]			Cruce, Öjehagen & Nordström (2012) [+]	Penn, Brooks & Worsham (2002) [+]; Tsai et al. (2010) [+]	Hodges et al. (2006) [-]	Villena & Chesla (2010) [++];Kozloff et al. (2013) [+]
Clear, comprehensible information and support for self-care						Cruce, Öjehagen & Nordström (2012) [+]			Rethink (2015) [-]
Continuity of care and smooth transitions	Johnson et al. (2013) [++]; Kozloff et al. (2013) [+]			Brooks et al. (2007) [+]; Hodges et al. 2006 [-]; Villena & Chesla (2010) [++]		Cruce, Öjehagen & Nordström (2012) [+]			VoiceAbility (2014) [-]
Effective treatment delivered by trusted professionals				Villena & Chesla (2010) [++]	Edland-Gryt (2013) [+];Kuo et al. (2013) [+]	Luciano & Carpenter-Song (2014)[+]			Cruce, Öjehagen & Nordström (2012) [+]; Edward & Robins (2012) [+]; Hodges et al. (2006) [-]; Holt & Treloar (2008) [-];

									Kozloff et al. (2013) [+]; Sorsa & Åstedt-Kurki (2013) [+]; Warfa et al. (2006) [+]; VoiceAbility (2014) [-]; Rethink (2015) [-]; Fraser et al. (2003) [-]
Emotional support, empathy and respect	Johnson et al. (2013) [++];			Green et al. (2015) [+]; Villena & Chesla (2010) [++]	Hodges et al. (2006) [-];Johnson et al. (2013) [++]	Cruce, Öjehagen & Nordström (2012) [+]; Hodges et al. (2006) [-]			Cruce, Öjehagen & Nordström (2012) [+]; Kozloff et al. (2013) [+];VoiceAbility (2014) [-]; Rethink (2015) [-]
Fast access to reliable health advice	Hodges et al. (2006) [-]; Kozloff et al. (2013) [+]			Brooks et al. (2007) [+]; Villena & Chesla (2010) [++]		Hodges et al. (2006) [-];			Hodges et al. (2006) [-]; Rethink (2015) [-]; Fraser et al. (2003) [-]
Involvement in decisions and respect for preferences				Brooks et al. (2007) [+]	Hodges et al. (2006) [-]				Sorsa & Åstedt-Kurki (2013) [+]
Involvement of, and support for, family and carers				EnglandKennedy (2011) [+]					Rethink (2015) [-]

6.3 ATTENTION TO PHYSICAL AND ENVIRONMENTAL NEEDS

This conceptual category contains the following themes:

- **Housing issues**
- **Employment issues**

6.3.1 Housing issues

Table 24: Summary of characteristics of studies contributing to the theme: housing issues

Author (year) [quality] Data collection method	Country	Target population (n)	Service setting	Geographical location
Cruce, Öjehagen & Nordström 2012 [+] Interview (face-to-face)	Sweden	Service users with severe mental illness and substance misuse (n=8)	Integrated outpatient programme/specialist dual diagnosis programme	Urban
Hodges et al. 2006 [-] Interview (format NR)	Scotland	Service users with severe mental illness and substance misuse (n=38)	Mental health services, substance misuse services and other psychosocial services in the statutory and voluntary sector	Mixed
Johnson et al. 2013 [++] Interview (multiple methods)	US	Female service users with major depressive disorder and substance misuse returning to the community from prison (n=54)	Participants were taken from 2 trials of treatment for co-occurring substance use and major depressive disorder among incarcerated women nearing release into the community	NR
Penn, Brooks & Worsham 2002 [+] Focus group	US	Female service users with severe mental illness and substance misuse (n=7)	Treatment centre running a project evaluating 12 step CBT versus self-management and recovery training	NR
Tsai et al. 2010 [+] Interview	US	Service users with severe mental illness and substance misuse and a history of homelessness	Supervised housing or independent housing	NR

(face-to-face)		(n=40)		
Villena & Chesla 2010 [++] Interview (face-to-face)	US	Service users with severe mental illness and substance misuse and general medical conditions (n=20)	Community treatment centres and supported housing sites	NR

Narrative summary

Evidence from 6 studies indicated that service users with a dual diagnosis face a number of barriers or facilitators in relation to accessing housing support. There are also factors that can facilitate access. Key characteristics of the studies contributing to this theme are summarised in Table 24.

Barriers

Five studies outlined a number of factors that inhibit access to housing support for service users with a dual diagnosis, and highlighted the impact of failing to provide adequate accommodation for this population (Cruce, Öjehagen & Nordström (2012) [+], Johnson et al. (2013) [++], Penn, Brooks & Worsham (2002) [+], Tsai et al. 2010 [+] and Villena & Chesla (2010) [++]).

Johnson et al. (2013) found a lack of transitional care for women leaving prison, which significantly impaired their ability to assimilate back into the community. In particular, this lack of support acted as a barrier to accessing safe and secure accommodation, as illustrated by 1 participant:

"Just getting' outta' jail and transitioning, ya' know, like into the real world. Like they don't know how hard it is (…) – just everything'- living situations, like apartments or whatever."

A lack of practical support was commonly mentioned by female ex-offenders as being problematic, and the provision of help on re-entry into the community was seen as key to avoiding relapse (Johnson et al. 2013). These women stated that they particularly wanted assistance with locating accommodation that was safe and preferably not in the same area in which they had previously taken drugs. These sentiments resonated with the findings of Penn, Brooks & Worsham (2002), as did the need for subsidised housing.

The desire to have housing needs recognised was often mentioned by service users in the context of addressing their wider multiple needs at the same time. These women sought a comprehensive integrated approach to care that would also provide both housing and employment assistance (Johnson et al. 2013).

In addition, female ex-offenders in Johnson et al. (2013) outlined that the provision of *"how to"* information in the absence of a mentor or key worker to assist with practical

support was unhelpful. This failing was seen as a further barrier to accessing support.

Both Johnson et al. (2013) and Tsai et al. (2010) revealed that the social stigma attached to mental illness also appeared to be a significant barrier to accessing housing in some instances:

"Housing is the number one problem getting out, but a lot of women don't make requests for housing help because it's embarrassing." (Service-user; Johnson et al. 2013)

"If you have a landlord that knows that you might have an illness, I got a feeling that they look at people differently (…). There's a hotel down here don't accept people from Thresholds [psychosocial rehabilitation agency]." (Service-user; Tsai et al. 2010)

In a detailed review of housing preferences among service users with a dual diagnosis by Tsai et al. (2010), some participants reported that their choices were limited due to miscommunication between staff. An additional barrier to accessing accommodation was the limited availability of housing for this group:

"Clients moved from place to place based on what was available and where treatment providers suggested they go."

Furthermore, Tsai et al. (2010) showed that there appears to be a misconception that people with a dual diagnosis have complete freedom to choose where they live:

"Housing options were provided by treatment staff or through their own searching, and sometimes these were superficial options (e.g., choosing dirty halfway house or own clean apartment)".

The failure to take account of service user preference may also constitute a barrier to accessing appropriate housing. In addition, Tsai et al. (2010) reported that people with a dual diagnosis often lack the requisite knowledge to access adequate housing and fail to ask about alternative options because they are not aware that other options exist. When 1 service user in supervised housing was asked why he did not get his own apartment, he responded:

"I didn't know about anything like that. I was offered just the one avenue. (...) You don't think about things like that, especially if you don't know those options are available."

Tsai et al. (2010) identified that financial problems stemming from low income, waiting for government benefits, poor credit history, previous criminal convictions and whether apartments accepted housing vouchers (for example, section 8 federal rental subsidy), also constituted significant barriers to accessing independent housing. This study also highlighted that long waiting lists are prohibitive to accessing other forms of accommodation, such as supervised housing.

Failures to provide support to this population, as described above, can impair their ability to live independently, and in some instances negatively impact on their mental and physical wellbeing. This point is illustrated by Villena & Chesla (2010).

"Informants who lived in SRO hotels perceived their unstable, unkempt, and crime-ridden housing and neighbourhoods as barriers to improving and/or maintaining their health. (…) The eight SRO hotels that served as recruitment sites for this study are located primarily in undesirable sections of the city and those with the highest crime rates."

"[A service user] lived in an SRO hotel where the property posed health risks like rodent and bed bug infestations. He described how his current living situation, specifically the uncontrolled bed bugs, led to severe mental distress and to "the verge of a breakdown at one time." (…) Thus, his bed bug infested housing created a domino effect on his health in that it impacted both his mental and physical health."

These sentiments were echoed in Cruce, Öjehagen & Nordström (2012), where it was found that supported housing often exposed service users to a turbulent living environment that had a negative influence on the recovery process.

People with a dual diagnosis also voiced a desire to receive assistance in accessing other social and legal services. In particular, the women in Penn, Brooks & Worsham (2002) stated that they wanted support in accessing legal advice, as well as help in navigating complex social care systems. They added that they felt they would benefit from having an advocate specifically allocated to them to assist in matters relating to the care of children (particularly in instances where there had been a loss of child custody).

Facilitators

Two studies (Cruce, Öjehagen & Nordström (2012) [+] and Hodges et al. (2006) [-]) discussed factors that facilitated access to housing support for people with a dual diagnosis. In particular, Hodges et al. (2006) found that voluntary services were instrumental in some instances:

"This project was viewed by one service user as being particularly good at resolving practical issues and addressing wider needs than simply the diagnosed problems. Staff helped with accommodation issues, clothing and practicalities such as form-filling." -

"They helped me get my flat. They helped me get out the gutter."

Cruce, Öjehagen & Nordström (2012) reported that living in a special housing scheme enhanced feelings of independence for people with a dual diagnosis, while also providing them with a sense of feeling safe and well supported:

"One participant greatly appreciated this form of housing, stating that it made him feel independent, i.e. not like a patient (...). Living in a special housing scheme (…) offered a feeling of safety through having enough to eat every day and ensuring

correct medication (...). [T]he alternative - living alone - could involve chaotic circumstances and probably homelessness."

Evidence statement 2.2.1: Housing issues

Evidence from 6 studies showed that people with a dual diagnosis face a number of barriers or facilitators when seeking to access social care services, particularly housing support.

Two US studies (2[++][3,6]) and 1 Swedish study (1[+])[1] reported consistent evidence suggesting that a failure to provide an adequate level of housing support or a suitable living environment for people with a dual diagnosis could have a negative impact on service users with the potential to trigger a relapse. One US study (1[++][3]) provided evidence to suggest that the lack of transitional support back into the community, as well as the social stigma associated with seeking assistance, were both factors that constituted barriers to accessing housing. The latter point was also reflected in another US study (1[+][5]), which in the context of seeking independent housing, also described how financial constraints and previous criminal convictions could act as barriers to accessing accommodation, and how long waiting lists were prohibitive when seeking access to supervised housing. This study also described a lack of choice of housing options for service users.

Views of supported housing were mixed. One US study (1[++][6]) and 1[+][1] Swedish study suggested that supported housing was often inadequate with reports of high levels of crime and unkempt facilities which had a detrimental impact on service users' health. Yet the same Swedish study ([+][1]) also suggested that 'special housing' could have a positive impact on service users, enhancing feelings of independence.

One Scottish study (1[-][2]) reported that voluntary services may facilitate access to accommodation for people with a dual diagnosis.

Applicability to UK:
Only 1 of the 6 studies was conducted in the UK (in Scotland), while the rest were conducted in either the US or Sweden. Despite the fact that most of these studies were not UK based, general themes such as the impact of poor transitional care, social stigma in regards to seeking support, and the deleterious effect of poor housing on both physical and mental health are likely to be directly applicable to most healthcare settings irrespective of geographical location.

Comments made relating to transitional care emerged in the specific context of women transitioning back to the community from prison. Nevertheless, these themes are still directly applicable to other transitional contexts (for example, when service users transition from inpatient care to community settings).
Some of the financial barriers to accessing housing support are only likely to be partially applicable to a UK setting. For example, whilst a landlord accepting federal rental subsidy housing vouchers is US specific[5], a UK landlord discriminating against individuals in receipt of UK social security benefits is

analogous.

[1]Cruce, Öjehagen & Nordström (2012) [+]
[2]Hodges et al. (2006) [-]
[3]Johnson et al. (2013) [++]
[4] Penn, Brooks & Worsham (2002) [+]
[5] Tsai et al. (2010) [+]
[6] Villena & Chesla (2010) [++]

6.3.2 Employment issues

Table 25: Summary of characteristics of studies contributing to the theme: employment issues

Author (year) [quality] Data collection method	Country	Target population (n)	Service setting	Geographical location
Johnson et al. 2013 [++] Interview (multiple methods)	US	Female service users with major depressive disorder and substance misuse returning to the community from prison (n=54)	Participants were taken from 2 trials of treatment for co-occurring substance use and major depressive disorder among incarcerated women nearing release into the community	NR
Kozloff et al. 2013 [+] Focus group	Canada	Service users with severe mental illness and substance misuse aged 18-26 (n=23)	Inner city agencies offering mental health services to homeless young people with co-occurring disorders	NR
Penn, Brooks & Worsham 2002 [+] Focus group	US	Female service users with severe mental illness and substance misuse (n=7)	Treatment centre running a project evaluating 12 step CBT versus self-management and recovery training	NR

Narrative summary

Evidence was found from 3 studies outlining barriers or facilitators that may influence the ability of people with a dual diagnosis to access employment support. Key characteristics of the studies contributing to this theme are summarised in Table 25

Barriers

Evidence from 2 studies outlined barriers to accessing employment support (Johnson et al. (2013) [++] and Penn, Brooks & Worsham (2002) [+]). Johnson et al. (2013) noted that possessing a criminal record was a barrier to gaining employment, and outlined a need for assistance in securing a job on re-entering the community:

"Just maybe programs where they can transition you, I mean transition you fully back into the world. To society. You know, maybe placing women into employment if they're able to work (…)."– (Service-user; Johnson et al. 2013)

The need for support in regards to gaining employment was also mentioned by female participants in Penn, Brooks & Worsham (2002).

Facilitators

One study outlined the facilitators to accessing support in gaining employment (Kozloff et al. (2013) [+]). This study found that services offering recreational activities and vocational support were successful in engaging young people with a dual diagnosis. Furthermore, this support may not only have served to improve access to employment and enhance social wellbeing, but may also have helped these individuals abstain from substance use.

Evidence statement 2.2.2: Employment issues

Evidence from 3 studies showed that individuals with a dual diagnosis face a number of barriers or facilitators when seeking to access support in regards to gaining employment.

Evidence from 1[++][1] US study described how service users with a dual diagnosis face difficult obstacles when seeking to access social care services, particularly employment support. This study also provided evidence to suggest that possessing a criminal record had a negative impact on re-entry into the community and employment prospects. One US based study (1[+][3]) similarly described a lack of support for people who wish to return to work, which acted as a barrier to gaining employment.

In contrast, 1[+][2] Canadian study outlined that services offering vocational support facilitated engagement with young people with a dual diagnosis.

Applicability to UK:
None of the studies reporting on this theme were conducted in the UK. Despite this, the importance of providing employment support for members of this population is a theme that is directly applicable to most job seeking individuals within this population, irrespective of geographical location.

[1]Johnson et al. (2013) [++]
[2]Kozloff et al. (2013) [+]
[3]Penn, Brooks & Worsham (2002) [+]

6.4 CLEAR COMPREHENSIBLE INFORMATION AND SUPPORT FOR SELF-CARE

This conceptual category contains the following theme:

- **The provision of information/training**

6.4.1 The provision of information/training

Table 26: Summary of characteristics of studies contributing to the theme: The provision of information/training

Author (year) [quality] Data collection method	Country	Target population (n)	Service setting	Geographical location
Cruce, Öjehagen & Nordström 2012 [+] Interview (face-to-face)	Sweden	Service users with severe mental illness and substance misuse (n=8)	Integrated outpatient programme/specialist dual diagnosis programme	Urban
Rethink (2015) [-] Not reported	UK	Service users and family/carers (n=55)	NR	NR

Narrative summary

Evidence from 2 studies outlined the barriers or facilitators to accessing clear, comprehensible information and support for self-care. The failure of healthcare professionals to provide information acted as a barrier, whilst the provision of self-care training was regarded as helpful. Key characteristics of the study contributing to this theme are summarised in Table 26.

Barrier

One study outlined barriers to accessing information in support of self-care (Rethink (2015) [-]).The main barrier to accessing information about support was a lack of knowledge about what was available locally. In particular, the authors described how GPs were unaware of services which they could signpost or refer people to, especially in relation to voluntary sector community groups and services.

Facilitators

One study outlined facilitators to accessing information in support of self-care (Cruce, Öjehagen & Nordström (2012) [+]). This study stated that the provision of

self-care skills training facilitated engagement with other activities, including activities of daily living. Participants in this study outlined that the training they received (which included housework, road safety and occupational support) was an essential part of the recovery process. Recognising the wider context of recovery (that is, the importance of helping service users develop practical skills) promoted a greater understanding of how to carry out daily tasks effectively and independently. In addition, this study outlined that encouraging service users to recognise early signs of relapse in psychosis or substance misuse could help to prevent further relapses.

Evidence statement 2.2.3: The provision of information/ training

Two studies reported on barriers or facilitators associated with access to clear and comprehensible information and support for self-care.

Evidence from 1[-][2] UK study revealed that a failure to signpost support services resulted in a barrier to accessing information in relation to community groups. In particular, GPs were described as being unaware of local community groups which service users could access for support.

Evidence from 1[+][1] Swedish study described how the provision of self-care skills training facilitated activities of daily living, such as housework, road safety and occupational support. Undertaking such activities was viewed as an essential part of the recovery process which could help prevent relapse.

Applicability to UK:
Although only 1 of the 2 studies was conducted in the UK, the views expressed are broadly transferable across geographical locations and are therefore directly applicable within the UK context.

[1]Cruce, Öjehagen & Nordström (2012) [+]
[2]Rethink (2015) [-]

6.5 CONTINUITY OF CARE AND SMOOTH TRANSITIONS

This conceptual category contains the following theme:

- **Fragmented care**

6.5.1 Fragmented care

Table 27: Summary of characteristics of studies contributing to the theme: fragmented care

Author (year) [quality] Data collection method	Country	Target population (n)	Service setting	Geographical location
Brooks et al. 2007 [+] Focus group	US	Service users with severe mental illness and substance misuse (n=35)	Intensive (outpatient) day treatment programme	NR
Cruce, Öjehagen & Nordström 2012 [+] Interview (face-to-face)	Sweden	Service users with severe mental illness and substance misuse (n=8)	Integrated outpatient programme/specialist dual diagnosis programme	Urban
Hodges et al. 2006 [-] Interview (format NR)	Scotland	Service users with severe mental illness and substance misuse (n=38)	Mental health services, substance misuse services and other psychosocial services in the statutory and voluntary sector	Mixed
Johnson et al. 2013 [++] Interview (multiple methods)	US	Female service users with major depressive disorder and substance misuse returning to the community from prison (n=54)	Participants were taken from 2 trials of treatment for co-occurring substance use and major depressive disorder among incarcerated women nearing release into the community	NR
Kozloff et al. 2013 [+] Focus group	Canada	Service users with severe mental illness and substance misuse aged 18-26 (n=23)	Inner city agencies offering mental health services to homeless young people with co-occurring disorders	NR

Villena & Chesla 2010 [++] Interview (face-to-face)	US	Service users with severe mental illness and substance misuse and general medical conditions (n=20)	Community treatment centres and supported housing sites	NR
VoiceAbility 2014 [-] Interview (format NR)	UK	Service users with a dual diagnosis	NR	Urban

Narrative summary

Seven studies reporting on the barriers or facilitators to accessing healthcare services centred on the impact of fragmented care provision for people with a dual diagnosis. Consistent views were expressed stating that fragmented care provision often obstructs access to care, and in some instances engenders a sense of apathy in service users. The need for continuity of care emerged as integral to the creation of service user/practitioner relationships based on trust. Key characteristics of the studies contributing to this theme are summarised in Table 27.

Barriers

Six studies outlined barriers to accessing services that embodied continuity (Brooks et al. (2007) [+], Hodges et al. (2006) [-], Johnson et al. (2013) [++], Kozloff et al. (2013) [+], Villena & Chesla (2010) [++], and VoiceAbility 2014 [-]). In Brooks et al. (2007) service users reported diminished trust with case managers due to high turnover rates. This inconsistency in service provision appeared to promote apathy among service users, which may precipitate disengagement:

"I ain't got nothing to talk about when I ain't going to see them next month. When they're going to be gone and I'm going to be assigned another case manager."

In Hodges et al. (2006) 1 service user commented that the lack of consistency and continuity in staff provision was difficult to cope with. Another service user also felt he would have benefited from more consistent care:

"I got five CPNs in a row. I find it hard enough to trust one person over a long period of time then to be asked to be moved to another person in two weeks, on to another person and then another it's just impossible."

These opinions were mirrored by service users in Villena & Chesla (2010), who felt that the high rotation of healthcare providers and their chaotic presence fractured service user/practitioner relationships. Poor aftercare was also highlighted as problematic in VoiceAbility (2014) [-], and appeared to increase the risk of relapse:

"In the last few months I had a breakdown. I went to [a crisis house] for 4 months with their crisis team. We sorted out my flat. Since then, they said they'd get me a

[community psychiatric nurse], but I haven't heard anything. I was promised everything (...) it never occurred. (...) It's like I've been left, it's like they think 'now you've recovered' (...) I'm scared I'll reverse back into it." (Service user; VoiceAbility 2014).

Given that many people with a dual diagnosis require long-term treatment, there is a clear need for access to continuous and consistent support. Frequent changes within support structures (such as high staff rotation) jeopardise the creation of trust. Furthermore, a lack of continuity of care during transitions has been directly implicated as a trigger for relapse in people leaving prison (Johnson et al. 2013).

Members of particularly vulnerable subgroups within this already vulnerable population (such as young people moving from prison back into the community), reported significant gaps in service provision. For example, even when young people were released on bail under the condition that they enter addiction counselling, they were not connected with these services on release back into the community (Kozloff et al. 2013). As such, transitional care, too, appears to be extremely fragmented.

Facilitators

One study outlined factors that facilitated access to services that embodied continuity (Cruce, Öjehagen & Nordström (2012) [+]). This study outlined the benefits of consistent care. Participants stated that continuity of care with both key workers and their psychiatrist enhanced feelings of safety. They felt that their relationship with their care provider improved when staff got to know the person 'behind the symptoms'. This facilitated engagement with healthcare services, and as a result, the provision of consistent care was regarded as the foundation for a secure recovery process.

Evidence statement 2.2.4: Fragmented care

Evidence from 7 studies outlined barriers or facilitators associated with the impact of fragmented care provision on continuity of care for people with a dual diagnosis.

Two US studies (1[++][6] and 1[+][1]), 1[-][3] Scottish study and 1[-][7] UK study reported a consistent view that fragmented care provision could have a negative impact on service users' experience of care and willingness to engage with services. The common thread running through these service user accounts was that they felt that high staff turnover rates, coupled with inconsistent care provision, eliminated the possibility of building trusting relationships. This resulted in a negative perception of staff, apathetic responses to treatment and an unwillingness to engage.

One US study (1[++][4]) and 1[+][5] Canadian study revealed a consistent view that transitional care from prison back into the community was particularly fragmented. In the 1[++][4] US study, female ex-offenders described how their relapse was in part due to an inability to access services. In the 1[+][5] Canadian study young people described difficulties in accessing addiction counselling when moving back into the community, even when these were conditions of their bail order.

One Swedish study (1[+][2]) revealed the benefits of consistent care, which in turn facilitated engagement. Service users described an enhanced sense of trust in healthcare professionals, and this was said to positively impact the recovery process. In 1[-][7] UK study, good after-care was viewed as an important aspect for preventing relapse.

Applicability to UK:
Of these 7 studies, 2 were conducted in the UK and are therefore directly applicable. The rest of the evidence came from studies conducted in the US, Canada and Sweden, however the barriers to engagement identified are directly applicable to the UK setting.

[1]Brooks et al. (2007) [+]
[2]Cruce, Öjehagen & Nordström (2012) [+]
[3] Hodges et al. (2006) [-]
[4]Johnson et al. (2013) [++]
[5]Kozloff et al. (2013) [+]
[6]Villena & Chesla (2010) [++]
[7]VoiceAbility 2014 [-]

6.6 EFFECTIVE CARE DELIVERED BY TRUSTED PROFESSIONALS

This conceptual category contains the following themes:

- **Care environment**
- **Integrated approach to care**

6.6.1 Care environment

Table 28: Summary of characteristics of studies contributing to the theme: care environment

Author (year) [quality] Data collection method	Country	Target population (n)	Service setting	Geographical location
Edland-Gryt & Skatvedt 2013 [+] Focus group and interview	Norway	Service users with severe mental illness and substance misuse (n=66)	A 'low threshold' service for people with poor physical and mental health and who have an extensive use of illicit substances.	NR
Fraser et al. 2003 [-] Interview (face-to-face)	UK	Service users (n=45)	NR	Mixed
Hodges et al. 2006 [-] Interview (format NR)	Scotland	Service users with severe mental illness and substance misuse (n=38).	Mental health services, substance misuse services and other psychosocial services in the statutory and voluntary sector	Mixed
Holt & Treloar 2008 [-] Interview (multiple methods)	Australia	Service users with severe mental illness and substance misuse (n=77)	Substance misuse services and user organisations	NR
Kuo et al. 2013 [+] Focus group	US	Pregnant and postpartum women with substance misuse (n=8)	Perinatal substance misuse treatment programme providing outpatient care for pregnant/postpartum women with a	Urban

			substance misuse	
Rethink (2015) [-] Not reported	UK	Service users and family/carers (n=55)	NR	NR
Sorsa & Åstedt-Kurki 2013 [+] Interview (face-to-face)	Finland	Mothers with severe mental illness and substance misuse (n=1).	Psychiatric hospital ward and 2 substance misuse rehabilitation settings	NR
Villena & Chesla 2010 [++] Interview (face-to-face)	US	Service users with severe mental illness and substance misuse and general medical conditions (n=20)	Community treatment centres and supported housing sites	NR
Warfa et al. 2006 [+] Interview (format NR)	UK	Male service users with severe mental illness and substance misuse in contact with health and social care services (n=9)	Health and social care services	NR

Narrative summary

Evidence from 9 studies revealed that people with dual diagnosis face numerous barriers or facilitators when seeking to access effective care by trusted professionals. The treatment environment, which was a pervasive theme across all studies, includes issues relating to an appreciation of cultural sensitivities, the role of stigma, the role of the non-statutory sector, and issues pertaining to staff/financial resources that impact on the delivery of care. Key characteristics of the studies contributing to this theme are summarised in Table 28.

Barriers

Nine studies reported barriers to accessing effective care by trusted professionals (Edland-Gryt & Skatvedt (2013) [+], Fraser et al. (2003) [-], Hodges (2006) [-], Holt & Treloar (2008) [-], Kuo et al. (2013) [+], Rethink (2015) [-], Sorsa & Åstedt-Kurki (2013) [+], Villena & Chesla (2010) [++], and Warfa et al. (2006) [+].). Edland-Gryt & Skatvedt (2013) and Villena & Chesla (2010) highlighted that many service users distrust health and social care systems, as well as the staff working in these services, which appears to be a barrier to accessing effective treatment:

"If you do not trust the people working at the centre, you do not dare to ask for help". (Service user; Edland-Gryt & Skatvedt 2013)

"Some of the staff are just here for the money. They do not really care about us, and are more interested in talking to each other." (Service-user; Edland-Gryt & Skatvedt 2013)

In Villena & Chesla (2010) it was reported that a service user who suffered from physical health problems (blood pressure and obesity issues) "(…) trusted his case manager and psychiatrist [but] was sceptical [sic] of his medical doctors". This theme was apparent in other studies. For example, a mother with a dual diagnosis was distrustful of health and social care services after her children were taken into care on her admission to a psychiatric hospital (Sorsa & Åstedt-Kurki (2013).It is worth noting that the participant in this study also outlined feeling annoyed at health and social care staff who she perceived to pity her. As a result, this created an additional barrier to engagement.

Hodges et al. (2006) reported that a lack of dedicated dually trained staff was considered by service users to be extremely problematic. Similar views were expressed by males using health and social care services in East London (Warfa et al. 2006). They felt neglected by care providers, with some voicing concerns that their clinicians did not allocate an appropriate amount of time to them. Services users in one study (Kuo et al. 2013) mentioned the same concerns and indicated that adequate contact time was important to them as they felt particularly vulnerable due to the stresses of pregnancy or becoming new mothers. They also noted services should be tailored to their needs; for example logistical concerns such as transportation or provision of childcare ought to be considered.

Another factor that acted as a barrier to accessing effective care was a perceived failure of healthcare professionals to appreciate cultural differences, as expressed by a black Caribbean male in Warfa et al. (2006):

"My religious needs. They're not recognising things (…) because they come from a different society than what I've been brought up in (…)."

An inability to appreciate cultural differences may undermine the relationship between healthcare staff and service users in a way that limits engagement and deprives black and minority ethnic groups of appropriate care.

The role of stigma emerged as a barrier to accessing effective treatment across 4 studies: Fraser et al. (2003), Holt & Treloar (2008), Rethink (2015) and Villena & Chesla (2010). Villena & Chesla (2010) found that gaining effective treatment for physical health problems appeared to be difficult due to the negative stereotyping of people with a dual diagnosis by healthcare professionals:

"[The service user] perceived that her appearance, her mental history, and alcohol addiction contributed to difficulties in obtaining adequate diagnosis and care for her health. (...) Repeatedly, [her] clinical presentation led her to be treated as if she were psychotic when, in fact, she was in severe withdrawal with and delirium tremens."

In addition, Holt & Treloar (2008) found that people receiving support at a substance misuse treatment centre perceived the label of 'comorbidity' as stigmatising. The imposition of such labels and the negative connotations attached to them were

thought to discourage people with a dual diagnosis from accessing services. Similar issues emerged from service users consulted in Rethink (2015) and Fraser et al. (2003):

"For me, it is entirely about stigma. I have not specifically asked for treatment support with drugs/alcohol because I don't know if I can bear the double whammy of being labelled (…) as having problems both with my mental health and with addiction." (Service user; Rethink 2015).

"Many people felt that more training and awareness raising among health professionals might help create an environment where there was less stigma." (Rethink 2015)

Another issue mentioned in Fraser et al. (2003) was the fact that in some instances service users had been rejected from mental health services after it had been discovered that they were suffering from a substance misuse problem. The result of such stigmatisation was to further marginalise members of this vulnerable group.

Facilitators

Three studies reported factors that facilitated access to effective care by trusted professionals (Edland-Gryt & Skatvedt (2013) [+], Fraser et al. (2003) [-] and Kuo et al. (2013) [+]).

Edland-Gryt & Skatvedt (2013) found that the provision of outreach services facilitated access for people who were otherwise difficult to engage. The need for such services was also emphasised in Kuo et al. (2013), in which women who lacked childcare provision and had no access to transportation stated that consideration of such issues would facilitate access to care. Furthermore, Edland-Gryt & Skatvedt (2013) found that service users tended to respond positively when they felt respected:

"Respect for the clients also has a bearing on trust. Many clients said that they were met with respect by the staff, and that this differed from some of the other services they had experienced."

In Fraser et al. (2003) service users were more likely to report positive experiences of voluntary service provision compared with statutory health and social care services. Positive aspects of service provision mentioned by service users included:

- practical help with housing and employment, and support in accessing a wide range of services
- quick or immediate access to services
- positive and consistent relationships with workers
- peer support (for example, in the context of group work).

Evidence statement 2.2.5 Care environment

Evidence from 9 studies revealed that people with a dual diagnosis face numerous barriers and facilitators when seeking access to effective care delivered by trusted professionals. These included issues related to an appreciation of cultural sensitivities, the role of stigma, and issues pertaining to staff/financial resource that impact the delivery of care. Facilitators included the role of the non-statutory sector and good relationships with staff.

Overall, 9 studies reported on barriers associated with access to effective care by trusted professionals. Of these, 1[++][8] US study, 1[+][1] Norwegian study and 1[+][7] Finnish study provided consistent evidence to suggest that service users' mistrust of health and social care professionals was a common reason for poor engagement with services. One UK study (1[+][9]), 1[+][5] US study and 1[-][3] Scottish study provided evidence to suggest that a lack of adequate staffing resources appeared to impair the ability of service users to access effective care. The UK study (1[+][9]) also suggested that a failure to recognise the cultural differences of black and minority ethnic individuals was a barrier to accessing care. There were consistent views from 2[-][2,6] UK studies, 1[++][8] US study and 1[-][4] Australian study suggesting that stigma acted as a barrier to access. The US study (1[++][8]) found that negative stereotyping by healthcare professionals hindered access to treatment for physical health problems. The Australian study (1[+][4]) and 1[-][6] UK study described how having a dual diagnosis had a particularly negative connotation. In the 1[-][6] UK study a service user with mental health problems described how they did not access care for drugs and alcohol specifically to avoid being labelled as having problems with both mental health and addiction.

One Norwegian study (1[+][1]), 1[+][5] US study and 1 [-][2] UK study described factors which facilitated access to care for people with a dual diagnosis. In 1[+][1] Norwegian study evidence was provided to support the use of outreach services to facilitate access to effective care, as did good service user and healthcare practitioner relationships. The UK study (1[-][2]) outlined that service users were likely to report positive experiences of voluntary service provision, including quick access to services and good relationships with staff. In 1[+][5] US study the provision of childcare was also regarded as a means for facilitating engagement with services.

Applicability to the UK:
Four of the 9 studies were based in the UK and are therefore directly applicable. The rest were based in the US, Europe and Australia. Irrespective of the fact that the majority of the data were drawn from non-UK based studies, the findings are highly salient within a UK context. Themes pertaining to service user mistrust and failure to engage due to poor provision appear broadly transferable across multiple settings or geographical location. However, generalisability of some findings may be limited in some instances. For example, impeded access to healthcare services due to a lack of child care support only affects those with children.

[1]Edland-Gryt & Skatvedt (2013) [+]
[2]Fraser et al. (2003) [-]
[3]Hodges (2006) [-]

[4]Holt & Treloar (2008) [-]
[5]Kuo et al. (2013) [+]
[6]Rethink (2015) [-]
[7]Sorsa & Åstedt-Kurki (2013) [+]
[8]Villena & Chesla (2010) [++]
[9]Warfa et al. (2006) [+]

6.6.2 Integrated approach to care

Table 29: Summary of characteristics of studies contributing to the theme: integrated approach to care

Author (year) [quality] Data collection method	Country	Target population (n)	Service setting	Geographical location
Brooks et al. 2007 [+] Focus group	US	Service users with severe mental illness and substance misuse (n=35)	Intensive (outpatient) day treatment programme	NR
Cruce, Öjehagen & Nordström 2012 [+] Interview (face-to-face)	Sweden	Service users with severe mental illness and substance misuse (n=8)	Integrated outpatient programme/specialist dual diagnosis programme	Urban
Edward & Robins 2012 [+] Internet forum data	US	Service users with severe mental illness and substance misuse (NR)	Participant data were drawn from web forums. The data related to various points of service access.	NR
Johnson et al. 2013 [++] Interview (multiple methods)	US	Female service users with major depressive disorder and substance misuse returning to the community from prison (n=54)	Participants were taken from 2 trials of treatment for co-occurring substance use and major depressive disorder among incarcerated women nearing release into the community	NR
Kozloff et al. 2013 [+] Focus group	Canada	Service users with severe mental illness and substance misuse aged 18-26 (n=23)	Inner city agencies offering mental health services to homeless young people with co-occurring disorders	NR

Kuo et al (2013) [+] Focus group	US	Pregnant and postpartum women with substance misuse and depression (n=18)	Participants were recruited from a perinatal substance abuse treatment programme that provides outpatient care for pregnant/postpartum women with SUD.	Urban
Luciano & Carpenter-Song 2014 [+] Interview (face-to-face)	US	Service users with psychosis and substance misuse aged 18-35 (n=12)	Integrated treatment centre for adults with early psychosis and substance use disorders	NR
Rethink (2015) [-] Not reported	UK	Service users and family/carers (n=55)	NR	NR
VoiceAbility 2014 [-] Interview (format NR)	UK	Service users with a dual diagnosis	NR	Urban

Narrative summary

Evidence from 9 studies revealed that people with a dual diagnosis tended to prefer an integrated approach to care that addressed their multiple needs simultaneously. This approach was seen as facilitating engagement, improving access to effective treatment and ensuring that service user needs were adequately met. Failing to integrate care provision, however, was shown to obstruct access to effective treatment. Key characteristics of the studies contributing to this theme are summarised in Table 29.

Barriers

Four studies outlined barriers faced by service users in accessing effective care (Brook et al. (2007) [+], Johnson et al. (2013) [++], Rethink (2015) [-] and VoiceAbility (2014) [-]). Brooks et al. (2007), Rethink (2015) and VoiceAbility (2014) found that failing to integrate care impeded access to effective treatment, resulting in some service user needs being overlooked. Typically, service users appeared to receive care for either mental health problems or substance misuse, but not both:

"The alcohol service were great, but they didn't acknowledge my mental health difficulties. I discovered they were massive when I stopped drinking. I was doing a detox, but no-one said 'you could probably see someone about the voices.' That's why I relapsed, I thought, I need to have a drink. If they had worked together my recovery would have been much better." (Service user; VoiceAbility 2014).

"Often I have been told that the mental health service can't do any work with me until I address my alcohol use, but the drug and alcohol service say they can't work with me until I address my mental health (…) so this makes it difficult and also becomes a game of "ping pong" where I bounce between the two services." (Rethink 2015)

Johnson et al (2013) [++] also highlighted service user dissatisfaction with current dual diagnosis care provision, and linked the failure to address multiple needs with potential relapse:

"In addition to general emotional factors, several women also described psychiatric problems playing a central role in their first post release substance use. (…) Not having access to treatment (…) was also described as a factor leading to relapse."

"The [dual] diagnosis treatments, I guess have a long way to go."

The VoiceAbility report (2014) found that some service users hid their substance use in order to gain access to services, as stringent eligibility criteria meant that they were often excluded:

"I had to pretty much hide my substance use so it didn't affect my referrals."

Facilitators

Nine studies outlined factors that facilitated access to effective care (Brooks et al. (2007) [+], Cruce, Öjehagen & Nordström (2012) [+], Edward & Robins (2012), Johnson et al. (2013) [++], Kozloff et al. (2013) [+], Kuo et al. (2003) [+], Luciano & Carpenter-Song (2014) [+], Rethink 2015 [-] and VoiceAbility 2014 [-]).

A desire for integrated care was a theme in Cruce, Öjehagen & Nordström (2012), in which service users receiving care in an outpatient treatment programme expressed a wish to receive comprehensive outpatient care with a multifaceted programme to meet their medical, social and psychological needs. Service users in Kozloff et al. (2013) reported that they were more likely to attend agencies that successfully integrated services for co-occurring disorders as well as for basic needs and healthcare. In Kuo et al. (2013) participants recognised the interdependence of depression and substance use, and outlined a preference for addressing these issues simultaneously. In Johnson et al. (2013) female ex-offenders were identified as being more likely to experience problems in several domains, and addressing these multiple issues was highlighted as an important aspect of treatment. Ideally, they desired a support person (such as a recover or transition coach) to help with appointments, practical issues, counselling and recovery. The need to address concurrent needs simultaneously was a point made in 4 studies: Edward & Robins (2012), Brooks et al. (2007), VoiceAbility (2014) and Rethink (2015):

"My life didn't really seem to click and come together until I started treating both of my diagnosis (sic)." (Edward & Robins 2012)

"Everyone through the system has understood that in addition to my mental disability I have a physical disability and have worked with me. You need to see more of that,

the people need to understand a lot of times that it's not dual sometimes it's triple [i.e. mental health problems, substance misuse, physical illness]).” (Service-user; Brooks et al. 2007)

“I've had a great help in dual diagnosis (…) when I moved to Camden they referred me to Response - a street project, they'd support you with drugs if you have mental health problems (…) I have a key worker, a psychiatric doctor I can see whenever I need, and a helpful GP. I have a care coordinator for my prescription. He helps me with my benefits, any appeals or tribunals ...maybe I've been lucky to be referred to this agency (...) I can call during the week. I know where the help is, I can get support.” - (Service user; VoiceAbility 2014).

“People wanted support that was tailored to their needs and where services worked more closely together. One respondent talked about their local area, where funding cuts had lead to the community mental health team and drug and alcohol service operating out of the same building. This had led to a much more integrated approach, with both teams realising they could improve outcomes by working together. This was echoed by other respondents, who felt that a more holistic approach was required. Where this more joined-up approach was available, people had seen clear benefits.”– (Rethink 2015)

Similarly, Luciano & Carpenter-Song (2014) suggested that positive changes in health, functioning and psychological wellbeing may be attributable to integrated treatment for psychosis and substance use. As a result, the provision of an integrated approach to care for people with a dual diagnosis appears to facilitate access to effective care.

Evidence statement 2.2.6 Integrated approach to care

Evidence from 9 studies outlined barriers or facilitators associated with an integrated approach to care.

Two US studies (1[++][4] and 1[+][1]) and 2[-][8,9] UK studies outlined barriers faced by service users when accessing effective care. These studies found that a failure to integrate care impeded access to effective treatment, resulting in some service user needs being overlooked.

Evidence from 5 US studies (1[++][4] and 4[+][1,3,6,7]), 1[+][2] Swedish study, 1[+][5] Canadian study and 2[-][8,9] UK studies provided consistent evidence to suggest that people with a dual diagnosis derived benefit from an integrated approach to care that addressed their multiple needs. The benefits of this approach included increased access to medical, social or psychological care, and increased engagement resulting in positive changes in health, functioning and psychological wellbeing.

Applicability to UK:
Two of the 9 studies were conducted in the UK and are therefore directly applicable. Though the remaining studies were not UK based, this theme is transferable across geographical locations, and as a result, it is directly applicable within the UK context.

[1]Brooks et al. (2007) [+]

[2]Cruce, Öjehagen & Nordström (2012) [+]
[3]Edward & Robins (2012) [+]
[4]Johnson et al. (2013) [++]
[5]Kozloff et al. (2013) [+]
[6]Kuo et al. (2003) [+]
[7]Luciano & Carpenter-Song (2014) [+]
[8]Rethink 2015 [-]
[9]VoiceAbility (2014) [-]

6.7 EMOTIONAL SUPPORT, EMPATHY AND RESPECT

This conceptual category contains the following theme:

- **Relationships with healthcare professionals**

6.7.1 Relationships with healthcare professionals

Table 30: Summary of characteristics of studies contributing to the theme: relationships with healthcare professionals

Author (year) [quality] Data collection method	Country	Target population (n)	Service setting	Geographical location
Cruce, Öjehagen & Nordström 2012 [+] Interview (face-to-face)	Sweden	Service users with severe mental illness and substance misuse (n=8)	Integrated outpatient programme/specialist dual diagnosis programme	Urban
Green et al. 2015 [+] Interview (face-to-face)	US	People with severe mental illness and substance use disorders (n=177)	Not-for-profit integrated health plan that provides comprehensive medical and behavioural healthcare	NR
Hodges et al. 2006 [-] Interview (format NR)	Scotland	Service users with severe mental illness and substance misuse (n=38)	Mental health services, substance misuse services and other psychosocial services in the statutory and voluntary sector	Mixed
Johnson et al. 2013 [++] Interview (multiple methods)	US	Female service users with major depressive disorder and substance misuse returning to the community from prison (n=54)	Participants were taken from 2 trials of treatment for co-occurring substance use and major depressive disorder among incarcerated women nearing release into the community	NR
Kozloff et al. 2013 [+] Focus group	Canada	Service users with severe mental illness and substance misuse aged 18-26 (n=23)	Inner city agencies offering mental health services to homeless young people with co-occurring disorders	NR
Rethink (2015)	UK	Service users and	NR	NR

[-] Not reported		family/carers (n=55)		
Villena & Chesla 2010 [++] Interview (face-to-face)	US	Service users with severe mental illness and substance misuse and general medical conditions (n=20)	Community treatment centres and supported housing sites	NR
VoiceAbility 2014 [-] Interview (format NR)	UK	Service users with a dual diagnosis	NR	Urban

Narrative summary

Eight studies reported views in relation to factors that may act as barriers or facilitators to accessing healthcare services that are underpinned by a sense of emotional support, empathy and respect. In particular, relationships between healthcare professionals and service users emerged as the dominant theme, and the perceived receipt of empathic care appeared to be contingent upon the characteristics of such relationships. Key characteristics of the studies contributing to this theme are summarised in Table 30.

Barriers

Five studies mentioned barriers to accessing emotional support, empathy and respect in the context of receiving care (Green et al. (2015) [+], Hodges et al. (2006) [-], Johnson et al. (2013) [++], Villena & Chesla (2010) [++], and VoiceAbility (2014) [-]).

The failure to act empathically arose as an issue of concern in Green et al. (2015). One service user outlined that the fatigue caused by his medication was not considered by programme administrators as a viable reason for him missing appointments. As such, a lack empathy for this service user acted as an impediment to the receipt of care:

"I went on Effexor, and I was missing appointments because I couldn't drive, those drugs were just kicking my ass, then I got a phone call, told I couldn't miss anymore or I would be kicked out because my recovery comes first."

Similarly, women released from prison also regarded some community treatment programmes as being overly punishing and judgmental, which resulted in a disinclination to engage with support (Johnson et al. 2013). In Villena & Chesla (2010) service users underscored the need for empathy, effective communication and establishing trust when engaging with healthcare services.

The aforementioned need for empathy in the context of the practitioner/service user relationship also emerged as a pervasive theme across other studies. In Hodges et al. (2006) 1 service user felt that his relapse after 6 years of abstinence had been caused by the single-minded approach to his previous addiction. As a result, he experienced a sense of betrayal that added to his vulnerability:

"I've been aff heroin for 6 years and they were still on at me every time they seen me. (…) And it got to the point where I didnae like going any more and I did try to kill myself. I tried to take an overdose it didnae work and I was honest with them; I told them that I took heroin for the first time in 6 years and it was like I was being punished for telling the truth."

For this person, the feeling of being punished rather than emotionally supported impeded service engagement. The impact of not treating members of this vulnerable population in an empathic manner appears to be destabilising.

VoiceAbility (2014) found that a poor service user and practitioner relationship could sometimes result in service users experiencing a sense of fear when discussing their substance misuse. The resulting failure to honestly disclose substance misuse may further impedes access to care:

I was 23, my GP was quite a bit older. She just asked, 'have you been taking drugs?' She was very accusatory (…) I was terrified about getting told off (…) I talked to my GP about my mental health and lied about my drug use - it's just a bit of weed."

Facilitators

Four studies mentioned factors that facilitated access to emotional support, empathy and respect in the context of receiving care (Cruce, Öjehagen & Nordström (2012) [+], Hodges et al. (2006) [-], Kozloff et al. (2013) [+] and Rethink (2015) [-]).

Cruce, Öjehagen & Nordström (2012) found that when service users felt that they were being treated with empathy and respect they tended to engage with support and treatment. In this study 1 service user viewed his relationship with his key worker as crucial for his survival. Another participant felt that staff members who demonstrated empathic understanding through expressions of acceptance and respect, even when he engaged in substance misuse, boosted feelings of self-worth and dignity.

In Hodges et al. (2006) 1 service user stated that he appreciated the persistence and perseverance of staff in trying to engage with him, and these sentiments were echoed by a young person in Kozloff et al. (2013):

"[My caseworker] (...) went above and beyond (…) calling me when I wouldn't return her call (…). It took a long time for me to come around. And she was really persistent with me (…) helped me get through a lot of stuff."

Participants in Hodges et al. (2006) felt that the proactive stance of care providers instilled a sense of self-worth. This sense of mutual respect and emotional support

may be said to enhance engagement, which can contribute to improved outcomes. This was further evidenced in Rethink (2015):

"I have become so well that I am no longer under mental health supervision and I am no longer abusing alcohol. It has taken a long time to get there but I will always be massively grateful to the two people who looked beyond the alcohol and saw the struggling person."

Evidence statement 2.2.7: Relationships with healthcare professionals

Evidence from 8 studies suggested that the nature of relationships between healthcare professionals and service users can act as either a barrier or facilitator to the receipt of empathic, respectful and emotionally supportive healthcare.

Three US studies (1[++][7] and 2[+][2,4]), 1[-][3] Scottish study and 1[-][8] UK study consistently described how service user and practitioner relationships that are characterised by a lack of empathic understanding and emotional support can act as a barrier to service user engagement with healthcare and support services. Additionally, 1[++][4] US study also found that women released from prison regard some community treatment programmes as being overly punishing and judgmental, which can result in a disinclination to engage with support.

Evidence from 1[+][1] Swedish study, 1[+][5] Canadian study, 1[-][3] Scottish study and 1[-][6] UK study suggested that the ability of healthcare practitioners to confer a sense of respect and act empathically enhanced feelings of self-worth and promoted engagement with services.

Applicability to UK:
Three of the 8 studies were conducted in the UK, while the rest were from Sweden, the US and Canada. All studies are considered to be directly applicable within the UK healthcare system because the importance of good relationships based on empathic understanding is a theme unlikely to be limited by geographical context.

[1]Cruce, Öjehagen & Nordström (2012) [+]
[2]Green et al. (2015) [+]
[3]Hodges et al. (2006) [-]
[4]Johnson et al. (2013) [++]
[5]Kozloff et al. (2013) [+]
[6]Rethink (2015) [-]
[7]Villena & Chesla (2010) [++]
[8]VoiceAbility (2014) [-]

6.8 FAST ACCESS TO RELIABLE HEALTH ADVICE

This conceptual category contains the following theme:

- **Service structure**

6.8.1 Service structure

Table 31: Summary of characteristics of studies contributing to the theme: service structure

Author (year) [quality] Data collection method	Country	Target population (n)	Service setting	Geographical location
Brooks et al. 2007 [+] Focus group	US	Service users with severe mental illness and substance misuse (n=35)	Intensive (outpatient) day treatment programme	NR
Fraser et al. 2003 [-] Fraser et al. 2003 [-]	UK	Service users (n=45)	NR	Mixed
Hodges et al. 2006 [-] Interview (format NR)	Scotland	Service users with severe mental illness and substance misuse (n=38).	Mental health services, substance misuse services and other psychosocial services in the statutory and voluntary sector	Mixed
Kozloff et al. 2013 [+] Focus group	Canada	Service users with severe mental illness and substance misuse aged 18-26 (n=23)	Inner city agencies offering mental health services to homeless young people with co-occurring disorders	NR
Rethink (2015) [-] Not reported	UK	Service users and family/carers (n=55)	NR	NR
Villena & Chesla 2010 [++] Interview	US	Service users with severe mental illness and substance misuse and general medical conditions (n=20)	Community treatment centres and supported housing sites	NR

(face-to-face)				

Narrative summary

Evidence from 6 studies revealed that people with a dual diagnosis face numerous barriers or facilitators when seeking fast access to reliable health advice. Service structure arose as a dominant theme across all studies. Key characteristics of the studies contributing to this theme are summarised in Table 31.

Barriers

Six studies outlined barriers to accessing expedient and reliable healthcare advice (Brooks et al. (2007) [+], Fraser et al. (2003) [-], Hodges et al. (2006) [-], Kozloff et al. (2013) [+], Rethink (2015) [-] and Villena & Chesla (2010) [++]).

In Brooks et al. (2007) people with a dual diagnosis stated that a significant barrier to the timely access of reliable healthcare was the lack of co-ordination of services across agencies. Poor service structure and the failure to integrate care provision were regarded as problematic. In addition, long waiting lists were noted as a barrier to fast access, with some service users in Hodges et al. (2006) expressing dismay that a particular substance misuse facility had a waiting time of 3 years. One service user in this study waited a year and a half to see a psychiatrist. She received no reminder notification of her appointment, overlooked the date and subsequently gave up trying to access a psychiatrist. Similar experiences emerged in Fraser et al. (2003) and Kozloff et al. (2013). In the latter study young people outlined that they had experienced problems gaining fast access to treatment due to a failure to meet narrow intake criteria, or having to wait for extended periods for assessment appointments:

"When I wanted to go to rehab, I basically had to go to detox, then wait until there was an opening at the rehab centre (...). I relapsed in the time I had to wait (...). I had a friend that basically relapsed, got so depressed he [hanged] himself. If only there was a place in the rehab."

In Rethink (2015) many service users talked about drug or alcohol use as a coping strategy for the symptoms of mental illness, especially in the context of not accessing appropriate services when needed.

Villena & Chesla (2010) identified bureaucracy and being denied services due to missed appointments as barriers to fast access to healthcare services for people with a dual diagnosis seeking physical healthcare in the US:

"They said that I missed an appointment, and I couldn't have my pills. I have to take pills for cholesterol and heart (...). I went without them for a whole month."

The same study noted that difficulty in understanding the structural complexities of the healthcare system was regarded as a barrier to accessing much needed healthcare support.

Hodges et al. (2006) noted that there was a general lack of awareness concerning available services and routes of access, which stood as further impediment to fast access of reliable health services. Another important concern raised in Hodges et al. (2006) was the lack of service provision during the weekends at residential rehabilitation services.

Facilitators

One study outlined factors that facilitated access to expedient and reliable healthcare advice; Hodges et al. (2006) [-]. This study found that barriers to accessing much needed healthcare support were overcome in instances where alcohol and addictions teams referred service users to other groups and services for further help with unmet needs. No further facilitators were reported.

Evidence statement 2.2.8: Service structure

Evidence from 6 studies revealed that service users with a dual diagnosis face numerous barriers when seeking fast access to reliable health advice. There were few facilitators.

Two US studies (1[++][6] and 1[+][1]), 1[+][4] Canadian study and 1[-][3] Scottish study consistently identified service structure as the overriding reason prohibiting fast access to healthcare for people with a dual diagnosis. Evidence from 1[+][4] Canadian study, 1[-][3] Scottish study and 1[-][2] UK study specifically described how long waiting lists acted as a barrier to the receipt of expedient care. One UK study (1[-][5]) also described how the failure to address mental health issues promptly could result in service users using drugs or alcohol as a coping strategy to deal with untreated mental health symptoms.

To overcome the issue of long waiting lists, 1[-][3] study based in Scotland indicated that direct referrals by alcohol and addictions teams could act as a facilitator, speeding up service user access to reliable health advice.

Applicability to UK:
Three of the 6 studies were conducted in the UK and are therefore directly applicable. The rest were based in the US, Canada and Finland. Owing to the differences in the UK and US healthcare systems (for example, health insurance considerations in regards to eligibility for service access), 1 US study[6] is not applicable to the UK context.

[1]Brooks et al. (2007) [+]
[2]Fraser et al. (2003) [-]
[3]Hodges et al. (2006) [-]
[4]Kozloff et al. (2013) [+]
[5]Rethink (2015) [-]
[6]Villena & Chesla (2010) [++]

6.9 INVOLVEMENT IN DECISIONS AND RESPECT FOR PREFERENCES

This conceptual category contains the following theme:

- **Service user focused approach**

6.9.1 Service user focused approach

Table 32: Summary of characteristics of studies contributing to the theme: service user focused approach

Author (year) [quality] Data collection method	Country	Target population (n)	Service setting	Geographical location
Brooks et al. 2007 [+] Focus group	US	Service users with severe mental illness and substance misuse (n=35)	Intensive (outpatient) day treatment programme	NR
Hodges et al. 2006 [-] Interview (format NR)	Scotland	Service users with severe mental illness and substance misuse (n=38)	Mental health services, substance misuse services and other psychosocial services in the statutory and voluntary sector	Mixed
Sorsa & Åstedt-Kurki 2013 [+] Interview (face-to-face)	Finland	Mothers with severe mental illness and substance misuse (n=1).	Psychiatric hospital ward and 2 substance misuse rehabilitation settings	NR

Narrative summary

Evidence from 3 studies outlined the barriers or facilitators encountered by people with a dual diagnosis with regards to their involvement in decision making in relation to their treatment, and receiving care that respected their preferences. Key characteristics of the study contributing to this theme are summarised in Table 32.

Barriers

Two studies outlined the negative impact of neglecting service user preference when making decisions about service user care (Brooks et al. (2007) [+] and Sorsa &

Åstedt-Kurki (2013) [+]). Service users in Brooks et al. (2007) outlined that their preferences were often neglected, highlighting the need for service user focused treatment. This was summed up by 1 service user who stated that the inability of practitioners to appreciate his treatment needs resulted in a lack of confidence in the care received:

"If they walked in my shoes they could probably get a better insight of what's me and what is good for me."

Similarly, in Sorsa & Åstedt-Kurki (2013) [+] a mother with a dual diagnosis felt coerced into using specific services without regard being given to her preferences:

"When her story became known to local social workers, she lost her freedom of choice and the services assumed a stronger role in counselling. The system enforced the use of specific services, and she was not allowed to choose them. She felt discouraged by the service system, but found out that adjusting to the rules was necessary so that she could regain custody of one of her children."

Facilitators

One study outlined the benefits of allowing service users to be involved in making decisions about the care they receive; (Hodges et al. (2006) [-]). In this study, service users expressed positive feelings about a rehabilitation service that consulted them and respected their preferences when formulating their care plans.

Evidence statement 2.2.9: Service user focused approach

Evidence from 3 studies outlined the barriers or facilitators encountered by people with a dual diagnosis being involved in making decisions about their treatment, and receiving care that respects their preferences. Evidence suggested that a service user focused approach can have a significant impact on the provision of healthcare to this population.

One US study (1[+][1]) revealed an unmet need for service user focused services. One Finnish study (1[+][3]) found that in some instances service users felt coerced into participating in treatment that did not reflect their preferences.

One Scottish study (1[-][2]) suggested that giving service users the ability to shape their own care plans facilitated access to care that was shaped around service user preference.

Applicability to UK:
One of the 3 studies was based in Scotland and it is therefore directly applicable to a UK context. The other 2 studies were based in the US and Finland. Nevertheless, the general theme of a service user focused approach is relevant in healthcare settings irrespective of their geographical location. As such, these studies are directly applicable within the UK context.

[1]Brooks et al. (2007) [+]
[2]Hodges et al. (2006) [-]

[3]Sorsa & Åstedt-Kurki (2013) [+]

6.10 INVOLVEMENT OF, AND SUPPORT FOR, FAMILY AND CARERS

This conceptual category contains the following theme:

- **Failure to provide information to family/carers**

6.10.1 Failure to provide information to family/carers

Table 33: Summary of characteristics of studies contributing to the theme: Failure to provide information to family/carers

Author (year) [quality] Data collection method	Country	Target population (n)	Service setting	Geographical location
EnglandKennedy & Horton (2011) [+] Interview (face-to-face)	US	Low income service users with severe mental illness and substance misuse (n=217)	Community mental health services, residential and outpatient treatment services and small group practices	NR
Rethink (2015) [-] Not reported	UK	Service users and family/carers (n=55)	NR	NR

Narrative summary

Evidence from 2 studies outlined that a major barrier faced by the families and carers of people with a dual diagnosis in relation to accessing support for themselves was the failure of services to provide adequate information about support groups. No factors facilitating involvement in treatment or receipt of support emerged. Key characteristics of the study contributing to this theme are summarised in Table 33.

Barriers

Two studies outlined barriers faced by the families and carers of people with a dual diagnosis with regards to accessing support for themselves (EnglandKennedy & Horton (2011) [+] and Rethink (2015) [-]).

EnglandKennedy & Horton (2011) found that the majority of families of people with a dual diagnosis were not involved in treatment planning for their relative, although 1 family member expressed a preference for further involvement. Furthermore, many added that they had not received any information about family support groups, nor

had they received any assistance with the difficulties associated with caring for a friend or relative with a dual diagnosis. Similarly, Rethink (2015) reported:

"Many felt that they were left to step in when the people they supported fell through gaps in services. This out [sic] a lot of pressure on carers and they were unclear where they could get support for themselves."

This study also raised around confidentiality and information-sharing with families and carers:

"[Services should:] Encourage patients to involve family with their care plans. Liaise with family members. Inform family members when patient's health is obviously deteriorating. Take a common sense approach to confidentiality and contacting relatives to maintain the patient's safety. Advise relatives as to how best they can help."

The failure to provide information about family support groups can prohibit access to such support. Furthermore, the desire of family members to be involved in care planning for their relative appears to have been overlooked.

Evidence statement 2.2.10: Failure to provide information to family/carers

Evidence from 2 studies outlined the barriers faced by the families and carers of people with a dual diagnosis in relation to receiving support for themselves. No facilitators were identified.

One US study (1[+][1]) and 1[-][2] UK study described a consistent view on the barriers faced by families and carers when seeking support. These included a lack of information about how to contact family support groups, and difficulties in gaining assistance for caring for a relative with a dual diagnosis.

Applicability to UK:
One out of the 2 studies contributing to this theme was based in the UK and is therefore directly applicable. Although 1 study was based in the US, the views expressed appear broadly transferable across geographical locations and are therefore directly applicable within the UK context.

[1]EnglandKennedy & Horton (2011) [+]
[2]Rethink (2015) [-]

6.11 DISCUSSION

Overall, there was a moderately good fit between the original framework selected and the data reviewed. The framework captured some significant barriers and facilitators to the receipt of health and social care reported in the included studies.

Key issues

The importance of the integration of care emerged as a recurrent issue. In particular, poor continuity of care and fragmented service provision were seen to impair the formation of trust-based relationships between people with a dual diagnosis and practitioners. Also, the failure to integrate services was reported as a barrier to timely access to health and social care. Positive changes in health, functioning and psychological wellbeing were reported as being linked to the integrated treatment of severe mental illness and substance use. Within the context of wider social care needs, an integrated approach to care that addresses the needs for support with both housing and employment issues was identified.

Given the long-term treatment needs of many people with a dual diagnosis, it is not surprising that a need for access to continuous and consistent support emerged as significant. Frequent changes within a person's support structure such as high staff rotation (which was frequently reported) appeared to jeopardise the creation of good service user/practitioner relationships and undermine continuity of care. Furthermore, lack of continuity of care (often prominent when moving between services) was identified as a possible trigger for relapse or dropping out of services.

The existence of an unmet need for adequate housing support was often overlooked, but even when it was identified, issues pertaining to a lack of service user choice, poor housing quality and long waiting lists for supervised housing still remained. This resulted in a negative perception of the quality of care received. Given that the potential benefits of secure and safe accommodation were a substance-free environment and improved staff/peer support, this represents a potentially significant failure to meet the needs of this population.

Obtaining gainful employment (for those able to take up employment) was also identified as an important theme, particularly for ex-offenders who faced additional problems finding employment due to the stigma of having a criminal record. However, service users voiced concerns over the fact that there was often little in the way of services to support active engagement in employment.

In regard to receiving effective care, service users often felt that their contact time with health and social care staff was inadequate. For example, pregnant/postpartum women highlighted that they were particularly vulnerable due to the stresses of pregnancy or becoming a new mother, and limited contact time failed to address their specific needs. Furthermore, there was a strong demand for a more service user focused approach to service provision and a greater acknowledgement of service user preferences.

Lastly, families and carers of service users with a dual diagnosis highlighted problems in relation to the provision of information and support for themselves.

Barriers included a lack of information regarding how they may contact family support groups, and an inability to gain assistance in dealing with the difficulties associated with caring for a relative with a dual diagnosis. This issue merits further consideration because of its potential impact on people with a dual diagnosis.

Limitations and gaps in the evidence

There were 20 included studies for this research question. The overall quality of included evidence was low to moderate, with only 2 studies rated [++]. This was mainly due to the absence of information regarding the study methodology, analysis of data, and relationship between interviewer and participant, which pointed towards potential bias in the views expressed.

Of these studies, only a small number directly identified barriers or facilitators to accessing health or social care resources by people with a dual diagnosis. For the main part, most of the included studies made relatively brief references to barriers or facilitators in the context of addressing wider issues. This limited the conclusions that may be drawn from this review. In other cases, relevant data were derived from only 1 study - for example, the failure to provide information emerged as a barrier to the family/carers of people with a dual diagnosis accessing support. This factor is, however, likely to be a significant barrier to accessing support, despite not featuring strongly in the other studies reviewed. Furthermore, little evidence was found pertaining to some of the matrix themes (for example, 'clear, comprehensible information and support for self-care'). It is important to note, however, that the lack of supporting studies for emergent themes might be the result of a lack of focus on these specific areas of research, as opposed to such issues not being perceived as important by service users. Another gap in the evidence related to the ambiguity surrounding which point on the care pathway some participant comments related to. As such, it was difficult to fully breakdown the experience of care received at various intervals along the care pathway.

Finally, following the considerable changes in service configuration in 2002, evidence of the impact of such changes on service user experience in important areas such as continuity of care, for example, should be a focus for further research.

7 CONCLUSION

Taking into account the evidence identified in both reviews it can be concluded that services for people with a dual diagnosis fail to provide a good experience to those using them. A number of factors contributed to this, including limited access to staff training, supervision and specialist support, poor continuity of care and limited access to specialist interventions. Due to the impact of current substance misuse and severe mental illness, services users with a dual diagnosis often had difficulties in engaging with services, which was not helped by prejudice or stigma from practitioners, particularly regarding substance misuse.

Despite a number of barriers, examples of good practice were identified. These included integrated assessment systems, access to specialist training and support, the co-management of cases between services and a person-centred approach to the delivery of care. Overall, the key challenge to improving health and social care services for people with a dual diagnosis lie in the commissioning and development of integrated services supported by effective staff training and supervision programmes.

8 REFERENCES

See Appendix 8 & 10 for included studies bibliography.

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9 APPENDICES

APPENDIX 1. SAMPLE SEARCH STRATEGY

RQ 2.1: What are the facilitators and barriers for commissioners or practitioners in their commissioning or delivery of health and social care community services for people with a severe mental illness who also misuse substances?

RQ 2.2: What are the facilitators and barriers to accessing and using health and social care community services, and to satisfaction with those services, for people with coexisting severe mental illness and substance misuse and their family or carers?

Database(s): **Ovid Medline(r)** 1946 to April week 2 2015
Search strategy:

#	searches
1	affective disorders, psychotic/ or exp bipolar disorder/ or depressive disorder/ or depressive disorder, major/ or depressive disorder, treatment resistant/ or exp psychotic disorders/ or exp schizophrenia/ or "schizophrenia and disorders with psychotic features"/ or schizophrenic psychology/
2	emergency services, psychiatric/ or hospitals, psychiatric/ or psychiatric department, hospital/ or (mentally ill persons/ and (inpatients/ or hospitalization/))
3	((bipolar* adj (depres* or disorder*)) or ((cyclothymi* or rapid or ultradian) adj2 cycl*) or rcbd or mania* or manic*).ti,ab.
4	(delusional disorder* or psychos* or psychotic* or schizophren*).ti,ab.
5	(psychiatric adj2 (admission* or admit* or comorbid* or co morbid* or emerg* or hospital* or inpatient* or in*1 patient* or morbid * or outpatient* or patient* or population*)).ti,ab.
6	depres*.ti,ab.
7	(((acute or chronic* or serious* or severe) adj (mental* or psychiatric* or psychological*) adj (condition* or disease* or disorder* or disturbanc* or ill*)) or smi*1).ti,ab.
8	(comorbidity/ and exp mental disorders/) or ((comorbid* or co morbid* or coexist* or co exist* or concur* or cooccur* or co occur*) adj2 (mental* or psychiatric* or psychological*) adj2 (condition* or disease* or disorder* or disturbanc* or ill*)).ti,ab.
9	or/1-8
10	exp alcohol-related disorders/ or alcoholics/ or amphetamine related disorders/ or cocaine related disorders/ or drug overdose/ or inhalant abuse/ or marijuana abuse/ or

	exp opioid related disorders/ or phencyclidine abuse/ or psychosis, substance induced/ or substance abuse, intravenous/ or substance related disorders/ or exp substance withdrawal syndrome/
11	designer drugs/ or drug overdose/ or needle exchange programs/ or needle sharing/ or exp street drugs/ or substance abuse detection/ or substance abuse treatment centers/
12	(alcohol* adj2 (abstain* or abstinen* or abus* or addict* or banned or excessive us* or criminal or depend* or habit* or illegal* or illicit* or intoxicat* or misus* or nonprescri* or non prescri* or overdos* or over dos* or recreation* or rehab* or unlawful* or withdraw*)).ti,ab.
13	((amphetamin* or crystal meth* or desoxyn or dexamfetamin* or dexedrine or dextroamphetamin* or methamphetamin* or psychostimulant* or stimulant* or uppers) adj2 (abstain* or abstinen* or abus* or addict* or banned or excessive us* or criminal or depend* or habit* or illegal* or illicit* or intoxicat* or misus* or nonprescri* or non prescri* or overdos* or over dos* or recreation* or rehab* or unlawful* or withdraw*)).ti,ab.
14	((amphetamin* or crystal meth* or desoxyn or dexamfetamin* or dexedrine or dextroamphetamin* or methamphetamin* or psychostimulant* or stimulant* or uppers) adj2 (usage* or use* or using or utiliz* or utilis*)).ti,ab.
15	((benzoylmethyl ecgonine or cocain* or crack*1 or codrenine or ecgonine methyl ester benzoate or erythroxylin or locosthetic or neurocaine or sterilocaine) adj2 (abstain* or abstinen* or abus* or addict* or banned or excessive us* or criminal or depend* or habit* or illegal* or illicit* or intoxicat* or misus* or nonprescri* or non prescri* or overdos* or over dos* or recreation* or rehab* or unlawful* or withdraw*)).ti,ab.
16	((benzoylmethyl ecgonine or cocain* or crack*1 or codrenine or ecgonine methyl ester benzoate or erythroxylin or locosthetic or neurocaine or sterilocaine) adj2 (usage* or use* or using or utiliz* or utilis*)).ti,ab.
17	((bhang or cannador or cannabis or ganja or ganjah or hashish or hemp or marihuana or marijuana or sativex or skunk) adj2 (abstain* or abstinen* or abus* or addict* or banned or excessive us* or criminal or depend* or habit* or illegal* or illicit* or intoxicat* or misus* or nonprescri* or non prescri* or overdos* or over dos* or recreation* or rehab* or unlawful* or withdraw*)).ti,ab.
18	((bhang or cannador or cannabis or ganja or ganjah or hashish or hemp or marihuana or marijuana or sativex or skunk) adj2 (usage* or use* or using or utiliz* or utilis*)).ti,ab.
19	((acetomorphine or anpec or diacephine or diacetylmorphin* or diacetylmorphine* or diagesil or diagesil or diamorf* or diamorf* or diamorphin* or diamorphin* or diaphorin or duromorph or epimorph or heroin or morfin* or morphacetin or morphia or morphian* or morphin* or morphium or opso*1 or skenan) adj2 (abstain* or abstinen* or abus* or

	addict* or banned or excessive us* or criminal or depend* or habit* or illegal* or illicit* or intoxicat* or misus* or nonprescri* or non prescri* or overdos* or over dos* or recreation* or rehab* or unlawful* or withdraw*)).ti,ab.
20	((acetomorphine or anpec or diacephine or diacetylmorphin* or diacetylmorphine* or diagesil or diagesil or diamorf* or diamorf* or diamorphin* or diamorphin* or diaphorin or duromorph or epimorph or heroin or morfin* or morphacetin or morphia or morphian* or morphin* or morphium or opso*1 or skenan) adj2 (usage* or use* or using or utiliz* or utilis*)).ti,ab.
21	or/10-20
22	abus* product*.ti,ab.
23	((drug*1 or polydrug* or psychotropic* or substance*) adj2 (abstain* or abstinen* or abus* or addict* or banned or excessive us* or criminal or depend* or habit* or illegal* or illicit* or intoxicat* or misus* or non prescri* or nonprescri* or overdos* or over dos* or recreation* or rehab* or unlawful* or withdraw*)).ti,ab.
24	(((alcohol* or drug*1 or polydrug* or recreation* or substance*) adj use*1) or alcoholi*).ti,ab.
25	((club or designer or street) adj (drug* or substance*)).ti,ab.
26	((crav* adj2 (alcohol* or inject*)) or hard drug* or needle fixation or soft drug* or vsa*1).ti,ab.
27	or/22-26
28	or/21,27
29	“diagnosis, dual (psychiatry)”/
30	(chemical* adj (user or addict*) adj3 ((mental* or psychiatric or psychological*) adj (condition* or disease* or disorder* or disturbanc* or ill*))).ti,ab.
31	((comorbid* or co morbid* or coexist* or co exist* or concur* or cooccur* or co occur*) adj5 (addict* or ((drug or substance*) adj5 (abus* or misus))) adj3 ((mental* or psychiatric or psychological*) adj (condition* or disease* or disorder* or disturbanc* or ill*))).ti,ab.
32	((dual* or tripl*) adj2 diagnos*).ti,ab.
33	or/29-32
34	(9 and 28) or 33
35	exp general practice/ or general practitioners/ or physicians/ or physicians, family/ or physician's practice patterns/ or physicians, primary care/ or physicians, women/ or primary health care/
36	(clinician* or ((general or family) adj practic*) or ((family or primary) adj (care or healthcare or medical care or medicine)) or family doctor* or gp*1 or physician* or practitioner*).ti,ab.

37	or/35-36
38	community care/ or community based rehabilitation/ or community health centers/ or exp community health nursing/ or community health services/ or community integration/ or community medicine/ or community mental health centers/ or community mental health services/ or community networks/ or community pharmacy services/ or community program/ or community psychiatry/ or emergency shelter/ or home care agencies/ or home care services/ or home care services, hospital-based/ or home health nursing/ or exp home nursing/ or house calls/
39	(exp rehabilitation/ or exp rehabilitation centers/ or rehab*.ti,ab. or rh.fs.) and communit*.sh,ti,ab.
40	(((communit* or home*) adj3 (agenc* or care or center* or centre* or clinic* or consultant* or doctor* or employee* or expert* or facilitator* or healthcare or instructor* or leader* or manager* or mentor* or nurs* or personnel* or pharmacy or pharmacist* or psychiatrist* or psychologist* or psychotherapist* or specialist* or staff* or team* or therapist* or tutor* or visit* or worker*)) or care management team* or domiciliary care* or homecare or linkworker* or link worker*).ti,ab.
41	(camhs or cmht*1).ti,ab.
42	(((communit* or home*) adj2 (assessment or evaluation or monitor*)) or (needs assessment and communit*)).ti,ab.
43	((communit* or home*) adj (based or deliver* or interact* or led or maintenance or mediat* or operated or provides or provider* or run or setting*)).ti,ab.
44	((communit* or home*) adj2 group*).ti,ab.
45	((communit* or home*) adj3 (advice* or advis* or aftercare or assist* or casework* or case work* or counsel* or educat* or help* or integrat* or liaison* or mentor* or network* or reinforc* or reintegrat* or sector* or setting* or support* or visit*)).ti,ab.
46	((communit* or home*) adj3 (intervention* or program* or rehab* or therap* or service* or skill* or treat*)).ti,ab.
47	(communit* adj5 (advocacy or apprenticeship* or awareness campaign* or development group* or empower* or employ* or inclusi* or individual support* or personal assistan* or selfadvocacy or selfemploy* or self advocacy or self employ* or support* or train*)).ti,ab.
48	(health adj (cent* or visit*)).ti,ab.
49	independent sector*.ti,ab.
50	((non institutional* or noninstitution*) adj2 (sector* or setting*)).ti,ab.
51	or/38-50
52	((pharmacist* or pharmacies or pharmacy) adj3 (advice* or care* or communit* or

	counsel* or educat* or intervention* or liaison* or program* or rehab* or service*)).ti,ab.
53	(pharmacist* adj3 (frontline or front line or face to face or one to one)).ti,ab.
54	or/52-53
55	foster home care/ or exp rehabilitation centers/ or social support/ or social work/ or social work, psychiatric/ or social welfare/
56	((child adj2 protect*) or (child* adj3 (foster* or in*1 care or looked after or residential care)) or foster care).ti,ab.
57	(social* adj2 (care or security or welfare or work*)).ti,ab.
58	((social* or welfare) adj3 (advice* or advis* or aftercare or assist* or casework* or case work* or counsel* or educat* or help* or integrat* or liaison* or mentor* or network* or reintegrate* or setting* or support* or visit*)).ti,ab.
59	(social* adj3 (intervention* or program* or rehab* or service* or therap* or treat*)).ti,ab.
60	or/55-59
61	ambulatory care/ or exp ambulatory care facilities/ or case management/ or day care/ or hospitals, rural/ or rural populations/ or exp outpatient clinics, hospital/ or rural health services/
62	((act adj (model* or team*)) or (assertive adj1 community adj1 treatment) or ((care or case) adj management) or (care adj1 program* adj1 approach) or cap or (madison adj4 model*) or (training adj2 (community adj1 living)) or pact or tcl).ti,ab.
63	((ambulatory or outreach* or out reach*) adj3 (advice* or advis* or aftercare or assist* or casework* or case work* or counsel* or educat* or help* or integrat* or liaison* or mentor* or network* or reintegrate* or sector* or setting* or support* or visit*)).ti,ab.
64	((ambulatory or outpatient* or out patient*) adj (based or deliver* or interact* or led or mediat* or operated or provides or provider* or run or setting*)).ti,ab.
65	((ambulatory or outpatient* or out patient*) adj3 (intervention* or program* or rehab* or service* or treat*)).ti,ab.
66	((outreach* or out reach* or remote or rural* or (social* adj2 (exclus* or isolat*)) or suburban* or urban*) adj3 (assist* or intervention* or program* or service* or treat*)).ti,ab.
67	(care program* or daily living program* or ((ambulatory or day or posthospital* or post hospital*) adj2 (care or center* or centre* or clinic* or facilit* or hosp* or intervention* or treatment* or unit*)) or daycare or day case or dropin* or drop in* or dispensar* or domiciliar* or (home adj2 (care or treatment)) or (partial* adj2 hosp*)).ti,ab.
68	mobile support* team*.ti,ab.
69	(visit* adj2 (clinic* or consultant* or consultation* or service* or special*)).ti,ab.
70	or/61-69

71	schools/ or exp students/
72	((mentor* or school* or teacher*) adj (based or deliver* or led or mediat* or operated or run or sector* or setting*)).ti,ab.
73	((mentor* or school* or teacher*) adj3 (intervention* or program* or rehab* or therap* or service* or skill* or treat*)).ti,ab.
74	((mentor* or pupil* or school* or teacher*) adj3 (advice* or advis* or aftercare or assist* or casework* or case work* or counsel* or educat* or integrat* or liaison* or mentor* or network* or reinforc* or reintegrat* or setting* or support* or visit*)).ti,ab.
75	or/71-74
76	charities/ or education, nonprofessional/ or friends/ or group processes/ or hotlines/ or peer group/ or exp psychotherapy, group/ or rehabilitation, vocational/ or self-help groups/ or voluntary workers/
77	(befriend* or be*1 friend* or buddy or buddies or ((community or lay or paid or support) adj (person or worker*))).ti,ab.
78	charit*.ti,ab.
79	((consumer* or famil* or friend* or lay or mutual* or peer* or social* or voluntary or volunteer*) adj3 (advice* or advis* or counsel* or educat* or forum* or help* or mentor* or network* or support* or visit*)).ti,ab.
80	((consumer* or famil* or peer* or self help or social* or support* or voluntary or volunteer*) adj2 group*).ti,ab.
81	((consumer* or famil* or friend* or lay or mutual* or peer* or self help or social* or voluntary or volunteer*) adj3 (intervention* or program* or rehab* or therap* or service* or skill* or treat*)).ti,ab.
82	(((consumer* or famil* or friend* or lay* or peer* or user* or voluntary or volunteer*) adj (based or counsel* or deliver* or interact* or led or mediat* or operated or provides or provider* or run*)) or voluntary work*).ti,ab.
83	((consumer* or famil* or friend* or lay* or peer* or relation* or support*) adj3 trust*).ti,ab.
84	(coping adj (behavio* or skill*)).ti,ab.
85	((emotion* adj (focus* or friend* or relation*)) or ((dyadic or loneliness or psychosocial* or psycho social*) adj2 (assist* or counsel* or intervention* or program* or support* or therap* or treat*)) or ((emotion* or one to one or transition*) adj support*) or (lay adj (led or run))).ti,ab.
86	((emotion* or network* or organi?ation* or peer*) adj2 support*).ti,ab.
87	(group*1 adj2 (advocacy or approach* or assist* or coach* or counsel* or educat* or help* or instruct* or learn* or module* or network* or participat* or program* or

	psychotherap* or rehab* or skill* or strateg* or support* or teach* or train* or workshop* or work shop*)).ti,ab.
88	((group* or network* or peer*1) adj2 (discuss* or exchang* or interact* or meeting*)).ti,ab.
89	(groupwork or (group adj2 work)).ti,ab.
90	(helpline or help line or ((phone* or telephone*) adj3 (help* or instruct* or interact* or interven* or mediat* or program* or rehab* or strateg* or support* or teach* or therap* or train* or treat* or workshop*)) or ((phone or telephone*) adj2 (assist* or based or driven or led or mediat*))).ti,ab.
91	(helpseek* or ((search* or seek*) adj4 (care or assistance or counsel* or healthcare or help* or support* or therap* or treat*))).ti,ab.
92	(((lay or peer*) adj3 (advis* or consultant or educator* or expert* or facilitator* or instructor* or leader* or mentor* or person* or tutor* or worker*)) or expert patient* or mutual aid).ti,ab.
93	(peer* adj3 (assist* or counsel* or educat* or program* or rehab* or service* or supervis*)).ti,ab.
94	((psychoeducat* or psycho educat*) adj3 (group or network* or service*)).ti,ab.
95	((social or psychosocial) adj (adapt* or reintegrat* or support*)).ti,ab.
96	(support* adj3 (approach* or educat* or instruct* or interven* or learn* or module* or network* or program* or psychotherap* or strateg* or technique* or therap* or train* or workshop* or work shop*)).ti,ab.
97	supportive treatment*.ti,ab.
98	(alcohol* anonymous or cocaine anonymous or narcotic* anonymous or recover inc or smart recovery or social interaction program* or (self management adj2 recovery training) or support* listening or supportive relationship* or schizophrenic* anonymous or visit* service* or (volunt* adj3 (aid* or support* or trained or work*))).ti,ab.
99	or/76-98
100	social skills/
101	(((psychosocial or social) adj3 skill*) or ((psychosocial or social) adj2 learn*) or ((psychosocial or social) adj3 competen*) or roleplay* or role play* or ((peer* or social* or psychosocial or support*) adj2 (group* or network*)) or ((group* or peer* or social* or psychosocial) adj2 (network* or support*))).ti,ab.
102	or/100-101
103	assisted living facilities/ or group homes/ or halfway houses/ or homeless persons/ or residential facilities/ or residential treatment/ or therapeutic community/
104	(((accommod* or bedsit* or bed sit* or flats or flatlets or homeless* or hous* or home* or

	hostel* or hous* or landlord* or lodge* or rent or rents or rented or renting or residen* or room* or runaway* or tenant*) adj3 (appointment* or care or cluster* or coach* or communit* or healthcare or integrat* or independen* or intervention* or model* or outreach or place* or program* or rehab* or reintegrat* or satellite or scheme* or service* or staffed or supervis* or support* or therap* or treatment* or warden* or visit*)) or ((rent or rents or rented or renting) adj3 (accommod* or bedsit* or bed sit* or flats or flatlets or homeless* or hous* or home* or hostel* or hous* or landlord* or lodge* or residen* or room* or runaway* or tenant*)) or shelter*).ti,ab.
105	((24 hour or day time or daytime or live in*1 or out of*1 hour*) adj (care or cover or healthcare or staff*)).ti,ab.
106	(((assist* or cooperative or co operative or independen* or staffed or supportive) adj2 (care or living)) or staff* model*).ti,ab.
107	(board* adj2 care).ti,ab.
108	((concept or support) adj house).ti,ab.
109	((communit* or mental health) adj2 (living or place* or resettl* or residence*)).ti,ab.
110	floating support.ti,ab.
111	(group adj (dwelling* or home*)).ti,ab.
112	(hous* adj2 (association* or officer* or resident*)).ti,ab.
113	(place* adj3 (adult* or famil* or person*)).ti,ab.
114	(resident* adj3 (continuum or facilit* or independen* or setting* or status)).ti,ab.
115	psychosocial therap*.ti,ab.
116	single room.ti,ab.
117	supporting people program*.ti,ab.
118	((therapeutic adj2 community) or modified tc).ti,ab.
119	or/103-118
120	employment, supported/ or occupational health/ or occupational medicine/ or occupational therapy/ or rehabilitation, vocational/ or return to work/ or vocational education/ or work/ or (employment/ and rh.fs.)
121	(club house* or clubhouse* or fountain house* or work therap*).ti,ab.
122	((employ* or job*1 or occupat* or reemploy* or vocation* or work*) adj3 (advice or advis* or assist* or coach* or counsel* or educat* or experience or integrat* or interven* or liaison* or placement* or program* or rehab* or reintegrat* or retrain* or scheme* or support* or service* or skill* or teach* or therap* or train* or transitional* or vocat*)).ti,ab.
123	((individual placement adj2 support) or ips model).ti,ab.

124	((permitted or voluntary or rehab*) adj3 work*).ti,ab.
125	((psychiatric or psychosocial or psycho social or social) adj2 rehab*).ti,ab.
126	rehabilitation counsel*.ti,ab.
127	(vocat* adj3 (advice* or advis* or assist* or casework* or case work* or counsel* or educat* or integrat* or interven* or liaison* or mentor* or network* or program* or rehab* or reintegrat* or service* or setting* or skill* or support* or retrain* or teach* or therap* or train* or treat* or specialist*)).ti,ab.
128	vocational outcome*.ti,ab.
129	or/120-128
130	crisis intervention/
131	(alternative* adj3 (hospital* or psychiatric care or ward*)).ti,ab.
132	((crisis or crises or recover*) adj3 (hous* or lodge* or shelter*)).ti,ab.
133	((crisis or residential) adj2 alternative*).ti,ab.
134	(crisis resolution adj2 home treatment team*).ti,ab.
135	crht.ti,ab.
136	(resident* and crisis).ti,ab.
137	or/130-136
138	exp *activities of daily living/ or exp self care/ or exp *daily life activity/
139	(assertiveness training or communication skills training).ti,ab.
140	((benefits* or bills or budget* or computer* or diet* or financ* or money or nutrition* or relationship*) adj3 (advice* or assist* or coach* or educat* or interven* or program* or skill* or support* or service* or teach* or tool*)).ti,ab.
141	((healthy living adj (intervention* or program*)) or exercise program* or harm reduction program*).ti,ab.
142	((advice* or assist* or coach* or educat* or interven* or program* or skill* or support* or service* or teach* or tool*) adj2 (living or life or social or self care or independen* or survival)).ti,ab.
143	(transition* adj2 (adult* or support* or service*)).ti,ab.
144	(independen* adj2 (live* or living)).ti,ab.
145	or/138-144
146	“early intervention (education)”/
147	(early adj (intervent* or treat* or recogni* or detect*)).ti,ab.
148	or/146-147
149	exp hepatitis/ or exp hiv/ or exp hiv infections/ or exp tuberculosis/
150	((((acquired immunodeficiency or acquired immuno deficiency or human immuno

	deficiency or human immune deficiency or human immunodeficiency or immunodeficiency or lymphadenopathy) adj2 (retrovirus or syndrome* or virus)) or aids or (blood adj2 borne) or drtb or hepatitis or hiv or mdrtb or tuberculosis or xdrtb) adj3 (referral* or screen* or test*)).ti,ab.
151	exp mass screening/ or exp population surveillance/ or "referral and consultation"/
152	((((acquired immunodeficiency or acquired immuno deficiency or human immuno deficiency or human immune deficiency or human immunodeficiency or immunodeficiency or lymphadenopathy) adj2 (retrovirus or syndrome* or virus)) or aids or (blood adj2 borne) or drtb or hepatitis or hiv or mdrtb or tuberculosis or xdrtb) adj3 (educat* or disinfect* or empower* or knowledge or information* or instruct* or intervention* or promot* or psychoeducat* or psycho educat* or teach* or train* or book*1 or booklet* or brochure* or leaflet* or manual*1 or material* or multimedia or multi media or pamphlet* or poster* or program* or resource or service or scheme* or sterilis* or steriliz* or system* or workbook* or ((oral or printed or written) adj3 inform*) or video* or screen* or test* or diagnos* or prevent* or detect* or referral*)).ti,ab.
153	needle exchange programs/
154	(((needle* or syring*) adj2 exchang* adj2 program*) or (supervis* adj2 inject* adj2 (cent* or facilit* or service* or setting* or unit*))).ti,ab.
155	(149 and 151) or (or/150,152-154)
156	(addiction health service or (addiction adj (team* or unit*)) or community drugs service or daat or (drug adj2 (alcohol treatment agenc* or drug treatment cent*)) or ((liaison or local or rehab*) adj (program* or service* or worker*)) or ((rehabilitation or treatment*) adj (center* or centre* or clinic* or facility* or organi?ation* or program* or service*)) or mobile clinic*).ti,ab.
157	(dual diagnosis adj2 (agenc* or care or center* or centre* or clinic* or intervention* or program* or service* or team* or treatment* or worker*)).ti,ab.
158	((augment* or collaborat* or coordinat* or co ordinat* or enhanc* or holistic* or integrat* or interdisciplin* or inter disciplin* or interagenc* or inter agenc* or interorganis* or inter organis* or interprofessional* or inter professional* or intraprofessional* or intra professional* or multiagenc* or multi agenc* or multidimension* or multi dimension* or multidisciplin* or multi disciplin* or multifacet* or multi facet* or multiprofessional* or multi professional* or multiple or shared or stepped or tiered or transdisciplin* or trans discliplin*) adj3 (approach* or care or healthcare or intervention* or manag* or model* or program* or psychotherap* or service* or system* or team* or therap* or treatment* or work*)).ti,ab.
159	or/37,51,54,60,70,75,99,102,119,129,137,145,148,155-158
160	attitude/ or exp attitude to health/ or exp patient satisfaction/ or patient education as

	topic/ or patient acceptance of health care/
161	((adult* or attende* or carer* or caregiver* or care giver* or client* or consumer* or customer* or famil* or father* or individual* or mentor* or men or minorities or mother* or outpatient* or patient* or people* or person* or population* or teacher* or women or user* or adolescen* or child* or teen* or (young* adj (people or person* or patient* or population*)) or youngster* or youth*1) adj3 (attitude* or choice* or dissatisf* or expectation* or experienc* or inform* or opinion* or (perception* not speech perception) or perspective* or preferen* or priorit* or satisf* or view*)).ti,ab.
162	((adult* or attende* or carer* or caregiver* or care giver* or client* or consumer* or customer* or famil* or father* or individual* or mentor* or men or minorities or mother* or outpatient* or patient* or people* or person* or population* or teacher* or women or user* or adolescen* or child* or teen* or (young* adj (people or person* or patient* or population*)) or youngster* or youth*1) adj3 (account* or anxieties or belief* or buyin or buy in*1 or concern* or cooperat* or co operat* or dissatisfaction or feedback or feeling* or idea* or involv* or needs* or participat* or perceived need* or voices or worries or worry)).ti.
163	"attitude of health personnel"/
164	((clinician* or commissioner* or commissioning or contracting or contractor* or consultant* or doctor* or employee* or expert* or facilitator* or fundholder* or fund holder* or fund holding or fund holding or gatekeep* or gate keep* or gp*1 or healthcare or health profession* or health visit* or instructor* or leader* or manager* or mentor* or nurs* or personnel* or physician* or practitioner* or occupational or pharmacist* or policy maker* or professional* or provider* or psychiatrist* or psychologist* or psychotherapist* or specialist* or staff* or team* or therapist* or tutor* or worker*) adj3 (attitude* or choice* or dissatisf* or expectation* or experienc* or inform* or opinion* or (perception* not speech perception) or perspective* or preferen* or priorit* or satisf* or view*)).ti,ab.
165	((clinician* or commissioner* or commissioning or contracting or contractor* or consultant* or doctor* or employee* or expert* or facilitator* or fundholder* or fund holder* or fund holding or fund holding or gatekeep* or gate keep* or gp*1 or healthcare or health profession* or health visit* or instructor* or leader* or manager* or mentor* or nurs* or personnel* or practitioner* or occupational or pharmacist* or physician* or policy maker* or professional* or provider* or psychiatrist* or psychologist* or psychotherapist* or specialist* or staff* or team* or therapist* or tutor* or worker*) adj3 (account* or anxieties or belief* or buyin or buy in*1 or concern* or cooperat* or co operat* or dissatisfaction or feedback or feeling* or idea* or involv* or needs* or participat* or perceived need* or voices or worries or worry)).ti.

166	((adult* or attende* or carer* or caregiver* or care giver* or client* or consumer* or customer* or famil* or father* or individual* or mentor* or men or minorities or mother* or outpatient* or patient* or people* or person* or population* or teacher* or women or user* or adolescen* or child* or teen* or (young* adj (people or person* or patient* or population*)) or youngster* or youth*1 or (clinician* or commissioner* or commissioning or contracting or contractor* or consultant* or doctor* or employee* or expert* or facilitator* or fundholder* or fund holder* or fund holding or fund holding or gatekeep* or gate keep* or gp*1 or healthcare or health profession* or health visit* or instructor* or leader* or manager* or mentor* or nurs* or personnel* or physician* or practitioner* or occupational or pharmacist* or policy maker* or professional* or provider* or psychiatrist* or psychologist* or psychotherapist* or specialist* or staff* or team* or therapist* or tutor* or worker*)) and ((attitude* or choice* or dissatisf* or expectation* or experienc* or inform* or opinion* or (perception* not speech perception) or perspective* or preferen* or priorit* or satisf* or view*) adj3 (care or healthcare or program* or therap* or psychotherap* or service* or treatment*))).ti,ab.
167	((information adj (need* or requirement* or support)) or (patient adj (adher* or complian* or concord*)) or (service adj2 (acceptab* or unacceptab*))).ti,ab.
168	or/160-167
169	health services accessibility/
170	((access* or attend* or aversion or barrier* or equit* or facilitat* or inequit* or inequalit* or non attend* or obstacle* or obstruct* or refus* or takeup* or take up * or uptake or utiliz* or utilis*) adj3 (care or general practice or healthcare or intervention* or program* or referral* or rehab* or service* or system* or therap* or treat*)).ti,ab.
171	((adult* or carer* or caregiver* or care giver* or client* or consumer* or customer* or famil* or father* or individual* or mentor* or men or minorities or mother* or outpatient* or patient* or people* or person* or population* or teacher* or women or user* or adolescen* or child* or teen* or (young* adj (people or person* or patient* or population*)) or youngster* or youth*1) adj3 (access* or attend* or aversion or barrier* or equit*or facilitat* or inequalit* or inequit* or non attend* or obstacle* or obstruct* or refus* or takeup* or take up * or uptake or utiliz* or utilis*)).ti,ab.
172	service use*1.ti,ab.
173	((clinician* or commissioner* or commissioning or contracting or contractor* or consultant* or doctor* or employee* or expert* or facilitator* or fundholder* or fund holder* or fund holding or fund holding or gatekeep* or gate keep* or gp*1 or healthcare or health profession* or health visit* or instructor* or leader* or manager* or mentor* or nurs* or personnel* or physician* or practitioner* or occupational or pharmacist* or policy maker* or professional* or provider* or psychiatrist* or psychologist* or

	psychotherapist* or specialist* or staff* or team* or therapist* or tutor* or worker*) adj3 (barrier* or obstacle* or facilitat* or obstruct* or takeup* or take up*)).ti,ab.
174	or/169-173
175	or/168,174
176	case stud*.ti,ab.
177	Interview/ or interviews as topic/ or qualitative research/ or (experience* or qualitative or interview* or themes).ti,ab.
178	or/175-177
179	34 and 159 and 178
180	(comment* or editorial* or historical article or letter).pt.
181	exp animals/ not humans/
182	or/180-181
183	179 not 182
184	limit 183 to english language
185	limit 184 to yr="2000 -current"

APPENDIX 2. EXAMPLE COMPLETED QUALITY APPRAISAL CHECKLIST FOR RQ 2.1

Study ID:	Barnes & Rudge (2003)

Bibliographic reference: Barnes L, Rudge T. Co-operation and co-morbidity: Managing dual diagnosis in rural South Australia. Collegian. 2003;10(2):25-28.

Checklist completed by: MB

Q1.1: Was there a clear statement of the aims of the research?		
Consider: • the goal of the research • why it was thought important • its relevance	*Response:* Yes	*Comment:* "In this study we contend that clients labelled as 'co-morbid' enter a treatment terrain that is made up of multiple disputed territories. Our question was, do clinicians at the coal face continue the terratorial debates, act them out, or do they resist despite these continuing fights over 'whose territory is it anyway?"'
Q1.2: Was a qualitative methodology appropriate?		
Consider: • If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants • Is qualitative research the right methodology for addressing the research goal?	*Response:* Yes	*Comment:* DA appears to be appropriate given the objective of exploring the way in which the label of 'dual diagnosis' contributes to the subjective understanding, management and treatment of co-morbid clients.
Q2.1: Was the research design appropriate to address the aims of the research?		
Consider: • If the research has justified the research design (for example, have they discussed how they decided which method to use)	*Response:* Unable to tell	*Comment:* No justification provided for research design

Q3.1: Was the recruitment strategy appropriate to the aims of the research?		
Consider: • If the researcher explained how participants are selected • If the researcher explained why the selected participants were the most appropriate to access the knowledge sought by the study • If there were discussions around recruitment (for example, why some people chose not to take part)	*Response:* Yes	*Comment:* "Volunteers [that is, participants] were called for from health professionals who were employed in the purposively selected selected rural health care settings."
Q4.1: Was the data collected in a way that addressed the research issue?		
Consider: • Is the setting for data collection justified? • Is it clear how data was collected, and are the methods justified and explicit? • Are any modifications in method explained? • Is the form of data clear (for example, audio recordings)? • Is data saturation discussed?	*Response:* Yes	*Comment:* Some detail was provided: "The interviews were audio-taped and the tapes transcribed verbatim. The interviews were guided by open ended questions." Any modifications to topic guide and/or data saturation/justification for setting of data collection were not mentioned.
Q5.1: Has the relationship between researcher and participants been adequately considered?		
Consider: • If the researcher critically examined their own role, potential bias and influence during formulation of the research questions and data collection • How the researcher responded to events during the study and whether they considered the implications of any changes	*Response:* Unable to tell	*Comment:* Paper does not report any consideration of the role of the researcher and their potential influence on the study outcomes
Q6.1: Have ethical issues been taken into consideration?		
Consider: • If there are sufficient details of how research was	*Response:* Yes	*Comment:* First, an ethics committee was approved. Second, no mention of

explained to participants • If approval has been sought from an ethics committee		issues such as informed consent and so on, or whether the research was explained to participants.
Q7.1: Was the data analysis sufficiently rigorous?		
Consider: • Is there an in-depth description of analysis process? • Is it clear how themes were derived from the data?	*Response:* Unable to tell	*Comment:* Sufficient data presented to support inferences made. No mention as to how data were selected for presentation, and no in-depth discussion of analysis process.
Q8.1: Is there a clear statement of findings?		
Consider: • If findings are explicit • Is there adequate discussion of evidence for and against researchers' arguments? • Researcher discussed credibility of findings (for example, triangulation, respondent validation, double-coding)? • Findings discussed in relation to the review question?	*Response:* Unable to tell	*Comment:* The researchers' interpretation of the data are explicit, however, there is no discussion in regards to contrary evidence/the credibility of the findings.
Q9.1: How valuable is research?		
Consider: • Is the contribution of the study to existing knowledge discussed, for example in relation to current practice/policy or relevant research-based literature? • Are new areas where research is necessary defined? • Is the generalisability of findings discussed?	*Response:* No	*Comment:* Criteria not met

APPENDIX 3. EXAMPLE COMPLETED QUALITY APPRAISAL CHECKLIST FOR RQ 2.2

Study ID:	Edland-Gryt & Skatvedt (2013)

Bibliographic reference: Edland-Gryt M & Skatvedt AH. Thresholds in a low-threshold setting: An empirical study of barriers in a centre for people with drug problems and mental health disorders. International Journal of Drug Policy. 2013;24:257-264.

Checklist completed by: MB

Q1.1: Was there a clear statement of the aims of the research?		
Consider: • the goal of the research • why it was thought important • its relevance	*Response:* Yes	*Comment:* "In this study we examine and explain different thresholds and how they affect the availability and process of help in a low-threshold setting. By presenting empirical data, we show how the obstacles shown in threshold theory (Jacobsen, Jensen, & Aarseth, 1982) affect people who visit the premises we studied."
Q1.2: Was a qualitative methodology appropriate?		
Consider: • If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants • Is qualitative research the right methodology for addressing the research goal?	*Response:* Yes	*Comment:* Appears to be appropriate.
Q2.1: Was the research design appropriate to address the aims of the research?		
Consider: • If the research has justified the research design (for example, have they discussed how they decided which method to use)	*Response:* Unable to tell	*Comment:* No justification provided for research design

Q3.1: Was the recruitment strategy appropriate to the aims of the research?		
Consider: • If the researcher explained how participants are selected • If the researcher explained why the selected participants were the most appropriate to access the knowledge sought by the study • If there were discussions around recruitment (for example, why some people chose not to take part)	*Response:* Yes	*Comment:* No extensive discussions around recruitment, but method of recruitment covered.
Q4.1: Was the data collected in a way that addressed the research issue?		
Consider: • Is the setting for data collection justified? • Is it clear how data was collected, and are the methods justified and explicit? • Are any modifications in method explained? • Is the form of data clear (for example, audio recordings)? • Is data saturation discussed?	*Response:* Yes	*Comment:* Some detail provided. Any modifications to topic guide and/or data saturation/justification for setting of data collection data were not mentioned.
Q5.1: Has the relationship between researcher and participants been adequately considered?		
Consider: • If the researcher critically examined their own role, potential bias and influence during formulation of the research questions and data collection • How the researcher responded to events during the study and whether they considered the implications of any changes	*Response:* Unable to tell	*Comment:* Paper does not report any consideration of the role of the researcher and their potential influence on the study outcomes
Q6.1: Have ethical issues been taken into consideration?		
Consider: • If there are sufficient details of how research was	*Response:* Yes	*Comment:* (1) Ethics committee approved.

explained to participants • If approval has been sought from an ethics committee		(2) Informed consent gained.
Q7.1: Was the data analysis sufficiently rigorous?		
Consider: • Is there an in-depth description of analysis process? • Is it clear how themes were derived from the data?	*Response:* Yes	*Comment:* Some discussion surrounding data analysis, but not particularly detailed.
Q8.1: Is there a clear statement of findings?		
Consider: • If findings are explicit • Is there adequate discussion of evidence for and against researchers' arguments? • Researcher discussed credibility of findings (for example, triangulation, respondent validation, double-coding)? • Findings discussed in relation to the review question?	*Response:* Unable to tell	*Comment:* The researchers interpretation of the data are explicit, however, there is no discussion in regards to double coding.
Q9.1: How valuable is research?		
Consider: • Is the contribution of the study to existing knowledge discussed, for example in relation to current practice/policy or relevant research-based literature? • Are new areas where research is necessary defined? • Is the generalisability of findings discussed?	*Response:* Yes	*Comment:* All criteria met

APPENDIX 4. QUALITY ASSESSMENT OF ALL INCLUDED STUDIES RQ2.1

	Screening questions		Study design	Sampling	Data Collection	Validity	Ethical Issues	Data Analysis	Findings	Value of research	Overall quality rating
Study ID	**1.1**	**1.2**	**2.1**	**3.1**	**4.1**	**5.1**	**6.1**	**7.1**	**8.1**	**9.1**	**(++, +, -)**
Barnes & Rudge (2003)	Yes	Yes	Unable to tell	Yes	Yes	Unable to tell	Yes	Unable to tell	Unable to tell	No	+
Brown et al. (2002)	Yes	Yes	Unable to tell	Unable to tell	Yes	Unable to tell	Yes	Yes	Yes	Yes	+
Carey et al. (2000)	Yes	Yes	Yes	Yes	Yes	Unable to tell	Yes	Yes	Yes	Yes	++
Coombes & Wratten (2007)	Yes	Yes	Yes	Unable to tell	Yes	Unable to tell	Yes	Yes	Yes	Yes	++
Deans & Soar (2005)	Yes	Yes	Yes	Unable to tell	Unable to tell	Unable to tell	Yes	Yes	Yes	Yes	+
Fonseca et al. (2012)	Yes	Yes	Unable to tell	Unable to tell	Unable to tell	Unable to tell	Unable to tell	Unable to tell	Yes	Yes	-
Hodges et al. (2006)	Yes	Yes	Unable to tell	Unable to tell	Unable to tell	Unable to tell	Yes	Unable to tell	Yes	Yes	-
Holt & Treloar (2008)	Yes	Yes	Unable to tell	Unable to tell	Unable to tell	Unable to tell	Yes	Unable to tell	Yes	Yes	-
Maslin et al. (2001)	Yes	Yes	Unable to tell	Yes	Unable to tell	Unable to tell	Unable to tell	No	Unable to tell	Yes	-
McLaughlin et al. (2008)	Yes	Yes	Unable to tell	Yes	Unable to tell	Unable to tell	Yes	Unable to tell	Yes	Unable to tell	-
Mericle et al. (2007)	Yes	Yes	Unable to tell	Unable to tell	Unable to tell	Unable to tell	Yes	Unable to tell	Yes	Yes	+
Perryman et al. (2011)	Yes	Yes	Yes	Yes	Yes	Unable to tell	Unable to tell	Yes	Unable to tell	Yes	+
Roberts & Darryl (2014)	Yes	Yes	Unable to tell	Unable to tell	Unable to tell	Unable to tell	Yes	Unable to tell	Yes	Yes	+

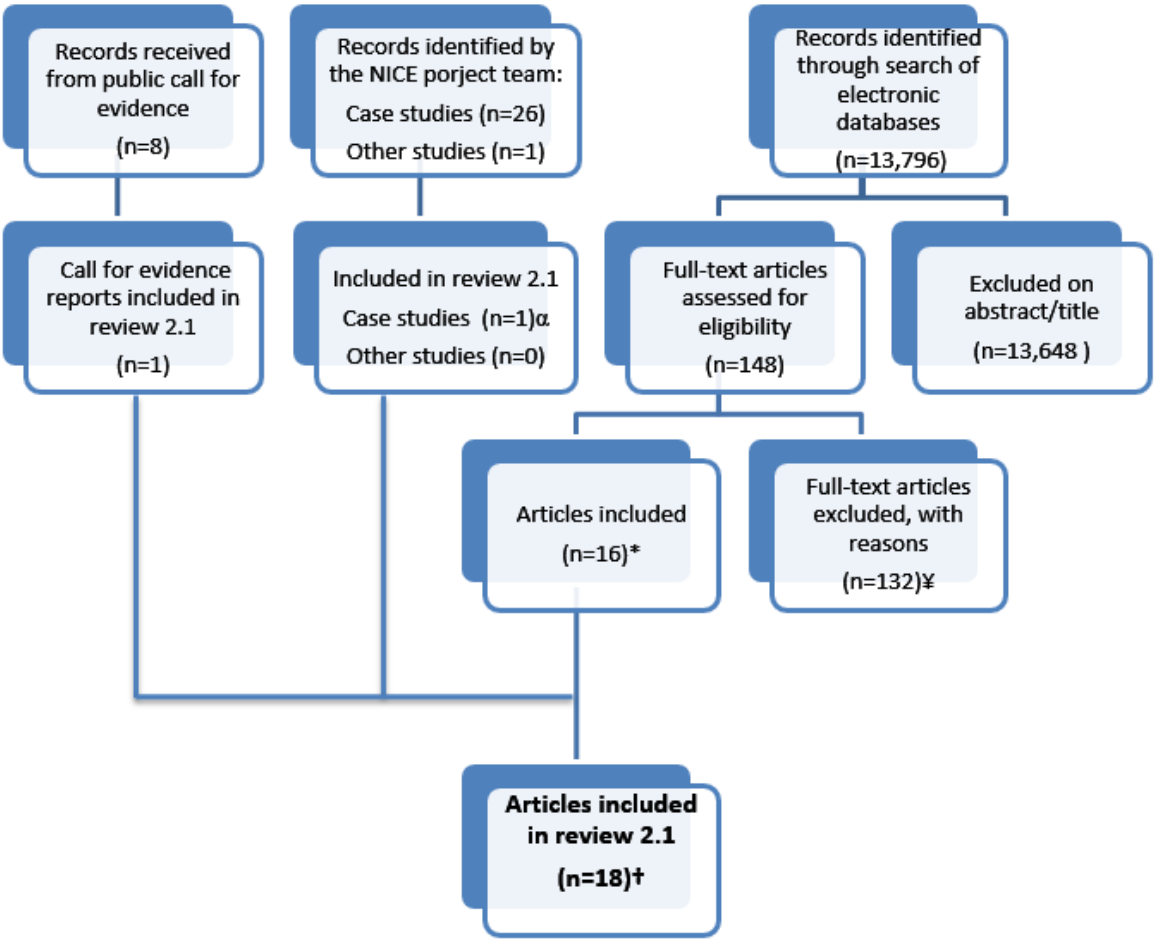
Siddiqui et al. (2009)	Yes	Yes	Unable to tell	Unable to tell	Unable to tell	Unable to tell	Unable to tell	Yes	Yes	Yes	+
St Mungo's Broadway (2015)	Unable to tell	Unable to tell	Unable to tell	Unable to tell	Unable to tell	Unable to tell	Unable to tell	Unable to tell	Unable to tell	Unable to tell	-
Sylvain & Lamothe (2012)	Yes	Yes	Yes	Unable to tell	Yes	Unable to tell	Unable to tell	Yes	Yes	Yes	+
Tiderington et al. (2013)	Yes	Yes	Yes	Unable to tell	Yes	Unable to tell	Yes	Unable to tell	Yes	Yes	+

APPENDIX 5. QUALITY ASSESSMENT OF ALL INCLUDED STUDIES FOR RQ2.2

	Screening questions		Study design	Sampling	Data Collection	Validity	Ethical Issues	Data Analysis	Findings	Value of research	Overall quality rating
Study ID	**1.1**	**1.2**	**2.1**	**3.1**	**4.1**	**5.1**	**6.1**	**7.1**	**8.1**	**9.1**	**(++, +, -)**
Brooks et al. (2007)	Yes	Yes	Unable to tell	Yes	Unable to tell	Unable to tell	Unable to tell	Yes	Yes	Yes	+
Cruce, Öjehagen & Nordström (2012)	Yes	Yes	Yes	Yes	Yes	Unable to tell	Yes	Yes	Yes	Yes	+
Edland-Gryt & Skatvedt (2013)	Yes	Yes	Unable to tell	Yes	Yes	Unable to tell	Yes	Yes	Yes	Yes	+
Edward & Robins (2012)	Yes	Yes	Yes	Unable to tell	Yes	Yes	Yes	Yes	Yes	Yes	+
EnglandKennedy & Horton (2011)	Yes	Yes	Unable to tell	Yes	Yes	Unable to tell	Yes	Yes	Yes	Yes	+
Fraser et al. (2003)	Yes	Yes	Unable to tell	Unable to tell	Unable to tell	Unable to tell	Unable to tell	Unable to tell	Unable to tell	Unable to tell	-
Green et al. (2015)	Yes	Yes	Unable to tell	Yes	Yes	Unable to tell	Yes	Yes	Yes	Yes	+
Hodges et al. (2006)	Yes	Yes	Unable to tell	Unable to tell	Unable to tell	Unable to tell	Yes	Unable to tell	Yes	Yes	-
Holt & Treloar (2008)	Yes	Yes	Unable to tell	Yes	Yes	Unable to tell	Yes	Yes	Yes	Yes	-
Johnson et al. (2013)	Yes	Yes	Unable to tell	Yes	Yes	Unable to tell	Yes	Yes	Yes	Yes	++
Kozloff et al. (2013)	Yes	Yes	Yes	Yes	Yes	Unable to tell	Yes	Yes	Yes	Yes	+
Kuo et al. (2013)	Yes	Yes	Unable to tell	Yes	Yes	Unable to tell	Yes	Yes	Yes	Yes	+

Luciano & Carpenter-Song (2014)	Yes	Yes	Unable to tell	Yes	Yes	Unable to tell	Yes	Yes	Yes	Yes	+
Penn, Brooks & Worsham (2002)	Yes	Yes	Unable to tell	Yes	Yes	Unable to tell	Unable to tell	Yes	Yes	Yes	+
Rethink (2015)	Yes	Yes	Unable to tell	Unable to tell	Unable to tell	Unable to tell	Unable to tell	Unable to tell	Unable to tell	Unable to tell	-
Sorsa & Åstedt-Kurki (2013)	Yes	Yes	No	Yes	Yes	Unable to tell	Yes	Yes	Yes	Yes	+
Tsai et al. (2010)	Yes	Yes	Unable to tell	Yes	Yes	Unable to tell	Yes	Yes	Yes	Yes	+
VoiceAbility (2014)	Yes	Yes	Yes	Unable to tell	Unable to tell	Unable to tell	Unable to tell	Unable to tell	Unable to tell	Unable to tell	-
Villena & Chesla (2010)	Yes	Unable to tell	Yes	Yes	Yes	Unable to tell	Yes	Yes	Yes	Yes	++
Warfa et al. (2006)	Yes	Yes	Unable to tell	Yes	Yes	Unable to tell	Yes	Yes	Yes	Yes	+

APPENDIX 6. PRISMA DIAGRAM - RQ 2.1



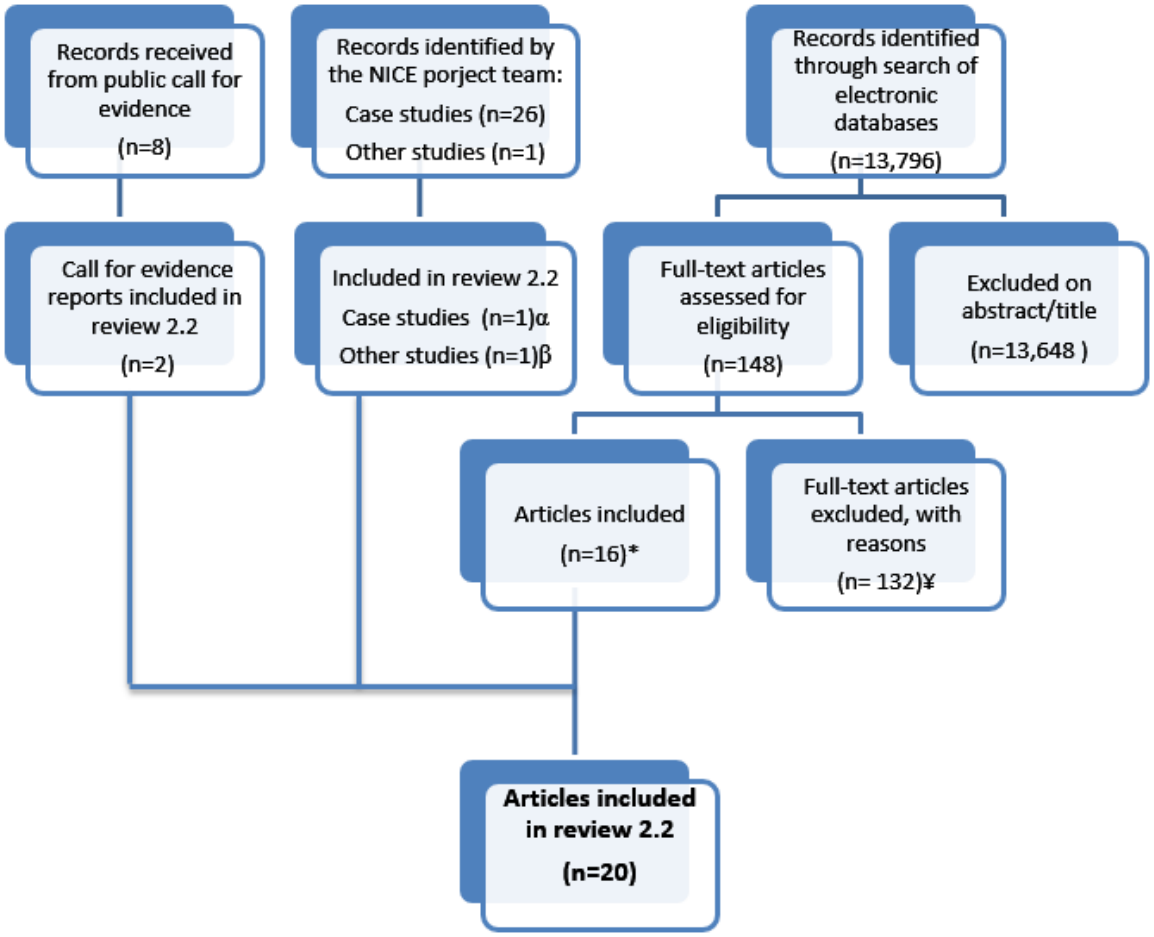
[α]Case study also included in review 2.2 [Hodges et al., (2006)]

*1 article also included in review 2.2 [Holt & Treloar (2008)]

¥Includes included and excluded articles for review 2.2

†17 studies in total; 2 articles included the same study [Roberts & Darryl (2014) and Roberts et al. (2013)]

APPENDIX 7. PRISMA DIAGRAM - RQ 2.2



αCase study also included in review 2.1 [Hodges et al., (2006)]

βFraser et al. (2003)

*1 article also included in review 2.1 [Holt & Treloar (2008)]

¥Includes included and excluded articles for review 2.1

APPENDIX 8. BIBLIOGRAPHY OF INCLUDED STUDIES FOR RQ 2.1

Barnes L, Rudge T. Co-operation and comorbidity: managing dual diagnosis in rural South Australia. Collegian. 2003;10:25–28.

Brown AH, Grella CE, Cooper L. Living it or learning it: attitudes and beliefs about experience and expertise in treatment for the dually diagnosed. Contemporary Drug Problems: an Interdisciplinary Quarterly. 2002;29:687–710.

Carey KB, Purnine DM, Maisto SA, Carey MP, Simons JS. Treating substance abuse in the context of severe and persistent mental illness: clinicians' perspectives. Journal of Substance Abuse Treatment. 2000;19(2):189–98.

Coombes L, Wratten A. The lived experience of community mental health nurses working with people who have dual diagnosis: a phenomenological study. Journal of Psychiatric & Mental Health Nursing. 2007;14:382–92.

Deans C, Soar R. Caring for clients with a dual diagnosis in rural communities in Australia: the experience of mental health professionals. Journal of Psychiatric and Mental Health Nursing. 2005;12:268–74.

Fonseca F, Gail G, Torrens M. Integrating addiction and mental health networks to improve access to treatment for people with alcohol and drug-related problems: a qualitative study. Advances in Dual Diagnosis. 2012;5:5–14.

Hodges C-L, Paterson S, McGarrol S, Taikato M, Crome I, Baldacchino A. Co-morbid Mental Health and Substance Misuse in Scotland. Edinburgh: Scottish Executive. 2006. Available from: http://www.gov.scot/Resource/Doc/127647/0030582.pdf [accessed 14 August 2015]

Holt M & Treloar C. Understanding comorbidity? Australian service-user and provider perspectives on drug treatment and mental-health literacy. Drugs: Education, Prevention and Policy. 2008;15:518–31.

Maslin J, Graham HL, Cawley M, Copello M, Birchwood M, Georgiou G, et al. Combined severe mental health and substance use problems: what are the training and support needs of staff working with this client group? Journal of Mental Health. 2001;10:131–40

McLaughlin DF, Sines D, Long A. An investigation into the aspirations and experiences of newly appointed dual diagnosis workers. Journal of Psychiatric and Mental Health Nursing. 2008;15:296–305.

Mericle AA, Alvidrez J, Havassy BE. Mental health provider perspectives on co-occurring substance use among severely mentally ill clients. Journal of Psychoactive Drugs. 2007;29:173–80.

Perryman K, Rose AK, Winfield H, Jenner J, Oyefeso A, & Phillips TS. The perceived challenges facing alcohol treatment services in England: a qualitative study of service providers. Journal of Substance Use. 2011;16:38–49.

Roberts BM, Darryl M. Dual diagnosis discourse in Victoria Australia: the responsiveness of mental health services. Journal of Dual Diagnosis. 2014;10:139–144.

Roberts BM, Darryl M, Jones R. Reflections on capacity-building initiatives in an Australian state. Advances in Dual Diagnosis. 2013;6(1):24-33.

Siddiqui NJ, Astone-Twerell J, Hernitche T. Staff perspectives on modified therapeutic community services for homeless dually diagnosed clients: an exploratory pilot study. Journal of Psychoactive Drugs. 2009;41:355–361.

St Mungo's Broadway. St Mungo's Broadway staff views and experiences of services for people with severe mental health and substance misuse. 2015. Available from: http://www.mungosbroadway.org.uk/documents/6172/6172.pdf [accessed 1 September 2015]

Sylvain C, Lamothe L. Sensemaking: a driving force behind the integration of professional practices. Journal of Health Organization and Management. 2012;26:737–757.

Tiderington E, Stanhope V, Henwood BF. A qualitative analysis of case managers' use of harm reduction in practice. Journal of Substance Abuse Treatment. 2013; DOI:10.1016/j.jsat.2012.03.007.

APPENDIX 9. BIBLIOGRAPHY OF EXCLUDED STUDIES FOR RQ 2.1

	Study	Reason for exclusion
1.	Askey J. Dual diagnosis: a challenging therapeutic issue of our time. Drugs and Alcohol Today. 2007:7;33-39.	Not a qualitative study
2.	Bailey D. Training together: An exploration of a shared learning approach to dual diagnosis training for specialist drugs workers and Approved Social Workers (ASWs). Social Work Education: The International Journal. 2002;21: 565-581.	Service description
3.	Baldacchino A. Co-morbid substance misuse and mental health problems: policy and practice in Scotland. American Journal on Addictions. 2007;16:147-159.	No presentation of primary evidence
4.	Barry KR, Tudway JA, Blissett J. Staff drug knowledge and attitudes towards drug use among the mentally ill within a medium secure psychiatric hospital. Journal of Substance Use. 2002;7:50-56.	Inpatient setting
5.	Bartholomew NG, Joe GW, Rowan-Szal GA, Simpson DD. Counselor assessments of training and adoption barriers. Journal of Substance Abuse Treatment. 2007;33:193-9.	Topic not relevant (evaluation of a training intervention)
6.	Baudze A, Stohler R, Schulze B, Schaub M, Liebrenz M. Do patients think cannabis causes schizophrenia?- A qualitative study on the causal beliefs of cannabis using patients with schizophrenia. Harm Reduction Journal. 2010;7:22	Not relevant (about causal link between cannabis and schizophrenia)
7.	Bell-Barnes SG. Integrated treatment for women with co-occurring disorders: The experiences of community mental health professionals.	Dissertation
8.	Borge L, Angel OH, Rossberg JI. Learning through cognitive milieu therapy among inpatients with dual diagnosis: a qualitative study of interdisciplinary collaboration. Issues in Mental Health Nursing. 2013;34:229-39.	Inpatient setting
9.	Brousselle A, Lamothe L, Sylvain C. Integrating services for	Inpatient setting

	patients with mental and substance use disorders: what matters? Health Care Management Review. 2010;35:206-11.	
10.	Brown G. Exploring perceptions of alcohol use as self-medication for depression among women receiving community-based treatment for alcohol problems. Journal of Prevention and Intervention in the Community. 2008;35:33-47.	Not a qualitative study
11.	Carroll L. A comparative exploration of the effectiveness of the rapid housing and supportive housing models in the treatment of homeless clients with a dual diagnosis. Unpublished.	Dissertation
12.	Clancy C, Oyefeso A. British nurse perceptions of mentally ill patients with co-morbid substance abuse disorders: toward a framework of continuing professional developments. Substance Abuse. 2004;25:68-68.	Conference abstract
13.	Clutterbuck R, Tobin D, Orford J, Copello A, Preece M, Birchwood M, et al. Exploring the attitudes of staff working within mental health settings toward clients who use cannabis. Drugs: Education, Prevention & Policy. 2009;16:311-27.	Not relevant (about staff attitudes to cannabis use)
14.	Cooper P. Psychosis: do they know it's drug-induced? Mental Health Nursing. 2003;23:14-17.	Not relevant (about drug induced psychosis)
15.	Corcoran CM. What is the role of cannabis in psychotic disorders? Primary Psychiatry. 2009;16:27-28.	Editor's letter
16.	Cornford CS, Umeh K, Manshani N. Heroin users' experiences of depression: a qualitative study. Family Practice. 2012;29:586-592.	Not relevant (about specific treatment)
17.	Dausey DJ, Pincus HA, Herrell JM, Rickards L. States' early experience in improving systems-level care for persons with co-occurring disorders. Psychiatric Services. 2007;58:903-05.	Not relevant (about implementation of policy)
18.	Deady M, Kay-Lambkin F, Teesson M, Mills K. Developing an integrated, Internet-based self-help programme for young people with depression and alcohol use problems. Internet Interventions. 2014;1:118-31.	Not relevant (feedback about the content of a pilot online self-help intervention)
19.	Edward KL, Hearity RN, Felstead B. Service integration for the	Not a qualitative study

	dually diagnosed. Australian Journal of Primary Health. 2012;18:17-22.	
20.	Georgeson B. The Matrix model of dual diagnosis service delivery: Practice development. Journal of Psychiatric and Mental Health Nursing. 2009;16:305-10.	Description of a service delivery model
21.	Gilchrist G, Blázquez A, Torrens M. Exploring the relationship between intimate partner violence, childhood abuse and psychiatric disorders among female drug users in Barcelona. Advances in Dual Diagnosis. 2012;5:46 – 58.	Not SMI patient population
22.	Gomes MB, Primm AB, Tzolova-Iontchev I, Perry W, THi Vu H, Crum RM. A description of precipitants of drug use among dually diagnosed patients with chronic mental illness. Community Mental Health Journal. 2000;36:351-362.	Not relevant (about causes of mental illness)
23.	Grella CE. Contrasting the views of substance misuse and mental health treatment providers on treating the dually diagnosed. Substance Use & Misuse. 2003;38:1433-46.	Not a qualitative study
24.	Havassy BE, Alvidrez J, Mericle AA. Disparities in use of mental health and substance abuse services by persons with co-occurring disorders. Psychiatric Services. 2009;60:217-23.	Not a qualitative study
25.	Henwood BF, Padgett DK, Tiderington E. Provider views of harm reduction versus abstinence policies within homeless services for dually diagnosed adults. Journal of Behavioral Health Services & Research. 2014;41:80-9.	Full text not available
26.	Hoxmark EM, Wynn R. Health Providers' Descriptions of the significance of the Therapeutic Relationship in Treatment of Patients with Dual Diagnoses. Journal of Addictions Nursing. 2010;21:187-193.	Full text not available
27.	Hughes E, Brown Y, Tummey R. "Acute concerns": is the mental health workforce equipped and supported to meet complex needs?. Advances in Dual Diagnosis. 2012:5;15-22.	Not a qualitative study
28.	Hughes G, Moynes P, Jones C. Engaging pre-contemplative dual	Not about a service

	diagnosis clients. Nursing Times. 2005;101:32–34.	
29.	Kavanagh D, Greenaway L, Jenner L, Saunders JB, White A, Sorban J, Hamilton G. Contrasting views and experiences of health professionals on the management of comorbid substance misuse and mental disorders. Australian and New Zealand Journal of Psychiatry. 2000;34:279-289.	Not a qualitative study
30.	Klinkenberg WD, Calsyn RJ, Morse GA. The case manager's view of the helping alliance. Care Management Journals. 2002;3:120-125.	Not a qualitative study
31.	Loneck B, Banks S, Wa B, Bonaparte E. An empirical model of therapeutic process for psychiatric emergency room clients with dual disorders. Social Work Research. 2002;26:132-144.	Inpatient setting
32.	Magura S, Laudet AB, Mahmood D, Rosenblum A, Vogel HS, Knight EL. Role of self-help processes in achieving abstinence among dually diagnosed persons. Addictive Behaviors. 2003;28:399-413.	Not a qualitative study
33.	Miller R, Caponi JM, Sevy S, Robinson D. The Insight-Adherence-Abstinence triad: an integrated treatment focus for cannabis-using first-episode schizophrenia patients. Bulletin of the Menninger Clinic. 2005;69:220-36.	Not a qualitative study
34.	Moggi F, Brodbeck J, Koltzsch K, Hirsbrunner HP, Bachmann KM. One-year follow-up of dual diagnosis patients attending a 4-month integrated inpatient treatment. European Addiction Research. 2002;8:30-37.	Not a qualitative study
35.	Morris JA, Stuart GW. Training and education needs of consumers, families, and front-line staff in behavioural health practice. Administration & Policy in Mental Health. 2002;29:377-402.	Not a qualitative study
36.	Mukherjee R. The stigmatisation of psychiatric illness: the attitudes of medical students and doctors in a London teaching hospital. Psychiatric Bulletin. 2002;26:178-81.	Not a qualitative study
37.	Primm AB, Gomez MP, Tzolova-Iontchev I, Perry W, Crum RM.	Not a qualitative study, case presentation

	Chronically mentally ill patients with and without substance use disorders: a pilot study. Psychiatry Research. 2000;95:261-70.	
38.	Raitakari S, Gunther K, Juhila K, Saario S. Causal accounts as a consequential device in categorizing mental health and substance abuse problems. Communication & medicine. 2013;10:237-48.	Not relevant (about causes of mental illness)
39.	Rani S, Byrne H. A multi-method evaluation of a training course on dual diagnosis. Journal of Psychiatric & Mental Health Nursing. 2012;19:509-20.	Not relevant (providers views about a training intervention for DD)
40.	Renner Jr JA. Training psychiatrists to treat dual diagnosis patients. Journal of Dual Diagnosis. 2007;3:125-36.	Not relevant (evaluation of a training interventions for psychiatrists about DD)
41.	Roberts B. Interprofessional relationships in dual diagnosis discourse in an Australian State: Are we respecting each other yet? Mental Health and Substance Use: Dual Diagnosis. 2012;5:148-59.	Not relevant (about dual diagnosis discourse)
42.	Roeg D, van de Goor I, Garretsen H. Towards quality indicators for assertive outreach programmes for severely impaired substance abusers: concept mapping with Dutch experts. International Journal for Quality in Health Care. 2005;17:203-8.	Not about dual diagnosis (focus on substance misuse)
43.	Saltman DC, Newman CE, Mao L, Kippax SC, Kidd MR. Experiences in managing problematic crystal methamphetamine use and associated depression in gay men and HIV positive men: in-depth interviews with general practitioners in Sydney, Australia. BCM Family Practice. 2008;9:45.	Full text not available
44.	Shaner A, Eckman T, Roberts LJ, Fuller T. Feasibility of a skills training approach to reduce substance dependence among individuals with schizophrenia. Psychiatric Services. 2003;54:1287-9.	Not a qualitative study
45.	Srebnik D, Sugar A, Coblentz P, McDonell MG, Angelo F, Lowe JM, et al. Acceptability of contingency management among clinicians and clients within a co-occurring mental health and substance use treatment program. American Journal on Addictions. 2013;22:432-6.	Not relevant (about specific treatment)

46.	Staiger PK, Long C, McCabe M, Ricciardelli L. Defining dual diagnosis: A qualitative study of the views of health care workers. Mental Health and Substance Use: Dual Diagnosis. 2008;1:194-204.	Not relevant (providers' views on the definition of dual diagnosis)
47.	Swinden D, Barrett M. Developing a dual diagnosis role within mental health. Nursing Times. 2008;104:26-27.	Service description
48.	Tammi T, Stenius K. Capabilities for handling complex substance abuse problems and its relationship to the treatment system: Using the DDCAT instrument to explore local treatment systems in Finland. Nordic Studies on Alcohol and Drugs. 2014;31:45-58.	Not a qualitative study
49.	Weiss RD. Treating patients with bipolar disorder and substance dependence: lessons learned. Journal of Substance Abuse Treatment. 2004;27:307-12.	Not a qualitative study

APPENDIX 10. BIBLIOGRAPHY OF INCLUDED STUDIES FOR RQ 2.2

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Cruce G, Öjehagen A & Nordström M. Recovery-promoting care as experienced by persons with severe mental illness and substance misuse. International Journal of Mental Health and Addiction. 2012;10:660–69.

Edland-Gryt M & Skatvedt AH. Thresholds in a low-threshold setting: an empirical study of barriers in a centre for people with drug problems and mental health disorders. International Journal of Drug Policy. 2013;24:257–64.

Edward KL & Robins A. Dual diagnosis, as described by those who experience the disorder: using the internet as a source of data. International Journal of Mental Health Nursing. 2012;21:550–59.

England-Kennedy ES & Horton S. "Everything that I thought that they would be, they weren't": Family systems as support and impediment to recovery. Social Science & Medicine. 2011;73:1222–29.

Fraser A, Barlow J, Bland N, Carroll J, Colvin I, Crome I et al. Mind the gaps. Meeting the needs of people with co-occurring substance misuse and mental health problems. Scottish Executive: Edinburgh, Scotland. 2003.

Green CA, Yarborough MT, Polen MR, Janoff SL, Yarborough BJH. Dual recovery among people with serious mental illnesses and substance problems: a qualitative analysis. Journal of dual diagnosis. 2015;11:33–41.

Hodges C-L, Paterson S, McGarrol S, Taikato M, Crome I, Baldacchino A. Co-morbid Mental Health and Substance Misuse in Scotland. Edinburgh: Scottish Executive. 2006. Available from: http://www.gov.scot/Resource/Doc/127647/0030582.pdf [accessed 14 August 2015]

Holt M & Treloar C. Understanding comorbidity? Australian service-user and provider perspectives on drug treatment and mental-health literacy. Drugs: Education, Prevention and Policy. 2008;15:518–31.

Johnson JE, Chatav Schonbrun Y, Nargiso JE, Kuo CC, Shefner RT, Williams CA, et al. "I know if I drink I won't feel anything": substance use relapse among depressed women leaving prison. International journal of prisoner health. 2013;9:169–86.

Kozloff N, Cheung AH, Ross LE, Winer H, Ierfino D, Bullock H, et al. Factors influencing service use among homeless youths with co-occurring disorders. Psychiatric Services. 2013;64:925–28

Kuo C, Schonbrun YC, Zlotnick C, Bates N, Todorova R, Kao JCW et al. A qualitative study of treatment needs among pregnant and postpartum women with substance use and depression. Substance Use & Misuse. 2013;48:1498–1508.

Luciano A & Carpenter-Song EA. A qualitative study of career exploration among young adult men with psychosis and co-occurring substance use disorder. Journal of Dual Diagnosis. 2014;10:220–25.

Penn PE, Brooks AJ & Worsham BD. Treatment concerns of women with co-occurring serious mental illness and substance abuse disorders. Journal of Psychoactive Drugs. 2002;34:355–62.

Rethink. Severe mental illness and substance misuse (dual diagnosis) - community health and social care services call for evidence: Rethink Mental Illness response. 2015.Unpublished.

Sorsa MA & Åstedt-Kurki P. Lived experiences in help-seeking from the perspective of a mother with a dual diagnosis. International Journal of Qualitative Studies on Health and Well-being. 2013;8.

Tsai J, Bond GR, Salyers MP, Godfrey JL, Davis KE. Housing preferences and choices among adults with mental illness and substance use disorders: a qualitative study. Community Mental Health Journal. 2010;46:381–88.

Villena ALD & Chesla CA. Challenges and struggles: Lived experiences of individuals with co-occurring disorders. Archives of Psychiatric Nursing. 2010;24:76–88.

VoiceAbility. ‘Deal with that first, and then we'll sort the other one out’: Peer research into lived experience of being supported with a dual diagnosis in the London Borough of Camden’. 2014. Available from: http://www.voiceability.org/images/uploads/Dual_diagnosis_peer_research_report.pdf [accessed 1 September 2015]

Warfa N, Bhui K, Phillips K, Nandy K, Griffiths S. Comparison of life events, substance misuse, service use and mental illness among African-Caribbean, black African and white British men in east London: a qualitative study. Diversity in Health and Social Care. 2006;3:111–21.

APPENDIX 11. BIBLIOGRAPHY OF EXCLUDED STUDIES FOR RQ 2.2

	Study	Reason for exclusion
1.	Agyapong, VIO, Milnes J, McLoughlin DM, Farren CK. Perception of patients with alcohol use disorder and comorbid depression about the usefulness of supportive text messages. Technology and Health Care. 2013;21:31-39.	Setting: Inpatient
2.	Bellamy CD, Rowe M, Benedict P, Davidson L. Giving back and getting something back: The role of mutual-aid groups for individuals in recovery from incarceration, addiction, and mental illness. Journal of Groups in Addiction & Recovery. 2012;7:223-236.	Study design: SR/Review
3.	Brandt, P. Homelessness and mental illness in Denmark: Focus on "Street-Dwellers". International Journal of Mental Health. 2001;30:84-92.	Perspective: People with a severe mental illness but no evidence of substance misuse
4.	Charles V, Weaver T. A qualitative study of illicit and non-prescribed drug use amongst people with psychotic disorders. Journal of Mental Health. 2010;19:99-106.	Topic not relevant
5.	Chia YH, Lunsky Y. Dual diagnosis and access to services. Journal of Developmental Disabilities. 2003:10:79-82.	Perspective: People with a severe mental illness but no evidence of substance misuse
6.	Childs HE, McCarthy-Jones S, Rowse G, Turpin G. The journey through cannabis use: A qualitative study of the experiences of young adults with psychosis. The Journal of Nervous and Mental Disease. 2011;199:703-708.	Topic not relevant
7.	Chue P, Tibbo P, Wright E, Van Ens J. Client and community services satisfaction with an assertive community treatment subprogram for inner-city clients in Edmonton, Alberta. Canadian Journal of Psychiatry - Revue Canadienne de Psychiatrie. 2004;49:621-624.	Study design: Service description
8.	Crome IB, Christian J, Green C. The development of a unique	Study design: Service description

	designated community drug service for adolescents: policy, prevention and education implications. Drugs: Education, Prevention, and Policy. 2000;7:87-108.	
9.	Davis KE, O'Neill SJ. A focus group analysis of relapse prevention strategies for persons with substance use and mental disorders. Psychiatric Services. 2005;56:1288-1291.	Topic not relevant: no implications for delivery of care
10.	Dugmore L. Partnership working in dual diagnosis. Nursing Times. 2010;107:20-21.	Study design: Editorial
11.	Dye MH, Roman PM, Knudsen HK, Johnson JA. The availability of integrated care in a national sample of therapeutic communities. The Journal of Behavioral Health Services & Research. 2012;39:17-27.	Study design: Service description
12.	Etheridge K, Yarrow L, Peet M. Pathways to care in first episode psychosis. Journal of Psychiatric and Mental Health Nursing. 2004;11:125-128.	Population: participants did not currently have dual diagnosis
13.	Fitzsimmons M, Bradshaw T, Lovell K. Understanding disengagement from early intervention services for psychosis: Perspectives from ex-service users and mental health staff. In Early Intervention Psychiatry. 2012;6:80-80.	Study design: Conference abstract
14.	Glassman S, Kottsieper P, Zuckoff A, Gosch E. Motivational interviewing and recovery: experiences of hope, meaning, and empowerment. Advances in Dual Diagnosis. 2013;6:106-120.	Topic not relevant: no implications for delivery of care
15.	Gottlieb JD, Mueser KT, Glynn SM. Family therapy for schizophrenia: co-occurring psychotic and substance use disorders. Journal of Clinical Psychology. 2012; 68:490-501.	Study design: Service description
16.	Grandy Watson, A. Physicians with a dual diagnosis: A qualitative exploration of physicians in recovery from a substance use disorder and a mental illness (Doctoral dissertation, CAPELLA UNIVERSITY).	Study design: Dissertation
17.	Greenwood K et al. Facilitators and barriers to early youth engagement in first episode psychosis services (the EYE project):	Study design: Conference abstract

	The subjective experience of engagement of service users, carers and young people. Schizophrenia Bulletin. 2013;39:S114.	
18.	Hack SM, Larrison CR, Gone JP. American Indian identity in mental health services utilization data from a rural Midwestern sample. Cultural Diversity and Ethnic Minority Psychology. 2014;20:68.	Population: only 1 out of 14 participants had a dual diagnosis. Not possible to determine which views were expressed by the individual with a dual diagnosis
19.	Harris M, Fallot RD, Berley RW. Qualitative interviews on substance abuse relapse and prevention among female trauma survivors. Psychiatric Services. 2005;56:1292-1296.	Topic not relevant: no implications for delivery of care
20.	Hawkins RL, Abrams C. Disappearing acts: The social networks of formerly homeless individuals with co-occurring disorders. Social Science & Medicine. 2007:65;2031-2042.	Topic not relevant: no implications for delivery of care
21.	Hipolito MM., Carpenter-Song E, Whitley R. Meanings of recovery from the perspective of people with dual diagnosis. Journal of Dual Diagnosis. 2011;7:141-149.	Topic not relevant: no implications for delivery of care
22.	Hodgson S, Lloyd C. Leisure as a relapse prevention strategy. British Journal of Therapy and Rehabilitation. 2002;9:86-91.	Topic not relevant: no implications for delivery of care
23.	Isaacs S, Jellinek P, Garcel JM, Hunt KA, Bunch W. New York State Health Foundation: Integrating Mental Health and Substance Abuse Care. Health Affairs. 2013;32:1846-1850.	Study design: Service description
24.	Johnson ED. Differences among families coping with serious mental illness: A qualitative analysis. American Journal of Orthopsychiatry. 2000;70:126.	Population: only 43/180 of participants had a dual diagnosis. Not possible to determine which views were expressed by those with a dual diagnosis
25.	Kim M, Roberts A. "Exploring trauma among homeless men in treatment for substance abuse: A qualitative approach." Journal of Social Work Practice in the Addictions. 2004;4:21-32.	Perspective: People who misuse substances who have not been diagnosed with a severe mental illness
26.	Klitzing, S. W. Women who are homeless: leisure and affiliation. Therapeutic Recreation Journal. 2004;38:348-365.	Topic not relevant: no implications for delivery of care
27.	Langan J, Lindow V. "Home is where the heart is?" OpenMind. 2001;110:10-11.	Paper unavailable

28.	Laudet AB, Magura S, Vogel HS, Knight E. Recovery challenges among dually diagnosed individuals. Journal of Substance Abuse Treatment. 2000;18:321-329.	Topic not relevant: no implications for delivery of care
29.	Laudet AB, Magura S, Vogel HS, Knight EL. Interest in and obstacles to pursuing work among unemployed dually diagnosed individuals. Substance Use & Misuse. 2002;37:145-170.	Topic not relevant: no implications for delivery of care
30.	Lecomte T, Leclerc C, Wykes T, Lecomte J. Group CBT for clients with a first episode of schizophrenia. Journal of Cognitive Psychotherapy. 2003;17:375-383.	Perspective: People with a severe mental illness but no evidence of substance misuse
31.	Leontieva L, Dimmock J, Cavallerano M, DeRycke S, Meszaros Z, Carey K et al. Patient and provider attitudes towards monitored naltrexone treatment of alcohol dependence in schizophrenia. The American Journal of Drug and Alcohol Abuse. 2009;35:273-278.	Topic not relevant: no implications for delivery of care
32.	Lichtenstein DP, Spirito A, Zimmermann RP. Assessing and treating co-occurring disorders in adolescents: Examining typical practice of community-based mental health and substance use treatment providers. Community Mental Health Journal. 2010;46:252-257.	Study design: Service description
33.	Liveng, A. The vulnerable elderly's need for recognizing relationships–a challenge to Danish home-based care. Journal of Social Work Practice. 2011;25:271-283.	Perspective: People who misuse substances who have not been diagnosed with a severe mental illness
34.	Lobbana F, Barrowclough C, Jeffery S, Bucci S, Taylor K, Mallinson S et al. Understanding factors influencing substance use in people with recent onset psychosis: A qualitative study. Social Science & Medicine. 2010;70:1141-1147.	Topic not relevant: no implications for delivery of care
35.	Magura S, Cleland C, Vogel HS, Knight EL, Laudet AB. Effects of “dual focus” mutual aid on self-efficacy for recovery and quality of life. Administration and Policy in Mental Health and Mental Health Services Research. 2007;34:1-12.	Study design: Quantitative data
36.	Magura S. Effectiveness of dual focus mutual aid for co-occurring substance use and mental health disorders: A review and	Study design: Quantitative data

	synthesis of the “double trouble” in recovery evaluation. Substance Use & Misuse. 2008;43:1904-1926.	
37.	Mojtabai R, Chen LY, Kaufmann CN, Crum RM. (2014). Comparing barriers to mental health treatment and substance use disorder treatment among individuals with comorbid major depression and substance use disorders. Journal of substance abuse treatment, 46(2), 268-273.	Study design: Quantitative data
38.	Nehls N, Sallmann J. Women living with a history of physical and/or sexual abuse, substance use, and mental health problems. Qualitative Health Research. 2005;15:365-381.	Perspective: People who misuse substances who have not been diagnosed with a severe mental illness
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APPENDIX 12. TEXT MINING

In light of time pressures, we employed a text mining and machine learning method, known as 'active learning' (Brunton et al., 2010) using the systematic review software EPPI-Reviewer 4 to screen titles and abstracts (Wallace et al., 2010). This was introduced in an attempt to improve study detection and was an addition to the standard methods and agreed protocol. The primary goal of text mining is to retrieve information from unstructured text and to present the distilled knowledge to users in a concise form (Ananiadou & McNaught, 2006). Active learning is a 'semi-supervised' method whereby the machine learns iteratively – from human interaction – to distinguish between relevant, and irrelevant citations during the screening phase of a systematic review. It does this by ranking citations in order of relevance, and presenting them to the reviewer for manual screening. After a small number have been manually screened (e.g. 50 citations), the machine re-orders the list, taking into account everything that has been screened thus far. Thus, rather than screening the documents in no particular order, those most similar to the studies already selected are moved to the top of the list, increasing the probability that the next document viewed will be selected for further review.

We initially truncated the screening process at the point when 3000 titles and abstracts were consecutively excluded, and therefore the rate of inclusion had dropped to less than the 0.5% agreed threshold (Thomas et al., 2011). As results from Eppi4 were not sufficient, we then screened a further 8,036 titles and abstracts giving a total of 11,036 which were screened by the machine learning method. We then sifted the top 12% of these records (1,324). As a validity check we compared the number of papers identified from this top 12% with those identified by a hand search of 20% (2,760) of the 13,796 records identified. If the machine learning method had performed well, we would have expected the majority, if not all, studies identified by the hand search to be in the top 12%. However, of the 56 full text appraisals identified in the hand search only 1 of 20 included studies and 4 of 36 excluded studies were located in the top 12% of the machine search. We therefore concluded that although overall rates of agreement between hand searching and text mining were 90% (which was essentially a function of the high rate of excluded studies), that as agreement on included studies between text mining and hand searching was only 5%, we should revert to hand searching as the preferred method for study identification.

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APPENDIX 13. EVIDENCE TABLES FOR RQ2.1: VIEWS AND EXPERIENCES OF PROVIDERS AND COMMISSIONERS

These are presented in a separate file.

APPENDIX 14. EVIDENCE TABLES FOR RQ2.2: VIEWS AND EXPERIENCES OF SERVICE USERS, THEIR FAMILY AND CARERS

These are presented in a separate file.

APPENDIX 15. DESCRIPTION OF RESULTS BY THEMES FOR RQ2.1: VIEWS AND EXPERIENCES OF PROVIDERS AND COMMISSIONERS

These are presented in a separate file.

APPENDIX 16. DESCRIPTION OF RESULTS BY THEMES FOR RQ2.2: VIEWS AND EXPERIENCES OF SERVICE USERS, THEIR FAMILY AND CARERS

These are presented in a separate file.