

# Pathways for people experiencing co-occurring mental health and drug and alcohol use conditions: A lived experience led evaluation

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## Executive summary

The current report details a project commissioned by Stoke-on-Trent City Council to evaluate pathways for people experiencing co-occurring mental health and drug and alcohol use conditions in Stoke-on-Trent.

Expert Citizens consulted with 37 stakeholders and 33 people with experience of co-occurring mental health and drug and/or alcohol conditions. Three Communities of Practice were held over the course of the project to enable stakeholders to action recommendations quickly and efficiently where ever possible, and to provide up to date feedback to shape recommendations.

Key findings relate to increasing understanding of complex trauma across the system and building ways to connect a fragmented system. The multifaceted nature of co-occurring mental health and drug and alcohol use requires comprehensive, integrated approaches to address both the psychological and environmental factors that contribute to the challenges individuals experience. By recognising drug and alcohol use as a response to underlying distress and addressing the root causes of such distress, practitioners can better support individuals in their journey towards recovery and healing.

Through the Community of Practice, it became clear that there is both a recognition of the challenges and a willingness to find solutions.

## Recommendations

There is a notable absence of a specific strategy to address the challenges faced across the city by professionals and people seeking support in relation to co-occurring mental health and drug and/or alcohol use conditions. Therefore, the current report and recommendations could be considered as a starting point to develop such a strategy.

Recommendations broadly fall into three categories: Learning, Specific Roles, and Innovation:

### Learning

1. Promote a universal understanding of complex trauma across services and professionals at all levels.
2. Promote awareness of co-occurring mental health and drug and/or alcohol use prevalence and the utilisation of accessible resources such as: [www.dualdiagnosis.org.uk](http://www.dualdiagnosis.org.uk)
3. Address training gaps in:
  - a. What is co-occurring mental health and drug and/or alcohol use and how it affects individuals.
  - b. The negative impacts of the social stigma of mental health and drug and/or alcohol use and how this influences service provision and individual recovery journeys.

- c. Psychosis and drug and/or alcohol use awareness.
  - d. Empathy, communication skills and strengths-based working.
  - e. Psychologically informed environments (PIEs) and trauma-informed care (TIC) are highlighted as valuable approaches to improving service delivery.<sup>1</sup>
4. Mapping exercise of stakeholders and services (get a handle on who delivers what, and who can help with what).
  5. Exploratory research identifying where multi-agency meeting referrals are coming from and who is attending/represented to identify where promotion is most needed/develop targeted approach.
  6. Professionals and people with lived experience to share learning spaces and engage in knowledge exchange to promote good practice, i.e. training sessions, communities of practice and multi-agency meetings.
  7. Identify the criteria for referrals to mental health support and include practical definitions. Particularly in relation to reducing drug and/or alcohol use before referral will be accepted.
  8. Promote the Stoke-on-Trent Multi-agency Resolution Group throughout mental health and drug and alcohol services.
  9. Promote community assets to support prevention and early intervention.

## Specific Roles

10. Introduction of qualified mental health professionals situated within Community Drug and Alcohol Services familiar with good practice approaches for working with people experiencing co-occurring mental health and drug and/or alcohol use conditions e.g. Solution Focussed Therapies. These mental health professionals should also be experienced in supporting people experiencing drug and/or alcohol use conditions.
11. Ensure that 'Dual diagnosis' workers have both mental health qualifications and comprehensive drug and alcohol treatment training. The salary should reflect this 'dual' expertise to attract appropriate skills to the role.
12. Invest in/recruit a facilitator to continue delivering the Dual Diagnosis Community of Practice to create a regular opportunity for cross organisation networking with a solution focus.
13. Multi-agency meetings:
  - a. Encourage senior staff from mental health, drug and alcohol support, housing, police and adult health and social care to attend. It is crucial that staff who attend multi-agency meetings have decision making authority to action solution focused planning.
  - b. 'Test and Learn' approach to involving customers in multi-agency meetings:
    - i. Creative ways to capture customer's wishes to share at the meeting (e.g., through the referrer, having a video or audio clip, Use Microsoft Teams to allow customer to attend)

- ii. Involve the customer more explicitly after the multi-agency meeting discussion, and feedback at the next meeting.

## Building on Current Support

14. Increase the availability of Solution Focused Therapy for people seeking support for co-occurring mental health and drug and/or alcohol conditions.
15. Invest in the sustainability of a Community of Practice.
16. Explore innovative approaches to prevention and early intervention, particularly for young people and children in schools in Stoke-on-Trent.
  - a. Outreach in schools and colleges.
  - b. Promote safe social media use for young people and upskill parents to use parental controls online.
  - c. Prioritise 'looked after' children and those at risk of homelessness.
  - d. Focus on strengths and solutions rather than 'scaremongering' i.e. promote engagement in sports, community groups and creative pursuits.
  - e. Develop a family focussed offer e.g. safe spaces for families experiencing challenges with co-occurring mental health and drug and/or alcohol use, family support and therapy options.
17. Diversify the workforce and provide adequate support to staff in adapting to culturally sensitive practice approaches.
18. Work with people with lived experience of co-occurring mental health and drug and/or alcohol conditions to develop, deliver and evaluate new ways to address the challenges faced by people currently seeking support.
19. Involving Lived experience in commissioning mental health and drug and alcohol services.

# Context

**Co-occurring mental health and drug and alcohol conditions**, often referred to as "dual diagnosis" or "comorbidity," describe the presence of both mental health and drug and/or alcohol use conditions in an individual simultaneously. This complex interaction can significantly impact the persons quality of life, as well as diagnosis, treatment, and outcomes of each condition.

National Institute of Health and Care Excellence (NICE, 2019)

## A complex cross-sector issue

Public Health England's guidance on commissioning emphasises that both commissioners and providers of mental health, drug, and alcohol services share a collective obligation to address the needs of individuals with co-occurring conditions.<sup>2</sup> The 2017 publication outlines two fundamental principles:

**Everyone's job:** It is the collaborative responsibility of commissioners and providers in the realms of mental health and drug and alcohol services to collaboratively address the needs of individuals with co-occurring conditions. The focus is on working together to find shared solutions.

**No wrong door:** Providers in mental health and drug and alcohol services, and other services to adopt an open-door policy for individuals with co-occurring conditions. It emphasizes making every contact meaningful, ensuring that treatment for any of the co-occurring conditions is accessible through every point of contact.

The drivers of drug and alcohol use and related harm are complex and cut across the responsibilities of a range of different organisations. The systems map shown in Figure 1, taken from *Harm to Hope: a 10-year drugs plan to cut crime and save lives* highlights the range of support that could be needed by an individual or a family,

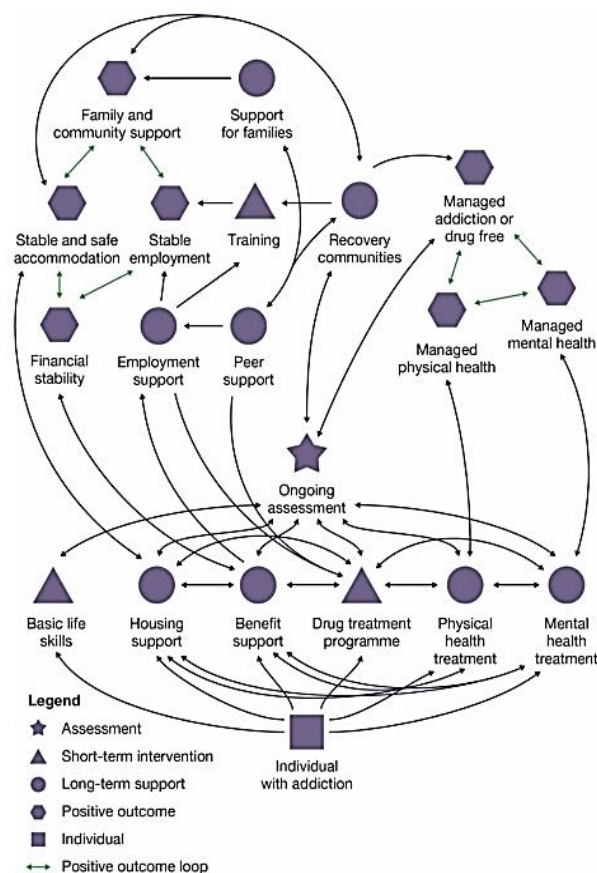


Figure 1. The systems map taken from *Harm to Hope: a 10-year drugs plan to cut crime and save lives*.

and potential pathways into the types of support they might need.<sup>3</sup> This needs to be co-ordinated to be effective but too often it is not, or the services are not in place to provide a journey to recovery. To address this, the strategy aims to coordinate efforts across various sectors to provide effective support and pathways to recovery, acknowledging the complexity of the drivers and harms and the need for integrated, trauma informed care.

The 'Harm to Hope' strategy involves a substantial financial commitment to address various aspects, focusing on treating drug and alcohol use conditions as chronic health conditions and breaking down the associated stigma.

Key points include rebuilding treatment services, enhancing the professional workforce, better integrating mental and physical health services, improving access to accommodation and employment, and addressing drug and alcohol use conditions in the criminal justice system.

'Harm to Hope' emphasises the strong link between mental health and drug and alcohol use conditions, acknowledging the high levels of mental health needs among individuals experiencing drug and alcohol use conditions. Efforts will be made to improve service provision between mental health and drug and alcohol services by encouraging integration and collaborative working.

## Early intervention and Prevention

The impact of mental health and drug and/or alcohol use conditions on families is recognised. There is a connection between mental health conditions in children and the risk of drug and alcohol use therefore interventions need to address the needs of families and be delivered using a trauma-informed approach for children and young people.<sup>3</sup>

Healthwatch England's poll of 2008 adults in England, conducted in January 2024 found the changes people have made due to the rising costs of living had negatively affected their health and wellbeing, and ability to work. Nearly two-fifths (38%) of people said the changes they've had to make have had a negative impact on their mental health, rising to 68% for those under the most financial pressure.

## Multi-agency working

Traditionally services are commissioned and delivered in a model that is driven by a primary diagnosis with limited integration.

There are challenges in navigating the complex support system for mental health needs, emphasizing the difficulties faced by both support staff and people accessing support. Issues include frustration in identifying the right mental health professional, long waiting lists, high eligibility thresholds, and a lack of understanding of *multiple*

**'Multiple disadvantage'** is defined by Making Every Adult Matter (MEAM) as experiencing a combination of homelessness, drug and alcohol use, poor mental health, contact with the criminal justice system and interpersonal violence. Multiple disadvantage is a systemic, not an individual issue. People facing multiple disadvantage live in every area of the country. They are often failed by services and systems that focus on singular issues.

**The 'Navigator' Model** is described by the Department of Communities and Local Government in 2017 as a model where service users have a named keyworker who supports them in a flexible, responsive way over the long term. The Navigator provides support with addressing presenting needs, accessing services to address these needs and then along a recovery pathway to sustained outcomes.

*disadvantages*, often resulting in inappropriate referrals and service exclusions.<sup>4</sup> Traditional service delivery models, lack of flexibility, and institutional settings are identified as barriers.<sup>4</sup>

Employing a 'Navigator Model' and establishing navigators within the system can play a crucial role in helping beneficiaries navigate the system, advocate for their rights, and secure entitlements.<sup>5</sup> The use of navigators is described as service-neutral, providing intensive, personalized, and holistic support.<sup>5</sup>

NICE guidance aims to enhance services for individuals diagnosed with coexisting severe mental health and drug and/or alcohol conditions.<sup>6</sup> It advocates for coordinated services addressing broader health and social care needs, employment, and housing. Intended for various professionals, including those in health, social care, public health, voluntary organizations, housing, and the criminal justice system, the recommendations emphasize identifying and supporting individuals at the first point of contact.

Similarly, NICE guidance suggests providing a care coordinator to act as a contact, involve family or carers, and develop a care plan.<sup>6</sup> This approach involves assessing, planning, coordinating, and reviewing services for individuals with mental health problems or complex needs.<sup>6</sup> The care coordinator is expected to collaborate with various services to address social care, housing, physical and mental health, and drug and/or alcohol use conditions, ensuring comprehensive support for the individual.<sup>6</sup>

## Stigma

Stigma is a mark or sign of "difference" often leading to being excluded. Stigma is seen as lacking knowledge or information, negative or pejorative attitudes (prejudice) and the consequent behavioural responses (such as discrimination, exclusion, inequity).

In the UK, Time to Change anti-stigma campaign has demonstrated some success with reducing stigma towards mental illness in the general population but has reported less impact on mental health staff. Hughes (2015) states in any consultation with people with lived experience of co-occurring mental health and drug and/or alcohol use, the consistent themes are exclusion, a lack of empathy and understanding, and rejection by the very services that should be opening the door.

The Anti Stigma Network states as well as being a barrier to healthcare, stigma creates barriers to other factors that contribute to a person's wider health and wellbeing such as financial resources through education and training and employment, housing and engagement in a local community, a sense of purpose and confidence in everyday life and personal relationships and social interaction.

NICE: This involves considering multiple needs, being aware of potential difficulties in accessing services due to stigma.<sup>6</sup> A person-centered approach is encouraged to reduce stigma and address access inequities.<sup>6</sup>

In 2023 Stoke-on-Trent City Council commissioned exploration of the synthetic cathinone known locally as 'monkey dust'.<sup>1</sup> The recommendations for training professionals are to provide evidence-based and experiential training to address the fear and stigma associated with 'monkey dust' use.<sup>1</sup> This includes understanding how the label impacts individuals and hinders their recovery. Frontline staff, including police, should receive trauma-informed training on approaching individuals with sensitivity to reduce the risk of exacerbating situations, especially given the links between 'monkey dust' use and heightened psychosis.<sup>1</sup>

Research carried out in the west midlands stated stigma was reinforced and widened through negative judgmental interactions with professionals, including drug and alcohol treatment providers, social workers, mental health and health care professionals, the police and criminal justice professionals.<sup>7</sup>

NICE recommendations for the referral to secondary care mental health services for individuals with co-occurring mental health and drug and/or alcohol use emphasise that these services should not exclude individuals based on their mental health or drug and/or alcohol use condition when accessing support services.

## Collaborating with lived experience

NICE Guidance emphasises the importance of involving individuals with coexisting severe mental illness and substance misuse, along with their family or carers if desired, in the development and periodic review of the care plan.<sup>6</sup> This collaborative process should consider the person's preferences, information about available services, and input from various practitioners, including mental health and substance misuse services, as well as professionals from other health and social care disciplines.<sup>6</sup> The care plan should be tailored to the individual's needs and goals, taking into account their abilities, past experiences, and support from identified carers. It should also address family or carer concerns, recognize and

reconcile individual goals, maintain an optimistic outlook on recovery, and be regularly reviewed.<sup>6</sup>

Additionally, the coproduction of services and strategies, incorporating the expertise of individuals with lived experience, is seen as a crucial step in addressing the limitations of existing services for people experiencing multiple disadvantages.<sup>4</sup>

Investment in supportive communities is recommended for prevention and ongoing support.<sup>1</sup> This includes fostering positive social networks, meaningful activities, and creating community hubs for accessing various services, including mental health support.<sup>1</sup> Additionally, consulting specific communities for their views on issues and solutions is advised.<sup>1</sup>

# Method

The current report details a project commissioned by Stoke-on-Trent City Council to evaluate pathways for people experiencing co-occurring mental health and drug and alcohol use conditions in Stoke-on-Trent.

The project used a participatory, appreciative inquiry approach.

Expert Citizens carried out interviews and focus groups to gather information about pathways, treatment and support access, and examples of good practice.

We spoke to:

- 37 stakeholders representing adult health and social care, community drug and alcohol services, social housing associations, mental health services, community pharmacies, the integrated care board, public health commissioning, and the department of work and pensions.
- 33 people with experience of co-occurring mental health and drug and alcohol use conditions.

We also hosted three online Community of Practice (CoP) meetings to support actioning recommendations in real time:

Date	Time	CoP Topic	Guest speaker
14 <sup>th</sup> March	10am - 11.30am	The impacts of complex trauma.	Stacey Bullock, Expert Citizens member.
18 <sup>th</sup> April	10am - 11.30am	Multi-disciplinary teams.	Fiona McCormack, Research Officer Staffordshire University. Gemma Finn, Strategic Manager, Changing Futures Programme.
23 <sup>rd</sup> May	10am - 11.30am	Integrated care models and training gaps.	Simon Bratt, Senior Mental Health and Substance Use Practitioner.

Recommendations were compiled in collaboration with stakeholders and people experiencing co-occurring mental health and drug and alcohol use conditions through a combination of feedback workshops and CoPs.

## Findings

Findings are split into subsections: understanding complex trauma, the self-medication hypothesis, a disconnected system, existing support, a 'revolving door', dual diagnosis roles and early intervention.

### Understanding complex trauma

Complex trauma refers to a type of psychological injury that arises from prolonged exposure to severe and pervasive stressors, often occurring within interpersonal relationships and typically during formative periods of development.

Common sources of complex trauma include prolonged emotional, physical, or sexual abuse, neglect, or exposure to domestic violence. The impact of complex trauma extends beyond the initial traumatic events and may disrupt the individual's sense of self, safety, and interpersonal relationships. It can lead to a range of persistent and complex symptoms, including but not limited to emotional dysregulation, dissociation, impaired self-esteem, difficulties with trust and attachment, and challenges in forming healthy relationships.

*"Both mental health and drug and alcohol are trauma responses and should be treated as such."*

*- Person with Lived Experience 4*

Several people with lived experience discussed experiencing trauma as a child resulting in mental health challenges that were never addressed.

*"I experienced abuse in my childhood and started drinking as a child. It escalated in adolescence. I was led to believe everything was my fault, I internalised it. Intoxication allowed me to release that responsibility. Let me not feel like everything was my fault. So, I craved that feeling, not the drink, the feeling.*

*In early adolescence I realised I had a problem with my mental health. And I was self-medicating. I didn't reach out because I didn't think I deserved help. I thought it was all on me to get better. I was in the YMCA at the time. No staff or key worker ever sat me down and asked me if I needed help."*

*- Person with Lived Experience 4*

Conversations with mental health practitioners and people with lived experience discussed how drug and/or alcohol use conditions is a result of mental health conditions and experiences of trauma.

*"It's not a chicken an egg situation. Mental health always comes first."*

- Mental Health Practitioner 2

Understanding complex trauma requires a holistic approach that considers the interconnectedness of the traumatic experiences and their profound influence on an individual's emotional, cognitive, and social well-being. Treatment often involves a combination of therapeutic modalities, such as trauma-focused therapies, to address the multifaceted impact of complex trauma on an individual's life.

Part of working with people with experience of complex trauma is meeting unmet needs which can be basics such as housing or having enough food to eat and feed their family. However, meeting these material needs is only part of the process.

*"When you work with someone who has a lot of trauma bottled up, you can get them housed but then they start to unpack all that trauma and it all comes spiralling out."*

- Mental Health Practitioner 1

What seems to be frequently underestimated, by both services and the 'system' more widely, is the impact that experiences of complex trauma have on people and their ability to do things like attend appointments, complete treatment programmes, or maintain a tenancy. All these things have a significant impact on a person's chances of recovering from co-occurring mental health and drug and/or alcohol use.

## The Self-medication Hypothesis

Addiction is often viewed as a form of self-medication; a coping mechanism individuals employ to alleviate the pain of trauma or simply the challenges of life itself. This perspective, known as the "self-medicating hypothesis," suggests that substance use serves as a means to alleviate symptoms of mental disorders or to mitigate suffering.

*"Addiction is a kind of medication, we're self-medicating some kind of trauma, or even just life."*

- Mental Health Practitioner 2

While acknowledging the physiological mechanisms of drug and alcohol use, the self-medicating hypothesis emphasizes the psychological aspects of a person's internal state that drive substance use. It underscores the importance of understanding addiction not solely as a response to a specific disorder or diagnosis, but rather as a response to the alleviation of painful feelings, which can stem from various environmental influences such as social isolation, poverty, and exposure to drug-saturated environments.

*"I got clean after a 27-year heroin addiction, and then my mum and brother died, and lockdown came, I had no distractions, and I slipped back again. To deal with the guilt and the grief."*

- Person with Lived Experience 2 (Focus Group)

Practitioner's noted the increasing prevalence of co-occurring mental health and substance use disorders highlights the growing complexity of addiction within contemporary society. They note that a significant portion of their case load consists of individuals grappling with both enduring mental health issues and concurrent drug use. Additionally, they highlight a recent trend wherein people experiencing acute distress, particularly related to financial difficulties such as debt and the rising cost of living, turn to alcohol as a form of self-medication.

*"70% of ppl we have on our case load have co-occurring to varying degrees. Some with enduring MH and concurrent drug use, recently in the past 5 or 6 years there has been an increase in acute distress that people medicate with alcohol for example they're struggling with debt and cost of living, so turning to alcohol."*

- Mental Health Practitioner 2

The multifaceted nature of co-occurring mental health and drug and alcohol use requires comprehensive, integrated approaches to address both the psychological and environmental factors that contribute to the challenges individuals experience. By recognising drug and alcohol use as a response to underlying distress and addressing the root causes of such distress, practitioners can better support individuals in their journey towards recovery and healing.

## Access to Mental Health Services for Racially Minoritised Groups

In this project there is a notable absence of customers and stakeholders from racially minoritised backgrounds.

In the UK, individuals from racially minoritised backgrounds are disproportionately affected by poorer health outcomes, increased mortality rates, and greater obstacles in accessing healthcare. These disparities are exacerbated by individual and systemic challenges such as racism, discrimination, and socio-economic inequalities, all of which significantly impact mental health.<sup>8,9,10</sup>

Members of racially minoritised groups consistently find themselves disadvantaged, with healthcare disparities perpetuated by societal racism and discrimination, which unfortunately extends into health and social care systems themselves. Studies indicate that members of racially minoritised groups are less likely than their white counterparts to reach out to their General Practitioners for mental health concerns, receive prescriptions, or be referred to specialized mental health services.<sup>8,9,10</sup>

For services and therapists to better serve members of racially minoritised groups, an anti-racist approach must be embedded within their ethos. Addressing gaps in skills and knowledge is essential, requiring continuous access to high-quality continuing professional development, reflective spaces, and supervision. This includes cultural adaptations and facilitating sensitive discussions about experiences of racism.<sup>8,9,10</sup>

Furthermore, diversifying the workforce within services is crucial to enhance representation and provide individuals with choices in their therapeutic interactions. It's imperative to provide ongoing support for racially-minoritised staff. Professionals in this field must engage in community outreach efforts and collaborate closely with people with lived experience and grassroots organisations to dismantle access barriers, such as stigma, and co-create services that are responsive to community needs.<sup>8,9,10</sup>

At the organisational level there tends to be an excessive focus on individual behaviour change, it is recommended to shift this focus and allocate resources towards policies and practices aimed at dismantling institutional and systemic racism. Adopting a multilevel approach that addresses racism at its core can lead to more meaningful and sustainable improvements in healthcare equity.<sup>8,9,10</sup>

## A Disconnected system

The sentiments expressed by mental health practitioners reflect a deep-seated frustration with the disconnected nature of mental health and drug and alcohol support services:

*"The system itself is so fragmented"* - Mental Health Practitioner 2

*"People just get given tablets and that's it. I say have you got any mental health support? They say I've got tablets from my GP. Anything else? No."*  
- Stakeholder 5

*"I see a completely and utterly crumbled, failed service that has let everybody down."* - Mental Health Practitioner 2

The fragmentation within the system has led to a sense of failure and disillusionment, leaving both practitioners and people seeking support feeling neglected and abandoned. The lack of collaboration between mental health services and Community Drug and Alcohol Services (CDAS) exacerbates this issue, creating significant barriers to effective care.

*"We don't work together with CDAS, the biggest fragmentation is CDAS and Mental Health"*

- Mental Health Practitioner 2

People feel marginalised and reduced to statistics in a system that fails to provide comprehensive and holistic support. The inability of services to address the complex needs of individuals, particularly those struggling with both mental health and drug and alcohol conditions, creates a 'revolving door' where people find it difficult to exit the support system.

*"I feel like a statistic, just another number. This has been going on for years, I've been around mental health services for so long it's unreal."*

- Person with Lived Experience 3

Their experience of feeling unheard and disregarded by mental health services reflects a systemic failure to provide personalized and responsive care.

*"Mental health aren't listening to me at all. I'm blacking out. I've got cupboards full of medication because I can't ever tell what day and time it is, I can't keep track of it. I'm scared to reduce alcohol in case I have a fit again. Last time I had a fit, I didn't know who [friend] was."*

- Person with Lived Experience 3

The challenges they face, including struggles with memory loss and fear of reducing alcohol consumption due to health concerns, highlight the urgent need for integrated and coordinated support.

Without adequate collaboration between different service providers, individuals are left to navigate a maze of disjointed services, exacerbating their vulnerability and health issues. However, it should also be considered that as long as the support landscape treats mental health and drug and/or alcohol use conditions as separate issues, better communication and multi-agency working will only do so much to alleviate the challenges experienced by individuals seeking support.

*"Increased communication still doesn't address the cause, which is distress"*

- Mental Health Practitioner 3

## The Integrated Care model

An integrated health and social care model involves a collaborative approach that combines healthcare and social services for seamless support, aiming to improve overall well-being, especially for those with multiple and complex needs. Key features:

**Collaboration:** Professionals from healthcare and social care sectors work together for a unified approach.

**Coordination of Services:** Minimizing duplication and ensuring continuity through joint planning and seamless transitions.

**Person-Centred Care:** Focusing on individual needs, considering social, economic, and environmental factors.

**Prevention and Early Intervention:** Emphasizing proactive measures to address issues before escalation.

**Shared Resources:** Pooling resources and expertise for efficient service delivery.

**Continuous Support:** Providing adaptable support across different life stages.

Integration overcomes fragmentation, enhances efficiency, and supports individuals with complex needs. In dual diagnosis, the integrated model addresses both mental health and substance use disorders concurrently, emphasizing collaborative and holistic care for improved outcomes.

## Existing support

The pathway to accessing support exists, but it is often blocked by stigma and fragmented services that fail to address the complex needs of individuals who require integrated care.

*“The pathway exists, but it’s blocked” – Stakeholder 14*

Using the term ‘blocked’ implies that something problematic needs to be removed and then all will return to functioning adequately. Caution is advised as the challenges touched on by mental health practitioners, people with lived experience and community drug and alcohol service staff paint a much more complex picture.

There are several barriers individuals face when seeking mental health support and experiencing drug and/or alcohol conditions not least having a current diagnosis. Experience of being diagnosed with Emotionally Unstable Personality Disorder (EUPD) and subsequently encountering reluctance from mental health services due to their diagnosis, despite being sober for nearly five years, highlights the systemic obstacles within the healthcare system.

*“Recently tried to access mental health support. Previously tried to access MH they diagnosed me with EUPD and told me to go away and stop drinking. Now when I try to access MH nobody will touch me because of the diagnosis, even though I’ve been sober for nearly 5 years now.”*

*– Person with Lived Experience 4*

The insights provided by this mental health practitioner further underscore the challenges in navigating the current system, particularly regarding the treatment of alcohol dependency alongside underlying trauma.

*“If you go to community mental health team, they’ll say right 10 o’clock Tuesday morning. And that’s you. Now, if you’ve been up all night, there’s noise in your supported accommodation, you’ve had a drink and overslept, there’s no flexibility, you get three strikes. The assumption is that if you’re presenting to the MH team, you’re ready for that kind of work, and they’re not.”*

*– Mental Health Practitioner 1*

Mental health services often stipulate that until a person must address their drug and/or alcohol use before a diagnosis and treatment plan for mental health can be formulated. However, this requirement can prolong the suffering for individuals who are simultaneously battling both issues. It becomes a relentless cycle where each condition exacerbates the other, leaving individuals caught in a limbo.

*"MH services say that while you're actively drinking, they can't diagnose you properly. So you need to deal with that first. But that can be a really long process and, in that time, you're still struggling with your mental health. You're using one to fend off the other."*

- Person with Lived Experience 2 (Focus Group)

Interviewees generally supported the idea that there needs to be a shift in how treatment is conceptualised. In particular, Solution Focused Therapy was viewed positively by both professionals and people with lived experience.

*"We need to re-think what we think of as treatment. Some people don't want to re-live their trauma, they want to move on. Psychiatry and psychology are always trying to correct a deficit, but the future is solution focused talking therapies."*

- Mental Health Practitioner 3

Solution Focused Therapy is a type of therapy that emphasises finding solutions to current problems rather than focusing on the problems themselves. The therapy highlights and utilises the client's existing strengths and resources. It assumes that clients have the ability and resources to solve their problems, even if they need help identifying and mobilising them.

Nevertheless, there is no one-size fits all as each person has unique experiences. What is the right path for one person, may not be the case for the next, and so a person-centre approach to supporting people into talking therapy, if the chose to pursue this as an option, is recommended.

Interviews with Mental Health Practitioners all highlighted that the loss of roles in other areas has had consequences. An example of this is the impact of social workers who would be able to work with people and support them to attend appointments and support them for extended periods of time. They were able to offer that flexible support that the Mental Health service is not able to do.

*"We lost social workers who would chase people up and see them over long periods of time. Quite often co-occurring is a long-term condition."*

- Mental Health Practitioner 3

As services are currently commissioned on a 'single issue' basis due to the on-going belief that mental health and drug and alcohol conditions are separate, social care plays a crucial role in ensuring that individuals with experiences of complex trauma, and mental health and drug and/or alcohol conditions, can access the necessities needed to begin to recover e.g. stable and safe accommodation.

*“First they need assertive social care outreach. Maslow’s hierarchy of needs.”*

- Mental Health Practitioner 3

Maslow's Hierarchy of Needs is a psychological theory proposed by Abraham Maslow in 1943. It is often depicted as a pyramid with five levels of human needs, arranged in a hierarchical order. The theory suggests that people are motivated to fulfil these needs in a specific sequence, starting from the most basic physiological needs and moving up to higher-level psychological needs and self-fulfilment.

## A 'revolving door'

There is a need for a more holistic and integrated approach within mental health services, one that acknowledges and addresses the complex interplay between drug and/or alcohol use and mental health struggles.

*“They might be alcohol dependent, but that dependency has come from somewhere. It might be trauma, and we can deal with the trauma side, but we can't deal with the alcohol. We haven't got anyone to deal with it. So we say, I'll refer you to CDAS and then when you've stopped drinking, I'll refer you to mental health, or refer to MH services at this moment in time but they'll just say come back when you've stopped drinking, but when you come back there's a 3 month waiting list. So most people start drinking again. As you would.”*

- Mental Health Practitioner 2

Challenges in supporting people experiencing co-occurring drug and/or alcohol use and mental health conditions concurrently often results in individuals being referred back and forth between mental health services and Community Drug and Alcohol Services (CDAS), exacerbating their struggles and perpetuating a cycle of dependence.

To make things more challenging, there does not seem to be one 'pathway' into support as people with lived experiences of trying to access support took different routes. Some tried to access support via their GP without much success, some were bounced between services due to not meeting certain thresholds of abstinence, and some dropped out of service and attained abstinence without the support of mental health or drug and alcohol services.

Transparency about criteria for accepting a referral is needed. Stakeholder discussed being advised by mental health services that a person they are working with needs to reduce their drug and/or alcohol use before they will be considered for support, however what this means is unclear.

*"We need clarity around what 'reducing' means for someone. It's different for everyone"*

- Stakeholder 14

Stakeholders also commented on the stigmatising attitudes held within mental health services that influence decisions about offering care options for people:

*"They judge and hold stigmatising views based on a person's history."*

- Stakeholder 5

This underlying stigma also leads to professionals being quick to dismiss someone's mental health needs by attributing it to drug and/or alcohol use.

*"I can challenge it, but I can't take away how being treated like that makes someone feel."*

- Stakeholder 3

This is contrary to the guidance discussed in the introduction laid out by NICE and Central Government:

*"They do Mental Health diagnosis on a snapshot of someone's life. I can appear at an appointment and seem fine but that's not how my MH works. I got passed from pillar to post. The guidelines say there should be no wrong door. But that's just not the case."*

- Person with Lived Experience 4 (Focus Group 1)

## Dual diagnosis roles

Posts situated within drug and alcohol services that hold titles connected to co-occurring mental health challenges i.e. dual diagnosis workers need to have people in post who hold mental health qualifications. Currently dual diagnosis worker roles are orientated more towards supporting general wellbeing and they are not equipped to support people experiencing the level of distress that many discussed during interviews and focus groups for this report.

*"[customer] was with CDAS and she got a dual diagnosis worker. We thought we'd hit the jackpot. But the mental health side is more social and wellbeing. They had no mental health training or qualifications."*

- Stakeholder 5

To address this key issue issues, stakeholders advocate for investing in mental health practitioner roles within CDAS, situated within the voluntary sector. By providing qualified professionals with the authority to assess and deliver therapies tailored to individuals with co-occurring drug and/or alcohol and mental health conditions e.g. solution focussed therapies. This approach aims to provide more accessible and integrated support for vulnerable populations.

*“Use money to fund mental health workers in CDAS. Full time and based in Hope Street so they are part of the multiple disadvantage sector. And qualified. With some authority to accept referrals and do assessments.”*

- Stakeholder 5

## Early Intervention

Discussions that took place in focus groups heavily highlighted the need for early intervention particularly for young people and children.

*“I feel very let down by services because its not been addressed in my younger years. At school and thing, I don’t think there was ever anything in schools. They just thought I was naughty. I remember my reports saying I don’t pay attention and I’m falling behind. I was in the top group and then it all went wrong.”*

- Person with Lived Experience (Focus Group 1)

People talked about the impact that early intervention could have had in addressing underlying issues before they escalated. This absence of early intervention not only perpetuates stigma but also deprives individuals of the opportunity for timely support and intervention when they need it most.

*“Def something about lack of early intervention. There are so many points along someone’s journey, like me, where somebody could have got involved.”*

- Person with Lived Experience (Focus Group 2)

By intervening at various points along the journey, individuals like FGLE2 believe that much of the distress they experienced could have been mitigated. Their insights underscore the importance of proactive measures to identify and support individuals at risk of developing mental health issues, thereby preventing them from spiralling into crisis later in life.

*“I’ve been told I’ve got CPTSD from childhood trauma, but I’ve never had any counselling or anything for that trauma. I’ve just carried it forward into adulthood.”*

- Person with Lived Experience (Focus Group 1)

Addressing the lack of early intervention requires a concerted effort to destigmatize mental health in educational settings, as emphasised by FGLE3. By creating a supportive and understanding environment in schools, children and young people can feel comfortable seeking help and support when needed.

*"It's dead important, catching it where it starts and getting rid of the stigma in schools. You need get rid of the stigma so you can get the kids in."*

*- Person with Lived Experience (Focus Group 2)*

Delivering accessible educational opportunities in schools and other group settings to promote an understanding of mental health and drug and alcohol use in young people continues to be of great importance.

*"Early intervention is so important. Education, education, education. Going into schools. I mean they might have parents who are using, and they need support."*

*- Stakeholder 16*

The above stakeholder also highlighted the importance of understanding the landscape of social media and the role it plays in young peoples lives in relation to drug use:

*"Social media as well, you can buy drugs with snapchat."*

*- Stakeholder 16*

# Case Study One

Miranda uses prescription painkillers to self-medicate feelings of depression, and symptoms of ADHD that she is struggling to get assessed.

*"The reason why I'm taking the painkillers, one they have codeine that subdues me and slows me down."*

## Early years

Miranda is now in her 50s and has experienced these symptoms for most of her life. Consequently, she has been seeking support from healthcare professionals for mental health and addiction for many years. She notes that the experience of having to explain her circumstances repeatedly makes her feel like she is not listened to.

*"I had my medical records from 1996 to present day, and every single thing says, 'low mood'; 'can't cope'; 'self-medication'. I went to see a doctor and said what I'm experiencing, and she said no and treated me like I was nothing. I left there thinking you know what, I'm going throw myself under a bus, nobody is listening. I'm always having to explain myself repeatedly, constantly."*

Miranda has been prescribed medication since she was a child, her earliest memory of antidepressants is at 13 years old. Recently, following a disappointing experience with a mental health professional Miranda has lost faith in medication as a way to help her and has decided to stop taking anti-depressants.

*"I am on medication that psychiatrist prescribed me. They gave me a diagnosis after asking me nine questions. He doesn't live with me; he doesn't see me day to day. He just saw me on a computer screen, he can't see me physically. I felt extremely let down."*

*I decided I didn't want to take them. This is the first time since I was 13 that I've ever not been on any kind of antidepressants."*

## Missed opportunities

Recently she has been attending appointments with a GP but feels they are not trained to deal with her case. Upon disclosing that she used prescription medication to 'subdue' her symptoms the GP encouraged her as they felt it was good for Miranda to help herself.

*"The GP commended me on self-medicating myself and taking them. I was shocked that a doctor had said that. He said it was good I was helping myself. I said this isn't helping me, its killing me."*

Miranda was not provided with any choice or integrated care option. She feels that she was coerced to stop using prescription medication in an unsustainable way with the suggestion that it would lead to mental health support.

*"Last year I felt backed into a corner and forced to come off them. I wasn't prepared to come off them, but I was desperate to be seen by Greenfields. They said I needed to come off them before they would see me. The hospital team assured me that I'd have a ring of support around me. There were no letters. No phone calls. No interaction. My addiction is seeping back in again."*

The options offered by mental health services resulted in Miranda feeling worse.

*"The care I got from Greenfields was a three-week group for anger management. And when I turned up it was just me."*

*The next thing they offered me was a classroom group, with a guy with a whiteboard. He stood at the front and said he was going to demonstrate what a panic attack looked like. I walked out. How is that helping people?*

*I said I need one-to-one; I need therapy. I need someone to sit with me and go through things with me."*

Miranda was also under a Recovery Service which she no longer attends. She feels that the service has let her down and that she did not receive the support that they said they would provide when she entered their care. In addition, when she relapsed, she feels she was pushed out by other service users as the space inside the service is abstinence based.

*"I asked SRS for one to one and nothing got put in the diary. I wasn't having any contact from my allocated support person at SRS either. Then when I relapsed someone said to me that I shouldn't be there."*

## Self-help

Miranda has sought out ways to help herself including finding employment. However, without addressing the underlying cause of her substance use and mental health challenges, the pressure of maintaining a job escalated her problems.

*"I got a job which was the wrong thing to do. I thought it would help but it didn't. I was popping pills all day long. I was on a cocktail. 25 pills a day. I was a mess. I'd lost me mum that year and that hadn't been dealt with. I was trying to paper over the cracks."*

## Case Study Two

In 2015 Nigel left prison with a diagnosis of depression and paranoid personality disorder. He had engaged in talking therapy and taken courses whilst in prison to help his mental health. When he left prison, staff told him if he was ever struggling and needed support that mental health services would provide that for him. There was no transition of mental health support from prison into community.

Nigel found work and managed his mental health for several years until 2023 when he lost his job. Nigel felt his mental health begin to deteriorate and he began to feel suicidal.

### Missed opportunities

He was admitted into hospital and then consequently referred to Greenfields and then discharged. Nigel received a letter from Greenfields informing him that the service would be closing his case as he had not been abstinent for at least 8 weeks, despite him not using any drugs or alcohol throughout his stay in hospital.

Nigel has been struggling with his memory and attention and has sought support from a mental health nurse who agreed he needed to be assessed. Nigel missed a call from the mental health nurse and has not been contacted since to discuss assessment.

### Positive experiences

Nigel says he's received the most support from a social prescriber who has helped him to address outstanding debts and encouraged him to get involved in activities such as courses at a Wellbeing College.

When Nigel lost his job, he lost his sense of purpose. Getting involved in community activities, creative writing and helping others are some of the things that have been helping him to move forward.

# Dual Diagnosis Community of Practice

The Dual Diagnosis CoPs that ran alongside this project were attended by 30 professionals representing adult health and social care, mental health services, drug and alcohol services and people with lived experience.

Date	Time	CoP Topic	Guest speaker
14 <sup>th</sup> March	10am - 11.30am	The impacts of complex trauma.	Stacey Bullock, Expert Citizens member, sharing her lived experiences of the impacts of complex trauma.
18 <sup>th</sup> April	10am - 11.30am	Multi-disciplinary teams.	Fiona McCormack, Research Officer Staffordshire University, sharing findings from Multi-agency Resolution Group Evaluation in Stoke-on-Trent.  Gemma Finn, Strategic Manager, Changing Futures Programme, sharing experiences of delivering a multi-agency programme.
23 <sup>rd</sup> May	10am - 11.30am	Integrated care models and training gaps.	Simon Bratt, Senior Mental Health and Substance Use Practitioner. Sharing his professional experiences and his PhD study examining integrated care models.

## Community of Practice attendees feedback

*"Keep conversation going - networking, engagement. Make sure we have joined up working - this could be a conference, charter."*

*"[We need] More of these chats to help get the message across that this is a common thing."*

*"I learnt that everyone seems to be in the same boat and there is opportunity for real change."*

## Community of Practice Recommendations

1. Carry out a stakeholder and organisational mapping to determine who delivers what, and what their referrals pathways and criteria are.
2. Create more opportunities to come together to discuss challenges and solutions for dual diagnosis and include a wider range of stakeholders e.g. GPs.
3. Training for staff around dual diagnosis and trauma informed approaches.
4. Working with people with lived experience of the topic area to develop a more nuanced understanding and improve service provision and evaluation.

5. Clear information sharing agreements and communication of service expectations and limitations to partners and to people accessing services.
6. There is a need for a universal risk assessment would be useful. Capacity is time and decision specific but if there is a relationship with the person, they can take previous issues into consideration.

## Positive practice

### Multi-agency Resolution Group

In Stoke-on-Trent, the Changing Futures programme hosts the Multi-agency Resolution Group (MaRG)<sup>8</sup>, part of a national initiative co-ordinating support for individuals facing homelessness, drug and alcohol use, mental health challenges, domestic abuse, and criminal justice involvement.

The MaRG brings together senior officers from partner agencies and other services locally, including Changing Futures, the Police and Fire service, Brighter Futures Rough Sleepers Team and Women's Service, With You and BAC O'Connors Community Drug and Alcohol Services, and Stoke-on-Trent City Council. It helps organisations collaboratively address complex cases, promoting flexibility, shared risk, and coordinated responses.

A 2024 evaluation by the University of Staffordshire's Centre for Health and Development highlighted the MaRG's benefits, including its monthly collaborative, solution-focused networking opportunities<sup>8</sup>.

The evaluation found that MaRG helps alleviate system pressures and navigate existing barriers, underscoring the need for broader systemic change to better serve customers. Adopting MaRG's collaborative and flexible approach system-wide could help achieve this<sup>8</sup>.

*"You go to MaRG, and you think you've thought of everything and then you've got all these creative and amazing ideas".*

*- P06, Taken from 'A review of the Multi-agency Resolution Group (MaRG): Undertaken as part of the Stoke-on-Trent Changing Futures evaluation.'<sup>8</sup>*

### Greenslate Farm: Community rehabilitation programme

Greenslate Community Farm was established by Billinge and Orrell Transition Group in 2012. Formerly a disused council-run education farm, the aim of the project is to utilise the 30-acre site as a community resource, providing volunteering, training, education, and therapeutic activities, as well as providing naturally grown food to the local community.

BAC O'Connor and With You partnership delivers a 12-week community rehabilitation programme from the farm that also offers volunteer and work placement opportunities at the Strawbale Cafe in Greenslate Community Farm. This will support people to build skills, confidence, and access long term employment opportunities.

*"I'd never heard of Greenslate, but upon stepping up the drive, it just felt like home straight away. As I spent more time there, I became symbiotic with the farm, and the farm me. All the comradery, community and cooperation makes it feel like home. If I hadn't come to the farm, I wouldn't be here. One of the reasons I ended up here is that I ended up in hospital. I'd never been in recovery before, but this now has become a way of life. Even now, even when I'm not in a group, this is where my heart is. It's where I feel safe."*

*"I was drinking 24 hours a day. I was trapped in a cycle of addiction, neglecting my children and lying to those around me. I was lost and alone, but then I found the farm. I started With You's recovery programme, and the combination of classroom teaching and being outside on the farm? Well, it saved my life. "Growing produce on the farm became my recovery—you see something grow from this little seed—something that you've nurtured and loved and cared for and you watch as it turns into something beautiful."*

Four volunteers were nominated for INSIGHT Awards in 2023 highlighting the contribution that individuals, groups and services make to tackling social disadvantage.

# Recommendations

There is a notable absence of a specific strategy to address the challenges faced across the city by professionals and people seeking support in relation to co-occurring mental health and drug and/or alcohol use conditions. Therefore, the current report and recommendations could be considered as a starting point to develop such a strategy.

Recommendations broadly fall into three categories: Learning, Specific Roles, and Innovation:

## Learning

20. Promote a universal understanding of complex trauma across services and professionals at all levels.
21. Promote awareness of co-occurring mental health and drug and/or alcohol use prevalence and the utilisation of accessible resources such as: [www.dualdiagnosis.org.uk/](http://www.dualdiagnosis.org.uk/)
22. Address training gaps in:
  - a. What is co-occurring mental health and drug and/or alcohol use and how it affects individuals.
  - b. The negative impacts of the social stigma of mental health and drug and/or alcohol use and how this influences service provision and individual recovery journeys.
  - c. Psychosis and drug and/or alcohol use awareness.
  - d. Empathy, communication skills and strengths-based working.
  - e. Psychologically informed environments (PIEs) and trauma-informed care (TIC) are highlighted as valuable approaches to improving service delivery.<sup>1</sup>
23. Mapping exercise of stakeholders and services (get a handle on who delivers what, and who can help with what).
24. Exploratory research identifying where multi-agency meeting referrals are coming from and who is attending/represented to identify where promotion is most needed/develop targeted approach.
25. Professionals and people with lived experience to share learning spaces and engage in knowledge exchange to promote good practice, i.e. training sessions, and communities of practice.
26. Identify the criteria for referrals to mental health support and include practical definitions. Particularly in relation to reducing drug and/or alcohol use before referral will be accepted.

27. Promote the Stoke-on-Trent Multi-agency Resolution Group throughout mental health and drug and alcohol services and adopt recommendations laid out in the MaRG Evaluation carried out as part of the Changing Futures programme in Stoke-on-Trent<sup>8</sup>.
28. Promote community assets to support prevention and early intervention.

## Specific Roles

29. Introduction of qualified mental health professionals situated within Community Drug and Alcohol Services familiar with good practice approaches for working with people experiencing co-occurring mental health and drug and/or alcohol use conditions e.g. Solution Focussed Therapies. These mental health professionals should also be experienced in supporting people experiencing drug and/or alcohol use conditions.
30. Ensure that 'Dual diagnosis' workers have both mental health qualifications and comprehensive drug and alcohol treatment training. The salary should reflect this 'dual' expertise to attract appropriate skills to the role.
31. Invest in/recruit a facilitator to continue delivering the Dual Diagnosis Community of Practice to create a regular opportunity for cross organisation networking with a solution focus.
32. Multi-agency meetings:
  - a. Encourage senior staff from mental health, drug and alcohol support, housing, police and adult health and social care to attend. It is crucial that staff who attend multi-agency meetings have decision making authority to action solution focused planning.
  - b. 'Test and Learn' approach to involving customers in multi-agency meetings:
    - i. Creative ways to capture customer's wishes to share at the meeting (e.g., through the referrer, having a video or audio clip, Use Microsoft Teams to allow customer to attend)
    - ii. Involve the customer more explicitly after the multi-agency meeting discussion, and feedback at the next meeting.

## Building on Current Support

33. Increase the availability of Solution Focused Therapy for people seeking support for co-occurring mental health and drug and/or alcohol conditions.
34. Invest in the sustainability of a Community of Practice.
35. Explore innovative approaches to prevention and early intervention, particularly for young people and children in schools in Stoke-on-Trent.
  - a. Outreach in schools and colleges.
  - b. Promote safe social media use for young people and upskill parents to use parental controls online.
  - c. Prioritise 'looked after' children and those at risk of homelessness.

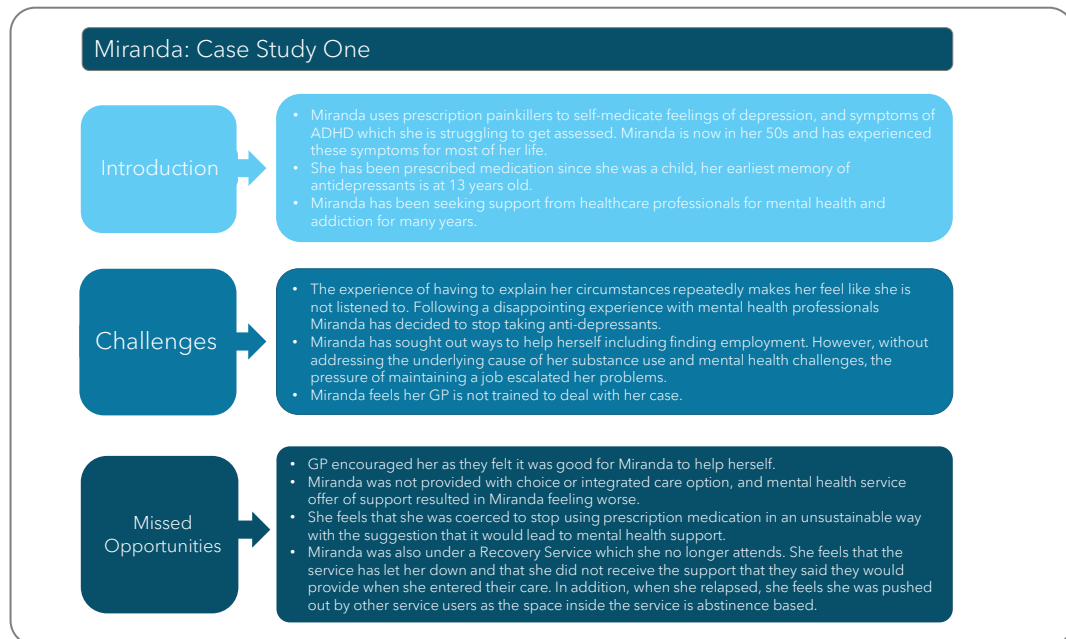
- d. Focus on strengths and solutions rather than 'scaremongering' i.e. promote engagement in sports, community groups and creative pursuits.
  - e. Develop a family focussed offer e.g. safe spaces for families experiencing challenges with co-occurring mental health and drug and/or alcohol use, family support and therapy options.
36. Diversify the workforce and provide adequate support to staff in adapting to culturally sensitive practice approaches.
37. Work with people with lived experience of co-occurring mental health and drug and/or alcohol conditions to develop, deliver and evaluate new ways to address the challenges faced by people currently seeking support.
38. Lived experience in commissioning mental health and drug and alcohol services

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# Appendix

## Case Study One Graphic





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