Dissertation Title:
Dual Diagnosis with the homeless population in the Midlands of Ireland.

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TITLE

Exploring the prevalence of dual diagnosis and treatment response with the homeless population.

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Declaration

I declare that this is entirely my own work and has been submitted as part of my MSC. It is all my own work and research.

Nuala Hyland

Signature: .......................................................... Date: .........................
Acknowledgments

I would like to extend my sincere gratitude to all those who assisted and supported me during this research study:

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Abstract
The aim of this study which will include a literature review is to explore how prevalent Dual Diagnosis is with the homeless residing in the hostels in the Midlands of Ireland and the treatment response with the homeless population.

(European Monitoring Centre for Drugs and Drug Addiction, 2004) refers to ‘comorbidity/dual diagnosis as the temporal coexistence of two or more psychiatric disorders as defined by the International Classification of Diseases, one of which is problematic substance use’.

It has been recognised that there is a lack of co-ordinated care for those who fall under this diagnosis. Kranzler & Rounsaville (2004) found that ‘Drug/Alcohol users with other psychiatric comorbid disorders have more emergency admissions, higher prevalence of suicide, medical conditions (e.g. HIV and HCV infection) and social problems than those who have only substance use disorders or other psychiatric diagnoses’.

So, the author wants to look at the relevance of dual diagnosis prevalence and treatment response by homeless people.

The motivation for carrying out this research arises from my work as a Nurse with this cohort of people. Having come across many individuals who reside in hostels and who have a dual diagnosis the author would like to explore how common it is and the level of treatment response to it by way of this research.

This study is timely as the HSE recently set up a National Clinical Programme for assessing and managing patients who have co-morbid mental illness and substance misuse issues. This clinical programme began in 2017 and its aim is to provide a comprehensive model of care for responding to this serious clinical issue. It so far is at the stage of a working group. (HSE, National Social Inclusion Office, 2017).
This research study will examine what are the reasons for treatment and non-treatment of Dual Diagnosis with the homeless population. Focus will be on the 60 homeless hostel beds in the Midlands of Ireland which incorporates five hostels. They include two Midlands Simon hostels, two St Vincent De Paul hostels and one Teach Failte charitable hostel. The four Midland local authority councils refer homeless people to these five hostels.

Methods

The aim is to interview the five hostel mangers with set questions on Dual Diagnosis with the homeless cohort of people and if they are getting treatment for both or one diagnosis only. Will break it down into five areas;

- Those receiving treatment for Mental Health Diagnosis
- Those receiving treatment for Addiction
- Those receiving treatment for both (M.H & Addiction)
- Those receiving treatment by GP only
- Those not receiving treatment at all.

Findings and Conclusions

In conclusion, previous research has highlighted lack of structures for treating dual diagnosis and this accounts for a high percentage of readmissions for patients with dual diagnosis. With two services working separately (Addiction services and Mental Health services) is this adding to the problem? This study wants to look at this and to investigate what is the uptake of treatment by those who are homeless and have a dual diagnosis.
**Introduction**

This study outlines the purpose of this research project which is to explore how common dual diagnosis is within the homeless population. The study will include partial focus on the Midlands of Ireland.

Dual Diagnosis has many different definitions, comorbidity, co-occurring, co-existing and concurrent being some of them. In this dissertation it will refer to ‘the simultaneous presentation of one or more mental health disorders with one or more substance use disorders. (Zideonis et al, 2005).

Dual diagnosis assessments could address both co-occurring conditions together, but this is currently not happening. The treatment response by homeless people can often be due to their transient way of life. The author wants to look at this and to explore what barriers are in place that those with dual diagnosis are not getting treatment.

“Dual diagnosis which is the co-occurrence of drug and/or alcohol use and mental health problems surfaced as the most pressing issue for both homeless and drug service providers in all four Irish cities” (National Advisory Committee on Drugs, 2005 pg. 113).

It also found that ‘Prevalence estimates of the level of drug use among the homeless population convey that levels of drug use among people experiencing homelessness are higher than the general population’ (National Advisory Committee on Drugs, 2005, pg. 111).

A possible first challenge in dual diagnosis is the actual diagnoses of both co-occurring conditions and without a correct diagnosis it can be difficult to know how to treat a person who has both a substance misuse problem and a mental health problem. Once a dual diagnosis is made, the next challenge is finding a way to treat both conditions simultaneously. Often a person must be out of withdrawal and a psychiatric condition must be stable before treatment is offered. Complete and total abstinence from all psychoactive substances may be
neither attainable nor desirable especially for those individuals who require medication for a psychiatric condition.

So, treatment responses could be challenging as both co-occurring conditions require addressing the symptoms of a person’s addiction and mental health at the same time.

Mc Allister (2018) states ‘The nature of the relationship between these two conditions is complex. Possible mechanisms include:

– a primary psychiatric illness precipitating or leading to substance misuse
– substance misuse worsening or altering the course of a psychiatric illness
– intoxication and/or substance dependence leading to psychological symptoms
– substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses.
– The nature of the relationship between these two conditions is complex’.

Treatment can be difficult due to the duality but by treatment the chances are that the person can overcome and manage both, remain well and lead a fulfilling life.

This study will focus on the homeless hostels in the Midlands of Ireland which includes Counties Laois, Offaly, Longford and Westmeath. As a nurse working in this area for the last nine years this dissertation was highly relevant to me as dual diagnosis became apparent as I carried out assessments on those within homeless accommodation.

Having seen many homeless people fall between two services but only allowed to access one has been an ongoing barrier to overcome in the Midlands. Both Addiction services and Mental Health services work separately in the Midlands and so a homeless person can have difficulty accessing both due to barriers in place.

A drug screen carried out by Mental health services and showing positive results at a first appointment has often been a case closure for the client attending that service. And a client
attending addiction services and having a violent outburst or displaying high emotions can be a case closure for the client attending that service. So, the client who is seeking help between two services is being let down by their honest presentation.

Garbare (2015) report concluded that ‘the complex and multifaceted nature of dual diagnosis makes assessment and treatment difficult. The key to the successful delivery of services is the competence of practitioners who should be cross trained and have the capacity to address dual diagnosis. Given its prevalence, dual diagnosis should be expected when assessing and treating people with severe mental illnesses or substance misuse disorders. Evidence-based national guidelines on the management of dual diagnosis developed for the Irish context are needed’.

Throughout this dissertation, the author would like to look at how common is dual diagnosis with homeless people. And to discover which mental health diagnosis are most prevalent and which substance addictions are most common among the homeless population.

The author will pose these questions to hostel managers to explore their perceptions on dual diagnosis and treatment response by those who reside temporarily at the homeless hostels. The five hostels comprise of 60 adult beds which the author will collate the data from. This will allow exploration of dual diagnosis and treatment response with the homeless population in the Midlands.
**Literature Review**

The aim of this study is to look at both Homelessness and Dual Diagnosis and how they are interlinked. ‘A number of research studies have indicated that comorbid psychiatric disorders and substance abuse occur more frequently with the homeless population thus leading to the ongoing cycle of homelessness. For many individuals, substance abuse and homelessness are inextricably intertwined. Indeed, substance use is often both a precipitating factor and a consequence of being homeless’ (Zlotnick et al, 2002).

This review will look at studies that have found that this is the case with the homeless population. ‘Further, individuals who are homeless rarely have substance use disorders alone—many have serious mental illnesses, acute and chronic physical health problems, and histories of trauma’ (Foster et al., 2010). Homelessness can mean sleeping rough, staying in emergency hostels, staying in temporary bed and breakfast accommodation or staying with friends and relatives when there is nowhere else to go, homelessness is all of these things. (Simon Communities of Ireland, 2012).

Growing public awareness of the issue has also raised questions on the homeless and their health both physical health, mental health and addiction specific.

‘Research has shown that ‘those who are homeless have higher rates of Hepatitis C, HIV, Tuberculosis, poor nutrition, drug and alcohol addiction and mental health difficulties than those of the general population’ (Bagget et al., 2010).

This study will explore the prevalence of dual diagnosis with homeless people and causal factors. It will explore the treatment response by those in homeless hostels when it comes to seeking treatment for both substance misuse and mental ill health. The study will explore relevant research which has been previously conducted and outline key areas around dual diagnosis and what screening tools are available.
As there is a growing amount of evidence that dual diagnosis is prevalent within the homeless population the author will send a questionnaire to the five hostel managers of the homeless hostels in the Midlands.

Homelessness is a complex social and political issue today and with an estimated 6,584 adults currently homeless in Ireland at present it is an ongoing problem. (Homeless Report, 2019).

The majority of the homeless are based in the cities of Dublin, Galway, Cork, Limerick and Waterford. As is often the case, homeless people will flock to cities due to further supports and charitable help that is provided there. (Simon Communities of Ireland, 2014) found ‘The availability of homeless services is lower in areas outside the larger cities of Ireland and access to services can be one of the major reasons why people migrate to cities. There may be little or no access to services in smaller towns, with a perception that homelessness does not exist or is not a serious problem in rural areas’.

The latest Government figures from April 2019 state that there are 122 adults homeless in the Midlands of Ireland (Homeless Report, 2019).

The Midlands is Co Laois, Co Offaly, Co Westmeath & Co Longford.

This comprises of 30 families of which 15 are single parent families.

Separately there is a total of 79 children homeless within those families.

So, an overall total of 201 homeless.
Each individual and the current stress that they are under due to homeless living conditions is only going to contribute to both mental health stress and could lead to addiction as a way of coping. This in turn is leading to further dual diagnosis and within the current climate, there does not seem to be a solution.

‘Dual diagnosis can lead to loss of accommodation, behavioural problems and an unwillingness to co-operate with services’ (O’Leary, 1997). However, (Manley, 1998) argues ‘that in practice individuals rarely receive a formal diagnosis, so the term is often simply used to demonstrate individuals who present with both alcohol/drugs and mental issues. Many tend to fall through the system without being treated by drug services or psychiatric services’.
**Dual Diagnosis Definition**

Dual Diagnosis for this study will indicate:

1 Contact with Mental Health Services

2 On daily Pharmacology

3 Formal diagnosis with documentation of mental health diagnosis

4 Use of a Substance (Alcohol or Drugs)

**Understanding Homelessness and Ill Health**

‘Alcohol abuse has been cited as the single most prevalent health problem for homeless persons. The prevalence ranges from 29% to over 50%’ (Holohan, 1997).

‘Mental health and substance misuse issues are high among the homeless population. 12% have both a mental health and substance misuse problem, while 41% of homeless people surveyed by Homeless Link said that they used alcohol or drugs to cope with their mental health issues’ (Homeless Link, 2014).

Mental ill health is both a major contributing factor in making people homeless and also a consequence of being homeless. When you include substance misuse with mental ill health then the consequences are further exacerbated. This paper will outline the reasons why homelessness and dual diagnosis are interlinked. This study will also look at the treatment available for dual diagnosis both internationally, national and locally.

Daiski (2005) found that ‘People who experience homelessness not only have multiple and complex health problems but frequently face barriers to accessing health care.’

This can be multifaceted but often in the Midlands it can take up to one month to set up a Medical card and GP allocation. Often by the time this happens a person may have moved on
or being asked to leave homeless accommodation due to behaviour, so health needs are not met.

Cockersell (2011) states that ‘Up to 70 per cent of people who use homelessness services have a mental health problem; many homeless people have been victims of abuse as children and, as a result, find it difficult to make and keep personal relationships. Alcohol and substance abuse, relationship breakdowns, bereavements and periods spent in prison are also common’. (Cork Simon Community, 2017) carried out an Adverse Childhood Experiences (ACE) study which confirms this further. See appendix C

This is further confirmed by research (Hopper et al., 1997) who found that ‘the single homeless in particular, traverse through a range of different institutions, from emergency accommodation to prisons and psychiatric hospitals, in an endless loop through an ‘institutional circuit’.

Lawless & Corr (2005) found that ‘Alcohol remains the primary drug of choice among the homeless population (70%), nearly half of all respondents (48%) reported having concerns regarding their psychiatric health with over three-quarters having sought help for these concerns (78%). Analysis revealed that those who scored as problematic drinkers were significantly more likely to report experiencing psychiatric concerns than their non–problematic drinking counterparts’.

The same report, Chapter 4, looked at Cork, Galway and Limerick cities only within Ireland, there was no focus on the Midlands. The Midlands of Ireland is often not highlighted in reports and this could be due to the lower numbers compared to city homelessness. Although hidden by way of hostel and emergency accommodation within the Midlands and so not as visible by way of homeless people on the streets, it is still an ongoing social and complex problem.
DSM-V: The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, DSM-V recognizes substance-related disorders resulting from the use of 10 separate classes of drugs: alcohol; cannabis; hallucinogens; inhalants; opioids; sedatives, hypnotics, or anxiolytics; stimulants; tobacco; and other or unknown substances. The DSM-5 recognizes various mental health disorders also under set standard classifications.

**Screening for Dual Diagnosis International, National and Local, what is in use?**

‘There is a need of valid screening instruments to detect co-occurring psychiatric disorders among people with Substance use disorders’ (Torrens et al., 2012)

‘Screening is critical because Substance misuse disorders tends to be covert and treatment depends on detection. It frequently goes undetected in psychiatric care settings mainly because many mental health programs do not screen at all’. (Stone et al. 1993)

Careya and Correiaa (1998) point out that ‘assessment serves multiple purposes, including screening, diagnosis, treatment planning and outcome evaluation’.

How can we have assessment when we do not have a comprehensive screening tool. The author wanted to find out what screening tools are in use thus far for Dual Diagnosis.

**International**

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services (DHHS) that leads public health efforts to advance the behavioural health of the nation and to improve the lives of individuals living with mental and substance use disorders, and their families’.
According to the last US survey on drug use and health, 9.2 million adults in the United States (4% of the adult population) met criteria for both a mental illness and substance use disorder in the past year (SAMHSA, 2018).

The DSM-IV PRISM: The Psychiatric Research Interview for Substance and Mental Disorders (PRISM) is a psychiatric diagnostic Interview designed to diagnose DSM-IV substance and mental disorders in patients who abuse alcohol or drugs.

The DSM-IV PRISM includes the following disorders:

1. Substance use disorders.
2. Primary affective disorders
3. Primary anxiety disorders.
4. Primary psychotic disorders
5. Eating disorders. Anorexia, bulimia, and binge eating disorder
6. Personality disorders. Two personality disorders are included due to their high prevalence anti-social and borderline personality disorder.
7. Substance-induced disorders. Major depression, mania, dysthymia, psychosis, panic disorder, and generalized anxiety disorder. (Hasin et al.,1996)

Taking the above into consideration, the semi structured diagnostic interview, PRISM, is not carried out widely that the author is aware of within Mental Health Services or Addiction services.

‘Although the PRISM could be considered as a gold standard to evaluate psychiatric comorbidity among substance users, its use is primarily meant for research purposes. Its
administration in routine practice in community health facilities is often not feasible, due to its length and the need of a trained professional to administer it’ (Torrens, et al., 2012).

**National**

‘It is estimated in the UK that a half of clients in drug and alcohol services also have mental health problems’ (Alcohol Concern, 2012).

National Institute for Care and Health Excellence (NICE) produce guidelines for Dual Diagnosis in the UK. All guidelines are stand alone for Mental Health and for Substance Abuse. The only joint dual diagnosis documented as a guideline and reflective of Dual Diagnosis is ‘Psychosis with coexisting substance use’. (NICE Guidelines, 2011).

Assanagkornchai & Edwards (2012) state that ‘Screening for dual diagnosis: The use of screening instruments in healthcare settings has been recommended by a range of authors as an aid to the identification of coexisting substance misuse and mental health problems. There is a wide range of screening tools available and studies have been carried out in a variety of settings including alcohol and drug treatment units in Australia, and emergency departments in the USA, and their findings have generally supported the use of screening tools for the identification of patients requiring further assessment for mental health and substance misuse problems. However, a recent review noted that further research is required to fully evaluate their use for this purpose. Local services use a range of different screening tools to assess clients’ mental health condition and use of substances, but their use is not standardized across the services’.

Dual Diagnosis Screening Instrument (DDSI): Was found to be a reliable valid screening interview for the detection of the most frequent and severe psychiatric disorders among
substance users: depression, mania, psychosis, panic, social phobia, and specific phobia disorders.

Taking it into consideration, as a diagnostic screening tool, the author is unaware of it in use within Mental Health Services or Addiction services.

Appendix D and Appendix E show assessment tools in use for Mental Health Services and Addiction Services.

**Local:**

‘Knowledge users in Ireland described six dual diagnosis programmes in different communities (Waterford, Limerick, Cork, Clondalkin, Kilkenny, and Dublin) that engaged in locally driven integration efforts across the drug and alcohol task forces, mental health or psychiatric services, and a Recovery College.

These six-local integrated programmes provide a starting place for learning and integrating knowledge about treatment and building a culture of coproduction that supports putting the individual at the center of the system. The wisdom gained from knowledge users and the literature synthesis reveals numerous ideas for building an integrated system’ (Minyard et al., 2019)

‘Common psychosocial interventions for dual diagnosis treatment include motivational interviewing, individual or group therapy, 12-step recovery, group and individual skills training and family psychoeducation’ (Cleary et al, 2008).

Reducing Harm, Supporting Recovery, (Department of Health, Ireland, 2017-2025) report states ‘The HSE’s Mental Health Division is working with the Clinical Strategy and Programmes Division to develop a new Mental Health Clinical Programme called “Dual Diagnosis: mental illness and co-morbid substance misuse”.'
Over the past decade there has been an awareness of dual diagnosis and the HSE have responded with a new clinical programme that commenced in 2017. ‘It is designing a model of care and plans to develop community dual diagnosis teams which will have access to inpatient drug treatment and rehabilitation units’ (Keenan, 2019).

Looking at the Midlands of Ireland and how it has two separate services, Community Mental Health Teams (CMHT) for Mental health and Community Alcohol & Drugs Service (CADS) for Addiction services.

Mental Health Services: guided by ‘A Vision for Change’ (Department of Health, 2006) sets out the direction for Mental Health Services in Ireland.

Addiction Services: guided by ‘Reducing harm, Supporting Recovery.’ (Department of Health, 2017-2025) sets out the strategy for the Government’s response to addressing the harm caused by substance misuse in our society over the next eight years.

So, both Mental Health services and Addiction services are already working separately in relation to policy.

Strathdee et al. (2002) & Mac Gabhann, et al., (2004), found that ‘the treatment of patients with dual diagnosis had a less successful prognosis when treated independently by both Mental Health and Addiction Services’.

(European Monitoring Centre for Drugs and Drug Addiction, 2004), found ‘Diagnosis and treatment of co-morbidity is hampered by the fact that drug treatment staff generally know little about psychiatry, and psychiatric staff generally know little about drug treatment. This, combined with the contrasting mindsets of the two disciplines, often prevents the development of a global, integrated perception of comorbidity’.
Mental Health Assessment Tools & Addiction Assessment Tools are separate within both services with no integration of shared information with either service.

‘The majority of instruments which are considered valid and reliable for the assessment of substance use problems do not include questions about mental health issues, likewise the majority of mental health instruments do not include substance use questions’ (Hamilton, 2014).

When looking for a dual diagnosis tool to use within homeless services, as clients can fall between both services, it was usual practice to use separate tools from both services as none currently exists for dual diagnosis. Due to parallel working with two separate teams, both were often unaware of the client’s treatment plan in place by each service.

Lawless and Corr (2005) found that ‘To date, few assessment tools have been developed in relation to dual diagnosis, and reliability and validity of those that do exist are still being established’. And further studies by (Delgadillo et al., 2011; Turner, 2013; Wheeler et al., 2014) found that ‘we need to improve the psychometric properties of assessment instruments used with clients who have dual diagnosis’.

**Studies incorporating Dual Diagnosis & Homelessness.**

‘General practitioners (GPs) are the most consulted health-care professionals for people with alcohol and drug use disorders and are the first and only point of contact for many people with mental health disorders’. (Teeson et al., 2002).

According to Byrne (2006) ‘GP’s experienced difficulties in getting specialized services to accept individuals with a dual diagnosis especially if they were homeless. GP’s also indicated poor communication links with mental health services’
Daly & Craig (2017) findings show ‘homeless admissions for the last ten years for those recorded as of no fixed abode (NFA) into psychiatric in-patient care in Ireland. The years recorded were 2007-2016. Results showed there were 2,176 admissions with NFA recorded in that 10-year period. The analysis shows that the characteristics of this cohort have remained largely unchanged in the 10 years;

Almost three-quarters (73.4%) were male, almost half (49.1%) were less than 35 years of age and three-quarters (75.2%) were less than 45 years.

Three-quarters (75.5%) were single and three-quarters were unemployed (75.4%).

In addition, the highest proportion had a diagnosis of schizophrenia (28.5%) followed by drugs/alcohol disorders (27.1%).

These characteristics are consistent with the single ‘chronically homeless’ people described in the literature. The paper concludes the need to use routinely collected data to help understand and address the need of specific homeless groups’.

Sellman (2010) confirms “It is “somewhat unusual to encounter a person presenting to outpatient addiction services with addiction problems alone. It is “the rule rather than the exception” that they would have a co-morbid mental disorder.”

These findings show that drugs/alcohol are the second highest reason that the homeless population are admitted into psychiatric care although the report did not specify specifically if dual diagnosis was the reason.

‘With diagnosed mental illness at an incidence of up to 50% in the homeless population, the incidence of co-morbidity between substance misuse and psychiatric illness is bound to be very high, particularly as many patients with significant mental illnesses remain undiagnosed
whilst homeless due to their relative invisibility among the homeless population and their tendency to move around the country’ (Winyard, 2005, p144).

(European Monitoring Centre for Drugs and Drug Addiction, 2004) found ‘About 30–50 % of psychiatric patients in Europe today have a mental illness as well as a substance use disorder, mainly with alcohol, sedatives or cannabis. Among clients from drug treatment centres, co-morbidity mostly implies another profile, with heroin, amphetamine or cocaine use and one or several personality disorders as the dominant diagnostic features, followed by diagnoses of depression and anxiety and, to a lesser degree, by psychotic disorders’.

Taking the above into consideration dual diagnosis continues to be labelled as drugs/alcohol disorders and not reported in recent findings as a duality which it seems reasonable to assume that it is, especially for those presenting for psychiatric care.

Research conducted by O’Reilly & O’Carroll (2005) compared the health status of the homeless to that of a 1997 research study by Holohan, (1997), it highlighted that the physical and mental health of homeless people have not improved. In fact, levels of illicit drug use and blood borne diseases, including HIV and hepatitis, have risen significantly’.

So, these findings over eight years show that both the physical and mental health of homeless people continues to deteriorate.

O’Carroll & O’Reilly (2008) suggest that ‘a small cohort of homeless people with complex, multi-factorial medical, psychological and social needs (such as those having significant physical and mental health problems, being addicted to alcohol or drugs and displaying challenging behaviors) require specialized services. They propose a specialized service to address the needs of people with complex medical, psychological and social needs’
Is this not further segregating those with a dual diagnosis by way of establishing another separate service which will have to be funded. Is it not better to utilize the resources already established as a treatment response to dual diagnosis.

Pinderup (2018) study found ‘Different challenges in the dual diagnosis treatment were identified and they suggested that the focus of treatment was mainly on the mental illness rather than the substance use disorder. The single focus of the treatment made it challenging to treat patients with dual diagnosis sufficiently’.

This can often be the case that there are many assessment tools for screening, assessment and monitoring outcomes in terms of severity of mental health symptoms, but substance abuse screening can be lacking in this area.

HSE Midlands put together an assessment portfolio entitled ‘Mental Health Assessment Tools’. It was very much based towards Mental Health rather than substance abuse. With twenty-two assessment tools for use by professionals only two were for substance abuse. (Health Board, 2008)

Lyons et al., (2010) carried out A study on the misuse of drugs and alcohol in the Midlands region looked at problem substance misuse in the Midlands of Ireland of 2449 clients. Taking into consideration the four counties of the Midlands, it found that (65%) of treated cases reported alcohol as their main problem, then opiates (22.3%), followed by cannabis (6.4%) and cocaine (3.1%)

‘The study found in conclusion key issues that needed to be addressed for those in addiction were improved communication between service users and services, improved communication between statutory and voluntary services to enable a better ‘continuum of care’ for the service user to move between the different treatment and services and on to recovery.
A health finding was the use of psychoactive drugs which may induce psychosis and people with mental health issues may self-medicate with illicit drugs to alleviate symptoms.

Other barriers identified was accessing residential detoxification services. There are no residential detox facilities in the Midlands and distances involved to other regions was problematic for people’.

Krausz et al., (2014) ‘found that those with a mental health problem face negative attitudes from society’. Lloyd (2010) ‘found those who have a problematic relationship with substances are subject to stigmatising views’. With multiple stigma already in place, if you include homelessness seen often as another stigma by society, it may be difficult to shift an individual’s thought processes about getting treatment at all.

**Current Interventions**

Appleby (2005) states “Services for people with ‘dual diagnosis’ – mental illness and substance misuse – are the most challenging clinical problem that we face”.

Mental Health Services and Addiction Services work separately in the Midlands.

**Mental Health**

Psychiatric Hospital and Community Mental Health Teams are based in each County towns.

Laois/Offaly:

St. Fintan's Hospital, Portlaoise

Community Mental Health Team, Birr

Community Mental Health Team, Portlaoise
Community Mental Health Team, Tullamore

Longford/Westmeath:

St. Loman's Hospital, Mullingar

Community Mental Health Team, Health Centre Mullingar

Community Mental Health Team, Health Centre Ré Nua Athlone

Community Mental Health Team, Health Centre Longford

Addiction Services

Community Alcohol and Drugs Service (CADS) are based in each county town.

Laois/Offaly:

CADS Portlaoise: St Fintan’s Hospital, Portlaoise,

CADS Tullamore: Midlands Regional Hospital Tullamore, Arden Road, Tullamore.

Longford/Westmeath

CADS Athlone: Primary Care Centre, Clonbrusk, Athlone, Co Westmeath

CADS Longford: St Joseph’s Care Centre, Longford.

CADS Mullingar: St Mary’s Campus Castlepollard Road, Mullingar, Co. Westmeath

Co-ordination of services in relation to dual diagnosis found that voluntary agencies play a key role in joint working with both services.
Conclusion of Literature Review

This concise literature review has highlighted the lack of a cohesive response to dual diagnosis both in assessment and interventions. It is clear from the literature that people with dual diagnosis face multiple barriers to assessing treatment and have complex needs. The ongoing debate about which is the primary or secondary condition and where treatment should take place has gone on for a number of years. This has not helped the clients who have a dual diagnosis that has no clear care pathway.

With two services working under two separate policy documents in Ireland, this further divides the professionals working with those in dual diagnosis.

In addition, an assessment tool that can be used between both services is not yet in place and even if it were in place many services run a parallel model anyhow. An integrated service model and a co-ordinated approach being implemented nationwide in the future could make a big difference with dual diagnosis going forward. But are both services willing to come on board to do this. Will explore further the prevalence of dual diagnosis and treatment response with the homeless population with a focus on the Midlands of Ireland.
Methodology

The overall aim of this study was to assess the prevalence of mental ill health and substance abuse of 60 homeless adults in the Midlands and to recognise if any dual diagnosis.

Data was collected from five homeless hostels in the Midlands which totals 60 beds. The method used was a set questionnaire that was sent to the Hostel Manager of each hostel (see appendix b).

This questions within it were to explore the views and experiences of hostel Managers in relation to those with dual diagnosis who reside in the hostels.

Looked at five areas

- Those receiving treatment for both Mental Health & Addiction
- Those receiving treatment for Mental Health diagnosis
- Those receiving treatment for Addiction
- Those receiving treatment from GP only
- Those not receiving any treatment.

The participants are all homeless adults who have been placed in the hostel due to their homeless situation by the local county council. Hostel Managers carry out a detailed assessment on those who arrive at the hostel and it incorporates questions on their physical health, mental health and addiction. The Hostel Managers supplied the data on the number of residents in each hostel and were able to confirm about all of the areas mentioned above.

The author carried out a mixed methods approach using both qualitative and quantitative research methods in conducting this study.

Qualitative research with the aim of obtaining rich data from the hostel Managers by way of set questions on the questionnaire that were dual diagnosis specific.

Quantitative data was collected to obtain numerical data which would offer further insights into dual diagnosis within homeless hostel accommodation.
Results

This study examined the prevalence of dual diagnosis within homelessness services in the Midlands of Ireland. The particular focus was on Mental Health diagnosis and Addiction and if both, if Dual Diagnosis was also prevalent.

The five hostels all responded to the questionnaire sent out to them.

The questionnaire was both quantitative and qualitative in its questions.

Data was transcribed using thematic analysis. Braun and Clarke (2006) define thematic analysis as: “A method for identifying, analysing and reporting patterns within data.”

The author has renamed the hostels A, B, C, D & E for confidentiality purposes.

Table B: Gender Profile from five hostels

Gender: 28 Males, 32 Females which is 53% Female compared to 47% Male.

<table>
<thead>
<tr>
<th>Hostel A:  5 M 1 F</th>
<th>Hostel B:  6 M</th>
<th>Hostel C: 14 F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hostel D: 17 M</td>
<td>Hostel E: 17 F</td>
<td></td>
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</tbody>
</table>

Hostel accommodation is usually for 6 months in duration and then a move on plan is put in place for a person or family. Due to the current housing crisis the length of time each family or individual are at the hostel is averaging over 8-10 months. Some individuals have been living at the hostels for over 1 year 8 months. The residents are currently known to the hostel managers due to being at the hostel for a duration of longer than one month. On arrival to the hostel an initial needs assessment is carried out to gain client information and link the person into appropriate services. Ongoing observation from staff is also part of the plan as there are set rules in place at each hostel.
Table C: Dual Diagnosis Findings: Five Areas

- Those receiving treatment for both M.H & Addiction 60%
- Those receiving treatment for Mental Health diagnosis 30%
- Those receiving treatment for addiction 30%
- Those receiving treatment from GP only 80%
- Those not receiving any treatment. 10%

Treatment

- Main treatment source was GP.

- GP only sourced if a Medical card was in use, if no medical card then no help was sought.

- Often not accessing Mental health services as GP not making the referral on and instead given prescriptions for anti-depressant or anti-anxiety medication by GP even when in full addiction.
- Those involved with Mental health services usually only attend CMHT every three months for a review appointment and no other service (such as group classes, talking therapy) offered.

- Voluntary services like Merchants Quay workers often accessed and referred to but residents do not always link in, often only when the resident may be in crisis.

- Prescribed medication addiction often becoming apparent as the hostel staff get to know the resident.

- Counselling offered by key workers at the hostel but this was not an ideal source. Private counselling not sourced as residents could not afford it. Otherwise it is not offered by any other professional.

- Those with Borderline Personality Disorder will not always link in with services and difficult also to know where to refer them to for their issues. Often asked to leave hostel accommodation due to chaotic behaviour.

- When the resident is at the hostel and has a stable address, it is often the first time that they seek help or get a service for either their addiction or mental health diagnosis otherwise it is often left untreated.

- Those with an undiagnosed learning disability or classed as a ‘slow learner’ were often the most difficult to link into services and unsure where to refer them to. They have fallen into the category of ‘not receiving any treatment’ which is often the case.

Weaver et al., (2001) ‘reported that large proportions of co-morbid patients in each community treatment population were not identified by services and receive no specialist intervention’. 
‘Health services have not adapted fast enough to the changing pattern of drug and alcohol use among people who are homeless. This report identifies alcohol and/or drug use with complications among people who are homeless who are living outside of urban areas where there are very limited drug related support services’ (O’Carroll et al., 2008).

**Table D: Dual Diagnosis Overview**

![Pie chart showing Dual Diagnosis rates in 60 hostel residents](image)

Out of 60 hostel residents residing in the Midlands, 37 adults had a Dual Diagnosis of Mental Health diagnosis and Substance abuse. This shows 61% having a Dual Diagnosis who are homeless.

**Table E: Hostel Breakdown**

<table>
<thead>
<tr>
<th>Hostel</th>
<th>Adults</th>
<th>Dual Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hostel A:</td>
<td>11 Adults</td>
<td>6 with dual diagnosis</td>
</tr>
<tr>
<td>Hostel B:</td>
<td>18 Adults</td>
<td>11 with dual diagnosis</td>
</tr>
<tr>
<td>Hostel C:</td>
<td>19 Adults</td>
<td>12 with dual diagnosis</td>
</tr>
<tr>
<td>Hostel D:</td>
<td>6 Adults</td>
<td>3 with dual diagnosis</td>
</tr>
<tr>
<td>Hostel E:</td>
<td>6 Adults</td>
<td>5 with dual diagnosis</td>
</tr>
</tbody>
</table>
Table F: Mental Health Diagnosis, Addiction and Dual Diagnosis figures.

Mental Health Diagnosis: Anxiety, Depression, Borderline Personality Disorder, Schizophrenia.

Addiction: Alcohol, Cannabis, Cocaine & Heroin.

Dual Diagnosis: Usually a combination of both from data.

(Dublin Simon Community, 2010) reported that ‘out of 211 hostel residents, 28% of all people interviewed, were diagnosed with a mental health condition and reported complications arising from their alcohol and/or drug use which was classed as dual diagnosis’. This continues to be the case with those homeless in the Midlands in 2019.
Findings and Analysis

The literature review highlighted a number of key themes including the lack of integrated care for dual diagnosis. The findings from this concise number showed how prevalent dual diagnosis continues to affect the homeless population. All of the hostel Managers partook in the research. Some of the themes showed:

1) Falling between the cracks.

Case Manager hostel B said ‘a client can be back and forward between two services with neither wanting to take responsibility for her, this I have found especially true for those with Borderline Personality Disorder residents who also have an Addiction problem and so are often classed as problematic.’.

‘Two hundred and twelve homeless people were studied in France, to elucidate the interrelation between personality disorders, drug use and homelessness; 95% of the homeless subjects had a personality disorder’ (Combaluzier et al., 2009).

2) Ideological Perspective.

Case Manager hostel C said ‘a client becoming suicidal and on the methadone programme will not be seen by mental health services even though staff with the client presented twice to Mental Health services to advocate for him. If he had not been on the methadone programme, he may have gotten help or even admitted for care’.

Barnard (2000) states ‘Dual diagnosis is often viewed very differently by staff in general adult psychiatry and drug services, with different priorities for service input and little liaison between the two. It has been suggested that there might not just be a gap in service provision, but a chasm’.
(European Monitoring Centre for Drugs and Drug Addiction, 2004) states ‘When we see drug users, we tend to attribute their problems to their use of drugs. However, more often than not, drug users have co-morbid mental health disorders, which we often fail to recognise. We need to take account of co-morbidity when treating drug users.

3) Dual Diagnosis Outlook

Case Manager hostel A said ‘staff have noticed that clients with dual diagnosis issues have been long term homelessness for longer periods of time. Some of the clients are there for over 1 year and become institutionalised within the hostel and do not want to leave should a place come up for them to move into’.

4) Prevalence of Anxiety and Depression

Case Manager hostel E said ‘anxiety and depression with addiction are not taken seriously and only that a person gets a GP whilst at the hostel and so gets help in that way, no other doors are open to them for these issues’.

Hamilton (2014) found ‘that people who use substances are at an increased risk of developing mental health problems compared to the general population, equally people who have mental health problems are more likely to use substances compared to the general population’.

With this dilemma in place dual diagnosis is very much a reality’.

5) Other diagnosis not confirmed

Case Manager hostel D said ‘many clients have a learning disability or would be known as a ‘slow learner’ and would also have an addiction but there is very little support for them as they continually slip through the system into chaos’.

“The Holistic needs of the individual are not being addressed. There are too many borders between homelessness, drugs, mental health; you need to be in one category or the other to be
dealt with, when you are in ‘multiple categories’ that is when you are in most need of assistance. I don’t see any joined-up thinking, or at least the practical delivery of services in a joined-up manner” (McVerry, 2019).
Discussion

The aim of this study was to explore the prevalence of dual diagnosis and treatment response with the homeless population.

The response by all five hostels in this study was 100%.

It further reiterates all the finding from previous studies listed in the literature review. Homeless people continue to have dual diagnosis at a level that is disproportionately high and although many studies throughout the years have highlighted the parallel system in use, there continues to be very little progress in this area in the Midlands.

The findings explored the prevalence of dual diagnosis and treatment of it showed very little input of treatment by either mental health or addiction services, hostel residents appear to rely heavily on GP support of which can be limited to a five-minute appointment.

When a comparison of previous studies is made, it highlights the connection between substance misuse and poor mental health in nearly all the studies.

A newly published study by (Minyard et al., 2019) found ‘The literature identified six different interventions that improve treatment and personal functioning for individuals with a dual diagnosis. These interventions are cognitive behavioural therapy (CBT), intensive case management (ICM), Day treatment centres and residential programmes, Dialectical behaviour therapy, Integrated Dual Disorder Treatment (IDDT) and general interventions that occurred in the outpatient or primary care setting’.

Out of the homeless cohort the author gained information on none of the above six interventions are occurring for those with dual diagnosis and neither has it been offered or is the author aware of two of the treatments been available in the Midlands (those being Dialectical behaviour therapy or Integrated Dual Disorder Treatment).
A Vison for Change, (Expert Group on Mental Health Policy, 2006), states ‘Acute presentations by service users with co-morbid mental health and addiction problems will be mostly seen by general adult CMHTs, who offer both addiction counselling expertise and mental health intervention as part of an integrated care plan’. ‘Individuals whose primary problem is substance abuse and who do not have mental health problems will not fall within the remit of mental health services’.

With this in place they will only see those whose primary problem is mental health, and this continues today as the parallel system continues to be in use for many years.

Mc Daid et al. (2017) reported that ‘There are a number of other gaps for homeless people with a dual diagnosis in getting the supports that they need, including:

- Addiction and mental health services do not work together to improve supports for individuals.
- Misdiagnosis of dual diagnosis is common.
- There is a lack of involvement of family members/carers and friends in dual diagnosis care.
- The relationship between trauma and dual diagnosis and trauma, dual diagnosis and homelessness is not properly understood.
- There is an over-use of doctors in working with people with dual diagnosis and not enough use of other professionals (e.g. counsellors). Specific training in dual diagnosis should be delivered to a range of different types of staff.
- There is a lack of preventative measures to address dual diagnosis. Homeless people should be educated about mental health and offered support services such as counselling’
(Department of Health, 2012) states ‘Develop joint protocols between mental health services and drug and alcohol services with the objective of integrating care planning to improve the outcomes for people with co-morbid, severe mental illness and substance misuse problems.

Establish a forum of stakeholders to progress the recommendations in A Vision of Change in relation to establishing clear linkages between the addiction services, primary care services, community mental health teams and specialist mental health teams to facilitate the required development of an integrated approach to service development, including:

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

This report which came six years after Vision for Change continues to make recommendations that both services develop and work together yet in 2019 this is still not happening in the Midlands.

This study shows the lack of treatment of Dual Diagnosis for those who have Depression, Anxiety and Personality Disorders along with addiction and highlights that if clients did not come into homelessness services, they may never get treatment. It opens doors for them that would otherwise remain closed. Addiction would continue, mental health would deteriorate, and homelessness would prevail.
Limitations

The aim of this paper was to explore dual diagnosis with the homeless in the Midlands. This study has a number of limitations. First in terms of numbers, the sample was 60 when Government figures state 120 are homeless in the Midlands. Others are placed in B&B accommodation which is not managed by professionals so it would have been difficult to access mental health and addiction information.

The self-reporting of dual diagnosis was accessed from the hostel Managers and no standardized interview (such as clinical interview for DSM IV) was performed. This may underestimate certain diagnoses.

Other physical health dualities were also present with the sample of 60 but were not focused on as the main theme for this report was mental health and addiction.
Conclusion

People who are homeless and who have a dual diagnosis can face many difficulties due to the complexity of those in active addiction and mental health instability. There is a growing amount of evidence that Homeless people and dual diagnosis appears to be a combination that will continue due to the nature of this lifestyle.

(Department of Health, 2006) found ‘dual diagnosis was viewed as ‘the most challenging clinical problem we face’ and requires ‘urgent attention’ with a broad co-ordinated response including better collaboration between agencies, training in assessment and clinical management, preventative work, and prevention of drug misuse on inpatient units’.

Many reports have confirmed that collaboration, integration and specialist teams are the way forward and with this in place it will make a difference. The need for Community Mental Health and Addiction services to work together has been a recurring theme throughout this study. Studies by (Delgadillo et al.,2012; & Brooner et al.,2013) ‘found that integrated treatment reduced psychiatric hospital use and contact with the penal system in comparison to the parallel model’.

The focus on the needs of people with serious mental illnesses such as schizophrenia and bipolar affective disorder and addiction problems is priority. According to Crowley (2003), ‘The most difficult and deprived group of dually diagnosed individuals are those who abuse alcohol and who also have severe psychiatric disorder’

But those who also have a dual diagnosis with anxiety, depression and personality disorders and an addiction problem seem to be the larger problem within society as many reports find higher percentages in those areas. If these are the more prominent diagnosis that are arising, then shouldn’t more be done in this area. The ‘revolving door’ of psychiatric admissions
would confirm this as often these clients become known to services and can be classed as problematic.

‘Often the most complex and challenging clients are those with a substance misuse disorder, an Axis 1 disorder and an associated Personality Disorder. These are also the people most likely to be excluded from services’ (Rasool 2002, p. 53)

(Dublin Simon Health Snapshot, 2013) showed ‘71% of its clients had a diagnosed mental health difficulty, of which 22% had a diagnosis of psychosis or schizophrenia. It showed Depression 63% and Anxiety 46%’.

(European Monitoring Centre for Drugs and Drug Addiction, 2015, Pg. 69) states ‘The most frequent psychiatric comorbidities among users of illicit substances are major depression, anxiety disorders and personality disorders (mainly antisocial and borderline). Among people with psychosis, comorbid substance use disorders are also common’.

Anxiety and Depression can both be common results of excessive alcohol or drug use and are also common triggers for excessive use. So dual diagnosis can take hold in this area very quickly especially when you include a homelessness situation.

As the responsibility for delivering care and treatment for people with a dual diagnosis resides primarily with mainstream mental health services, the challenge is to develop a framework which best supports this approach.

Examples could be integration that also involves residential treatment services as part of the plan going forward and so be more aligned with Community Mental Health teams also as this is a linkage that is not in place.

To mainstream services further again, psychiatric in-patient services could have a set number of beds to carry out an in-patient detox by assessment and withdrawal observation. This
would further integrate services as a dual diagnosis working model in action. A person in addiction usually has to seek out a residential treatment bed in a different area before serious addiction is addressed. Instead of barriers in place at psychiatric in-patient services this would allow full integration of addiction and mental health.

Currently screening instruments for comorbid mental and substance use disorders are either for mental health or for addiction, one that combines both would be a useful assessment for early indication of dual diagnosis.

‘The majority of instruments which are considered valid and reliable for the assessment of substance use problems do not include questions about mental health issues, likewise the majority of mental health instruments do not include substance use questions’. (Hamilton, 2014).

As there is no set assessment tool in place a missed opportunity occurs which could explore the relationship between both dualities. So, a screening device that assesses mental health and substance abuse problems for all to use is required.

Designated dual diagnosis link workers between both services whose primary aim is to establish the links between all three services (Mental Health, Addiction and Residential Treatment) would be a working solution put into practice as a co-ordination role in caring for dual diagnosis patients.

Change in service delivery can only occur if there is motivation by the professionals to make it happen. There is now a significant raft of national policy and guidance to drive the dual diagnosis agenda in local organisations, and it should not be side-lined by any organisation; it is everyone’s business.
The author concludes that the way forward is a dual diagnosis service of Community Mental Health Teams, Addiction Services and Residential Treatment Services all working together in synergy.

Rather than dual diagnosis been seen as double discrimination within services itself, services should be there to provide the care plan and ideally all work together to eradicate barriers for the benefit of the person. This report found that dual diagnosis is the expectation not the exception now in homelessness services and it will continue to keep growing unless dealt with.
Appendix A – Letter to hostel Managers in the Midlands.

Dear MSC/SVP/TF Hostels,

I work as Community Liaison Nurse (Homelessness) within the Midlands from 2010 to present day.

I am currently studying towards a MSc Addiction Counselling & Psychotherapy Skills which will conclude this year.

A requirement of my course is a dissertation study and I am carrying out my study on ‘Exploring the prevalence of dual diagnosis and treatment response with the homeless population’.

I would really appreciate it if you would complete this two-page questionnaire and return it to me in the pre-paid envelope within two weeks. If it suits you, it can be emailed to me either by return.

The term Dual Diagnosis defined within this research study as ‘the co-existence of both mental health and substance misuse problems for an individual’.

I would like to say thank you for completing this for me and that this research will be shared once completed with the relevant statutory bodies. All anonymity has been assured and guaranteed.

Yours sincerely

Nuala Hyland
Community Liaison Nurse (Homelessness)
Nuala.hyland@hse.ie
Appendix B - Questionnaire on Dual Diagnosis

**Questionnaire on Dual Diagnosis**

The aim of these questions is to find out how prevalent Dual Diagnosis is within this homeless cohort of people and if they are getting treatment for both or one diagnosis or none.

Number of residents in Hostel

Male _____ Female _____

Those with a Mental Health Diagnosis

State which diagnosis’s of M.Health:-

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Those with an Addiction

State which Addiction (Drugs or Alcohol or both, please state which drug):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Five areas:

No. linked with Community Mental Health Team (CMHT)

____________

No. linked with GP only

____________

No. linked with CADs or MQI for Addiction

____________

No. linked with CADs/MQI & CMHT

____________

Those not receiving treatment for Mental Health

____________

Those not receiving treatment for Addiction

____________
If not getting treatment for Mental Health what are the reasons:

________________________________________________________________
________________________________________________________________
________________________________________________________________

If not getting treatment for Addiction what are the reasons:

________________________________________________________________
________________________________________________________________
________________________________________________________________

Have you noted any inconsistencies in treatment of those with dual diagnosis?

________________________________________________________________
________________________________________________________________
________________________________________________________________

From your professional experience what are the difficulties involved with services for homeless people with dual diagnosis?

________________________________________________________________
________________________________________________________________
________________________________________________________________

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

________________________________________________________________
________________________________________________________________
Appendix C: ACE Study by Cork Simon Community, 2014
Appendix D: Mental Health Assessment Tools

Mini-Mental State Examination (MMSE)

KGV (Modified) Symptom Scale

Risk Assessment Tool

DASS – Depression/Anxiety/Stress Scale Overview and uses DASS – Scoring sheet

PSYRATS – Hallucinations Subscale

PSYRATS – Delusions Subscale

Geriatric Depression Scale Beck’s Depression Inventory

Beck’s Depression Scale

Beck’s Suicidal Intent Scale

Beck’s Anxiety Inventory

Self-Evaluation Screening Tools

Rosenberg Self Esteem Scale

Sleep Scale

Evaluative Belief Scale

Medication Effect Screening Tools

LUNSERS – Side-effect rating scale
Appendix E: Addiction Assessment Tools

MAST- Michigan Alcohol Screening Tool (25 item Questionnaire)
DAST - Drug Use Questionnaire (DAST 20)
AUDIT Alcohol Use Disorders Identification Test
DUDIT Drug Use Disorders Identification Test
CAGE Questionnaire
SAOR Model (Screening & Brief Interventions)
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