Dual Diagnosis (Co-Occurring Mental Health Problems and Substance Misuse) in Birmingham JSNA Deep Dive Report (2025)

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Councillor Mariam Khan - *Cabinet Member for Health and Social Care, and Chair of the Birmingham Health and Wellbeing Board, Birmingham City Council.*

This deep dive represents a rare opportunity to delve into the health inequalities associated with dual diagnosis (the coexistence of mental ill-health and substance misuse), and the wider determinants of these inequalities. For people living with dual diagnosis, there is an estimated 15 to 20 year reduction in life expectancy, representing a significant inequality that cannot be ignored. People living with dual diagnosis often face challenges in multiple areas of life including accessing safe and appropriate housing, long-term employment, and accessing services and support. Our citizens with dual diagnosis also face stigma and social isolation, further hindering them from leading fulfilling lives.

This deep dive shines a light on the fantastic work Birmingham is doing to support people and highlights areas where we can do better to support those living with dual diagnosis. Services such as the Homeless Health Exchange, Change Grow Live, Aquarius and Spring Housing are providing much needed support for those who are most vulnerable in our city. Important programmes of work are also taking place, including the Quality Standards for supported exempt accommodation which strives to improve standards across the exempt accommodation sector, and the Family Drug and Alcohol Court, which aims to support families to reduce the number of children taken into care.

As the Cabinet Member for Health and Social Care and the Chair of the Birmingham Health and Wellbeing Board, I am committed to the work being done in Birmingham to prevent and reduce inequalities in our society, including those faced by people with dual diagnosis. To do this, we must work in partnership across many organisations, the health and care system, including our third sector.

For this report, work has been undertaken to gather together relevant research, local data, service mapping and importantly, lived experience, to understand the current evidence base around dual diagnosis in Birmingham. The research in this deep dive is relevant for service providers, professionals in the health and care sector, commissioners and citizens, to understand the health and wellbeing implications of dual diagnosis. In addition, the gaps in research and evidence identified will be of interest to academics. Tackling the inequalities faced by these citizens will require collaboration, compassion and care. Doing this will bring us a step closer to achieving the overarching ambitions of the Health and Wellbeing Strategy, creating a Bolder, Healthier City.

We are very grateful to all those who have contributed to this research, in particular those who have taken part in the lived experience groups as their honesty and openness adds understanding, depth and emotion to the evidence.

We want Birmingham to be a place where everyone is able to achieve a happy and healthy life. We must be committed to a future where this is possible for all, without exception.

Jo Tonkin - *Interim Director of Public Health, Birmingham City Council.*

This deep dive seeks to understand the health and wellbeing of Birmingham's citizens living with co-existing mental ill-health and substance misuse. In this deep dive, experiencing these co existing conditions is referred to living with a 'dual diagnosis'.

These citizens experience unacceptable, avoidable inequalities in health and life expectancy. Their experience of stigma, difficulties accessing, engaging and benefiting from services contribute to this.

We are grateful for the many stakeholders who shared their knowledge and experience with the research team. We are most grateful for those citizens with lived experience who contributed to the report and its recommendations.

This report highlights work already happening in the city to improve outcomes for these citizens. It also highlights opportunities for action and system-wide improvement. The report has already led to change.

Understanding and addressing the inequalities experienced by citizens with coexisting mental ill health and substance misuse issues requires our collective commitment and persistence. We hope that this deep dive report co-produced with stakeholders including those with lived experience helps us to together navigate the complex changes required.

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Executive Summary

"These individuals are not horrendous people on the earth, but they are often seen as untreatable, criminal. They've often experienced situations which have affected their mental health which underpins most, if not all substance misuse cycles. Continuation of poor knowledge and understanding amongst professionals – the people paid to support individuals – further contributes to the horrendous experiences these individuals face."

CGL Professional in Birmingham

This deep dive report into the health and wellbeing of citizens living with dual diagnosis is part of a series of Joint Strategic Needs Assessment (JSNA) deep dive reviews. We have examined multi-agency data and evidence relating to dual diagnosis in Birmingham to inform the Birmingham City Council Health and Wellbeing Board of the needs of this demographic.

It should be noted that the term *dual diagnosis* is used in reference to individuals with co-occurring mental health problems and substance misuse. These and other definitions are discussed in more detail in the Introduction chapter.

This research has been undertaken within the context of existing strategies and guidelines. The Birmingham Joint Health and Wellbeing Strategy (2022-30) aims to create a city where every citizen, whoever they are, wherever they live and at every stage of life, can make choices that empower them to be healthy and happy.[1] The Strategy also recognises that significant health inequalities affect citizens living with mental health issues and is committed to 'closing the gap'. Birmingham's Triple Zero Strategy (2022) sets out the city's aspirational targets of having zero deaths due to drug or alcohol addiction, zero overdoses due to drug or alcohol addiction, and for every citizen to be able to receive support when this is needed (i.e. zero people unable to receive the support for their addiction when they need it).[2]

In this deep dive report's Opportunities for Action section, we have set out the key findings and recommendations of this report, identifying how local partners can work towards our strategic ambitions for Birmingham. In summary these are:

- There is demand for system leadership, partnership working and co-ordination of key services for citizens living with dual diagnosis.
- There is currently insufficient data to allow a full understanding of dual diagnosis prevalence in Birmingham and the associated health and wellbeing needs.
- There are opportunities to further understand training needs and embed specific dual diagnosis training opportunities.
- There are opportunities to improve holistic and person-centred support for citizens living with dual diagnosis.
- There is a need for more local research to take place to build the evidence base around health inequalities for citizens living with dual diagnosis.

[1] Birmingham City Council. Creating a Bolder, Healthier City (2022 to 2030). Accessed October 2023.
[2] Birmingham City Council. Triple Zero City Strategy. Accessed July 2022.

1 Introduction

1.1 Purpose of the Deep Dive

The deep dive reports are in-depth needs assessments, which are intended to provide a focused and thorough exploration of a specific topic area or population of need, to inform strategy, commissioning and practice.

This deep dive is part of the Joint Strategic Needs Assessment (JSNA) Deep Dive Programme, which is overseen by Birmingham's Health and Wellbeing Board. The findings are presented through a series of publications, and this report (the Dual Diagnosis Deep Dive) is accompanied by an Easy Read report.

1.2 Why Focus on Dual Diagnosis?

Citizens living with dual diagnosis (the co-occurrence of mental health problems and substance misuse) experience significant health and wellbeing inequalities throughout their lives. It is recognised that many citizens living with dual diagnosis will endure poorer health and die at a younger age than the general population. The Birmingham Health and Wellbeing Board aimed to reduce these inequalities by commissioning this Dual Diagnosis Deep Dive, to provide an evidence base for the commissioning processes and the delivery of care and support services. For example, the report is being used to inform the Birmingham Dual Diagnosis Steering Group and the development and implementation of Birmingham's Dual Diagnosis Joint Working Protocol between Change Grow Live (CGL), Birmingham and Solihull Mental Health Trust (BSMHFT), and Forward Thinking Birmingham (FTB).

1.3 Scope

This deep dive report focuses on the health and wellbeing of Birmingham citizens living with dual diagnosis (the co-occurrence of mental health problems and substance misuse), through a life course approach. The aim is to establish an evidence base to support strategy development, commissioning processes and delivery in Birmingham, including identifying the level of need in the population, and the gaps and barriers in service provision. The specific objectives were to:

- Use epidemiological approaches and a broad range of quantitative and qualitative data to comprehensively and comparatively assess the needs of citizens living with dual diagnosis in Birmingham, across the life course.
- Review service provision in Birmingham (e.g., health, social care, community and accommodation) to identify gaps and areas of unmet need and inequalities.
- Make evidence-based recommendations to address the needs of Birmingham.

This deep dive report has incorporated the lived experience of individuals living with dual diagnosis in Birmingham. In addition, the views of staff working within services to support citizens living with dual diagnosis have been collected through qualitative research.

1.4 Terminology and Definitions

Given the complexity of dual diagnosis and the specific terminology used in this field to describe certain aspects of the condition, we have defined important terms in an attempt to remove ambiguity throughout this document.

Terminology is continually being revised as a way of reducing the negative stereotypes around drug taking and mental health. This section will outline which terms are appropriate to use,

and which terms may be inadvertently or intentionally perpetrating stigmatising attitudes towards people living with dual diagnosis.

1.4.1 Dual Diagnosis

The term 'dual diagnosis' refers to the co-occurrence of a substance misuse and a mental health disorder (Figure 1), and this term has been used by people working within the substance misuse sector for many years.

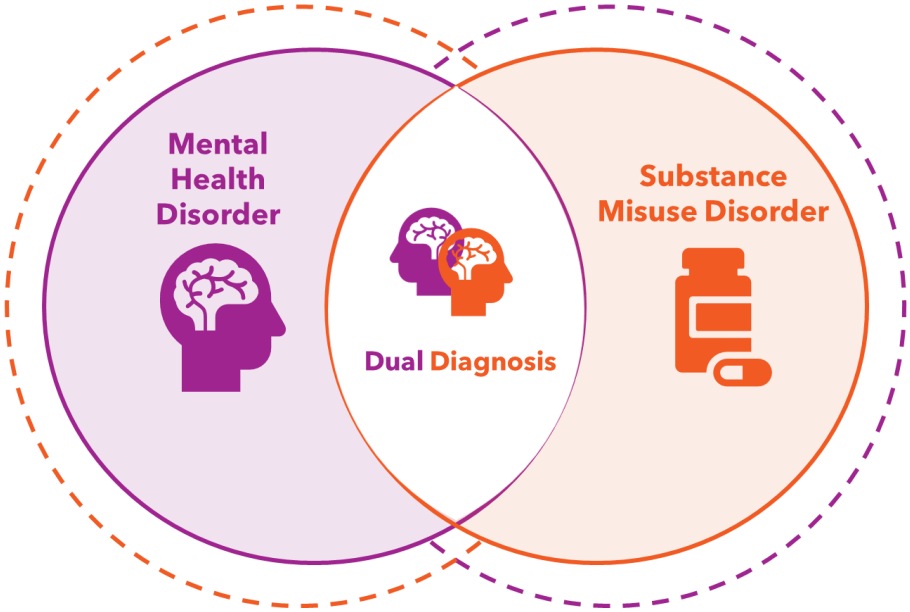


Figure 1: Dual Diagnosis is the Co-occurrence of a Mental Health Disorder and a Substance Misuse Disorder.

Source: Created internally.

National policy guidance currently lacks a general consensus on the definition of dual diagnosis. For example, the ***Medical Subject Heading Descriptor Data (2022)*** defined dual diagnosis as 'the co-existence of a substance abuse disorder with a psychiatric disorder'.[3] Other definitions state that dual diagnosis is the comorbidity of at least one substance misuse disorder and one severe mental illness.[4] However, this does not account for other mental health disorders which do not fall under the definition of 'severe mental illness', such as anxiety or personality disorders. The NICE Guideline ***'Severe Mental Illness and Substance Misuse (Dual Diagnosis): Community Health and Social Care Services' [NG58]*** acknowledges that 'dual diagnosis' has been defined in multiple ways. For this guideline, the term includes those with severe mental illness and substance misuse, where severe mental illness refers to schizophrenia, bipolar affective disorder, and severe depressive episodes with or without psychotic episodes. In this guideline, tobacco was not considered one of the substances constituting dual diagnosis.[5]

However, tobacco is an addictive drug which many people with mental health conditions misuse to assist them with their mental health. Therefore, for the purposes of this report, the co-occurrence of tobacco misuse and a mental health condition has been included within our

[3] National Library of Medicine. Diagnosis, Dual (Psychiatry) MeSH Descriptor Data 2022. Accessed Feb 2022.
[4] Science Direct. Dual Diagnosis. Accessed Jul 2022.

'dual diagnosis' data analysis. This places the scope of this deep dive in line with the Public Health England guidance ***'Better Care for People with Co-occurring Mental Health and Alcohol/Drug Use Conditions' (2017)*** which covers all substance misuse (including tobacco), and all mental health problems (including both common and severe forms).[6]

Recent national and clinical guidance has tended to use the terms 'co-occurring' or 'co-existing serious mental illness and substance misuse', 'substance misuse and mental health' or 'complex needs'. This is because not all patients will have received a formal mental health diagnosis.[7] Research has shown that individuals with a substance misuse disorder are at an increased risk of comorbid mental health problems and vice versa. There is also a direct link between substance misuse and mental health disorders, with the magnitude of comorbidity being strongly associated with the severity of the substance misuse disorders.[8]

1.4.2 Substance Misuse Disorders

A substance misuse disorder is a complex condition that affects a person's thoughts and behaviours which can lead to an inability to control one's use of substances (e.g., legal or illegal drugs, alcohol, or medications).[9]

In 2022, the World Health Organisation (WHO) introduced a new set of ICD codes for use in identifying admissions to hospital and causes of death, called ICD-11. In the ICD-11, disorders due to substance misuse are made by identifying the substance used (e.g., due to alcohol, cannabis or opioids) and combining this with one of four primary diagnoses relating to the pattern of substance use:[10]

- Episode of harmful psychoactive substance use.
- Harmful pattern of psychoactive substance use.
- Substance dependence.
- Disorder due to substance use, unspecified.

These are followed by an associated diagnosis reflecting the impact of the substance misuse (e.g., substance dependence, intoxication, withdrawal).[11] The new ICD-11 code(s) have only recently been introduced to Hospital Episode Statistics (HES). Therefore, the HES data that is used throughout this document utilises the ICD-10 coding(s) of F10-F19 (Mental and behavioural disorders due to psychoactive substance use). Each number between F10 and F19 represents a substance. For example, F10 represents mental and behavioural disorders due to use of alcohol, and F11 represents mental and behavioural disorders due to use of opioids. Within these, the clinical state can also be specified (e.g., F10.1 represents mental and behavioural disorders due to use of alcohol: harmful use).[12] The codes F10 to F19 have been used in analysis throughout this deep dive. These codes include tobacco among other substances, in line with the definition of dual diagnosis used in this report for any co-occurring substance misuse and mental health conditions. As noted in section 1.4.1., we recognise that other organisations may not include tobacco in their definition of dual diagnosis.

[6] Public Health England. (2017). Better care for people with co-occurring mental health, and alcohol and drug use conditions. Accessed Apr 2024.
[7] Turning Point. Substance Use and Mental Health Training. Accessed Jan 2024.
[8] Jané-Llopis and Matytsina. (2006). Mental health and alcohol, drugs and tobacco: a review of the comorbidity between mental disorders and the use of alcohol, tobacco and illicit drugs. Accessed Jul 2022.
[9] National Institute of Mental Health. Substance Use and Co-Occurring Mental Disorders. Accessed Jul 2022.
[10] ICD-11. Disorders due to Substance Use. Accessed Apr 2024.
[11] ICD-11. 6C40 Disorders due to use of alcohol. Accessed Apr 2024.
[12] ICD-10. (2019). Mental and behavioural disorders due to psychoactive substance use (F10-F19). Accessed Apr 2024.

1.4.3 Dependence Versus Addiction

The terms 'dependence' and 'addiction' are often used interchangeably, but they are separate concepts which require differentiation. There has been much debate within the field of substance misuse about the coding and description of addiction and dependence in the ICD-10 codes, with a call for the ICD-10 to move in line with the DSM-5. This would mean that the term 'physical dependence' would be used to refer to the adaptations that result in withdrawal symptoms when drugs are ceased to be used. However, these are distinct from the adaptations resulting in addiction, which refers to the loss of control over urges to take the drug. In contrast, dependence is currently described in the ICD-10 and ICD-11 as a strong desire to take the drug.[13,14,15]

1.4.4 Drug Use Versus Drug Misuse or Abuse

The terms 'drug use' or 'substance use' refer to the taking of a drug, through any method that gets the drug into a person's bloodstream (e.g., swallowing, injecting or smoking). These terms imply that although drug taking has some risks, it is not necessarily wrong or dangerous. Therefore, the terms 'drug use' or 'substance use' are preferred by people working within the dual diagnosis or related fields to avoid placing judgement on their clients. The terms 'drug misuse' or 'substance misuse' and 'drug abuse' or 'substance abuse' refer to drug use that is problematic or harmful and may be used by those who perceive drug taking beyond a medical context as wrong.[16] Evidence has shown that language such as 'substance abuser' can lead to more negative attitudes among professionals than the term 'having a substance use disorder'.[17] The evidence shows that language should be chosen sensitively, due to some of the terminology producing an adverse effect, by evoking negative judgements.

Recreational drug use is the use of drugs for pleasure or leisure.[18] The term 'problematic substance use' can refer to dependent or recreational use where there are negative impacts on the person's life because of this drug use.[19]

Within this deep dive we have chosen to consistently use the terms 'drug misuse' or 'substance misuse' because they most clearly represent the type of drug use we are discussing. These terms imply that drug taking carries certain risks and can be harmful, but do not attach any fault or blame to the individual. Terms including 'abuse' or 'abuser' are avoided by the research team due to possibly carrying more negative connotations about the individual involved.

1.4.5 Stigmatising Language

It is important that we carefully consider the language used within this deep dive, to ensure it doesn't perpetrate stigma towards citizens living with dual diagnosis. Evidence suggests that regardless of the intent behind using it, stigmatising language can cause 'self-stigma'. For example, if subjected to stigmatising language, an individual living with dual diagnosis may feel shame, inferiority and an understanding that the problem is solely their fault.[20] This is likely to deter people from disclosing their mental health condition or substance misuse disorder,

[13] Szalavitz et al. (2021). Drug dependence is not addiction—and it matters. Accessed Jan 2024.
[14] ICD-10. (2016). Mental and behavioural disorders due to psychoactive substance use (F10-F19). Accessed Feb 2024.
[15] ICD-11. (2024). Disorders due to substance use or addictive behaviours. Accessed Apr 2024.
[16] DrugWise. Drug abuse or misuse. Accessed Jan 2024.
[17] Kelly & Westerhoff. (2010). Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. Accessed Jan 2024.
[18] Drugwise. Recreational Use. Accessed Feb 2024.
[19] Drugwise. Problem drug use. Accessed Feb 2024.
[20] Corrigan & Rao. (2012). On the self-stigma of mental illness: stages, disclosure, and strategies for change. Accessed Feb 2024.

meaning they're unlikely to attempt to receive treatment.[21] In addition, 'courtesy stigma' is when negative feelings extend to family members and friends of the individual, and can even impact clinical and public health level responses, which contributes to the inequalities in health and care delivery within dual diagnosis.[22]

Table 1 outlines some examples of stigmatising language that is not used within this deep dive and the alternative language that we use instead, with reasoning behind each decision. This should not be viewed as a definitive list because language is dynamic and the meaning and opinions surrounding certain terms have potential to change depending on the scientific, cultural and political landscapes.[23]

Table 1: Adaptations to Stigmatising Language.

Stigmatising Language	Proposed Language	Reasoning
'Addict' or 'user'	Person living with a substance misuse disorder.	It is important to use language that prioritises the person and avoids individual blame. (i.e., the person 'has' a problem, rather than 'is' the problem).
'Drug/substance abuse'	Drug/substance misuse.	The term 'abuse' may perpetrate negative and damaging perceptions about people with dual diagnosis.
'Habit'	Having a substance misuse disorder.	The term 'habit' implies behaviour is a choice and the individual can choose to stop if they want to. It also undermines the severity of the health condition.
'Being clean' or 'sober'	Being substance free, abstinent or in remission.	It is important to use clinically accurate, non-stigmatising language, as is the case for other medical conditions.

Source: Created internally (adapted from Zgierska[23] and National Institute on Drug Abuse[24]).

1.4.6 Drug Types

There are many different types of drugs which may be implicated when a person has dual diagnosis. These include alcohol, anabolic steroids, cannabis, classifications of controlled drugs, club drugs, cocaine, khat, psychoactive substances, opioids, and prescription medicine.

1.4.7 Disability and the Equality Act

A mental health condition is considered a disability when it has long-term effects on daily activity, lasting longer than one year. This is defined under the Equality Act (2010).[25]

Dependency on alcohol or other substances are not considered impairments, and do not constitute disabilities under the Equality Act. However, one exception is where there is an addiction or dependency consequent to being medically prescribed. However, whilst a person

[21] Hammarlund et al. (2018). Review of the effects of self-stigma and perceived social stigma on the treatment-seeking decisions of individuals with drug- and alcohol-use disorders. Accessed Feb 2024.
[22] Stangl et al. (2019). The Health Stigma and Discrimination Framework: a global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas. Accessed Feb 2024.
[23] Zgierska. (2022). Language matters: It's time we change how we talk about addiction and its treatment. Accessed Jan 2024.
[24] National Institute on Drug Abuse. (2021). Words Matter: Preferred Language for Talking About Addiction. Accessed Jan 2024.
[25] GOV.UK. When a mental health condition becomes a disability. Accessed Jan 2023.

would not be considered to have a disability due to their addiction, they may have a disability due to a condition caused by this addiction (e.g., liver disease or mental health problems).[26]

Understanding the definition of disability under this Act has important implications for obtaining some types of support and help. For example, some types of benefits and financial aid are available to people with certain conditions and disabilities.

1.4.8 Mental Health Conditions

Mental health conditions (MHC) are a broad term covering mental disorders, psychosocial disabilities and mental states which involve impairment in functioning or significant distress.[27] MHCs are typically characterised by adverse changes in mood, behaviour, thoughts, perceptions, emotions and relationships with others. MHCs can manifest in different levels of severity: mild, moderate and serious. A mild MHC is characterised by a small number of symptoms and has a limited effect on a person's daily life. A moderate MHC will have more symptoms, making it more difficult for the individual to operate in their daily life. Furthermore, a serious MHC is when a person has many symptoms, making their daily life extremely difficult. Serious MHCs were previously referred to as 'severe' or 'severe and enduring', however, the current term is 'serious'.[28] Common examples of MHC diagnoses include depression, bipolar disorder, schizophrenia and other psychoses, dementia, anxiety disorders, and addictive behavioural disorders. Patients can respond differently to receiving an MHC diagnosis. For example, in some cases an MHC diagnosis may feel like a negative label. However, for others, an MHC diagnosis may provide relief and reassurance that a name can be given to certain experiences.[29]

Mental Health Europe defined 'mental distress' as experiences which negatively influence a person's wellbeing. It can be caused by many different things and can lead to the development of mental health problems. 'Mental illness' or 'mental disorder' is a narrower term for a mental health problem which focuses on medical symptoms.[30]

The primary reason for referrals to secondary mental health services for both children and young people's services and adult services in England (2021-22) are presented in the table below. 'Unknown' was the largest category, accounting for 31.3% of referrals. Table 2 presents the top 15 recorded referral reasons (after 'unknown'), and shows 'in crisis' to be the most common reason (24.7%), followed by anxiety (7.3%), organic brain disorder (6.9%) and depression (6.2%). Drug and alcohol difficulties accounted for 0.8% of referrals.[31]

[26] GOV.UK. (2013). Disability: Equality Act 2010 - Guidance on matters to be taken into account in determining questions relating to the definition of disability (HTML). Accessed Jan 2023.
[27] WHO. Mental Disorders. Accessed Jul 2022.
[28] NICE. (2011). Common Mental Health Disorders. Identification and pathways to care. Accessed Jan 2024.
[29] Turning Point. Substance Use and Mental Health Training. Accessed Jan 2024.
[30] Mental Health Europe. Mental Health Europe Explained. Accessed Jul 2022.
[31] NHS Digital. (2023). Number of referrals to secondary mental health services in England. Accessed Feb 2024.

Table 2: Primary Reason for Mental Health Services Referrals in England (2021-22).

Primary Reason for Referral	Number	Percentage
In crisis	1,077,377	24.7%
Anxiety	319,718	7.3%
Organic brain disorder	301,910	6.9%
Depression	269,788	6.2%
Adjustment to health issues	199,016	4.6%
Self-harm behaviours	143,782	3.3%
Neurodevelopmental conditions, excluding autism	86,384	2.0%
Unexplained physical symptoms	76,032	1.7%
Ongoing or recurrent psychosis	65,542	1.5%
Perinatal mental health issues	62,541	1.4%
Eating disorders	58,472	1.3%
Suspected autism	55,266	1.3%
Conduct disorders	51,259	1.2%
Personality disorders	43,972	1.0%
Drug and alcohol difficulties	35,371	0.8%

Source: NHS Digital.[31]

Figure 2 illustrates the substance induced mental disorders that are outlined in the ICD-11.

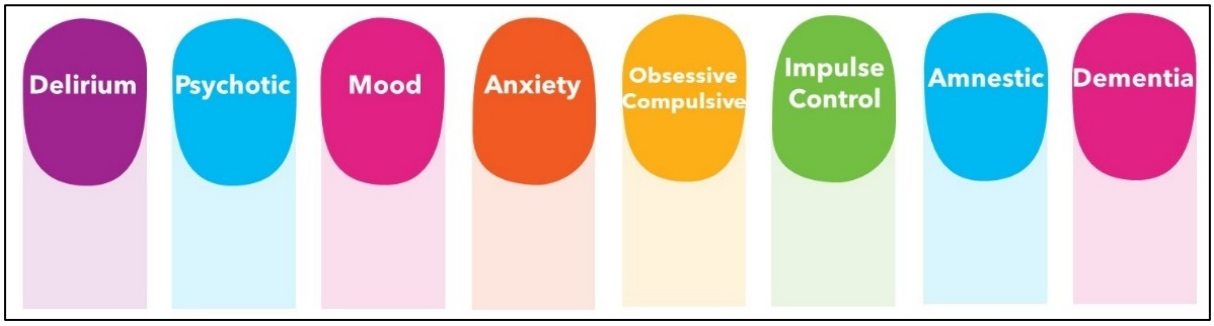


Figure 2: Substance Induced Mental Disorders (ICD-11).

Source: ICD-11.[32]

1.4.9 Reciprocal Training

The term 'reciprocal training' refers to cross-training between professionals in different services. In the context of dual diagnosis, this would refer to staff in drug and alcohol services undergoing mental health training and staff in mental health services undergoing drug and alcohol training. Reciprocal training is a way that collaborative working protocols can be developed.[33]

[32] ICD-11. Disorders due to substance use. Accessed Apr 2024.
[33] NHS. (2023) The Improving Access to Psychological Therapies Manual. Accessed Mar 2023.

1.4.10 Treatment Groupings

The National Drug Treatment Monitoring System (NDTMS) reports on adults in contact with drug and alcohol services in England. This database divides adults into four substance groups:[34]

- The 'opiate' group includes people who have problems with opiates, mainly heroin.
- The 'non-opiate' group includes people who have problems with non-opiate drugs only, such as cannabis, crack and ecstasy.
- The 'non-opiate and alcohol' group includes people who have problems with both non-opiate drugs and alcohol.
- The 'alcohol only' group includes people who have problems with alcohol, but do not have problems with other substances.

Figure 3 contains a visual flowchart of how people are categorised into these groups.

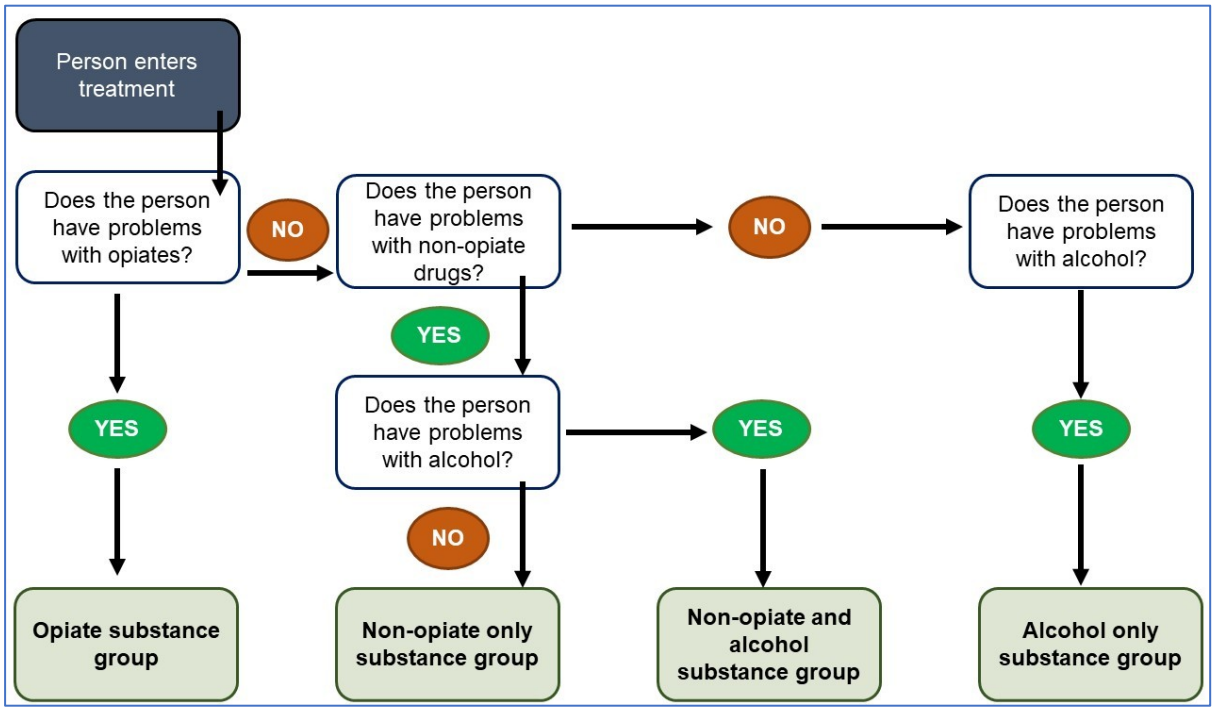


Figure 3: Treatment Groupings for Adults in Drug and Alcohol Treatment.

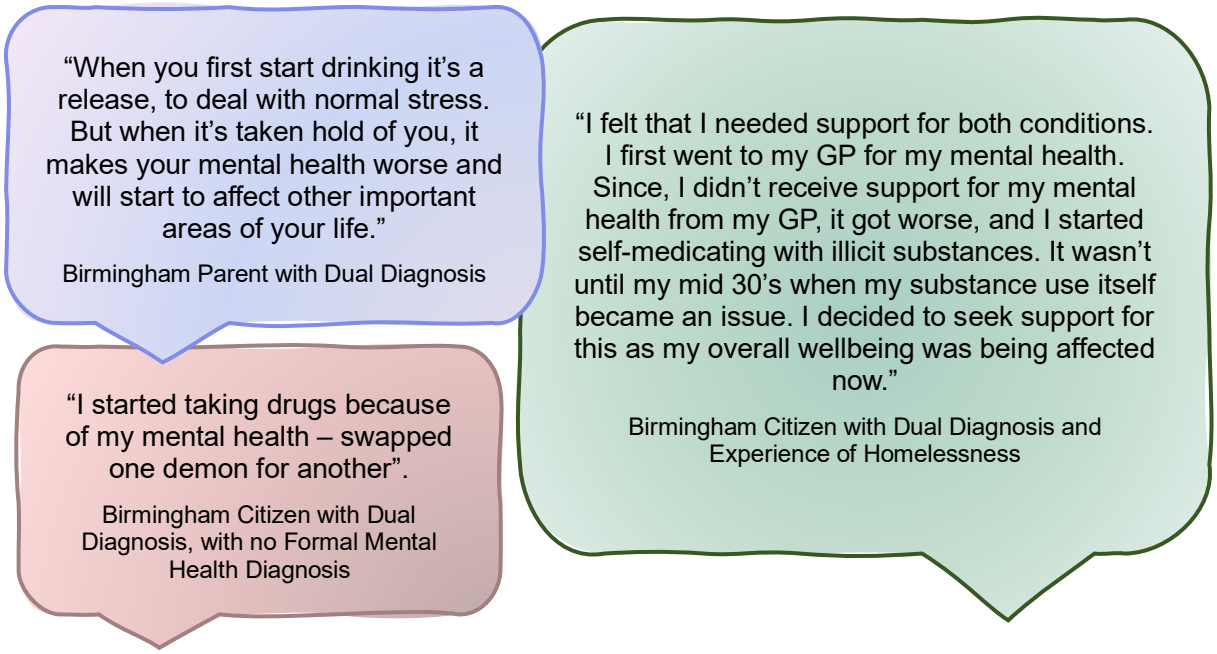
Source: OHID.[34]

1.5 Aetiology of Dual Diagnosis

The relationship between substance misuse and mental illness may vary between individuals and can change over time. The two conditions interact, and each can exacerbate the other. Identifying dual diagnosis is very difficult, due to the cognitive and behavioural effects of drugs and alcohol often being similar to the effects caused by mental health issues. It is also difficult to understand the relationships and causal pathways between poor mental health and substance misuse, due to them differing across different substances and disorders.[35] The co-existence of mental health and substance misuse problems is also highly individualised, and their development may be due to multiple experiences endured over a period of time. It is

[34] OHID. Adult substance misuse treatment statistics 2021 to 2022: report. Accessed Apr 2024.
[35] Jané-Llopis and Matytsina. (2006). Mental Health and alcohol, drugs and tobacco: a review of the comorbidity between mental disorders and the use of alcohol, tobacco and illicit drugs. Accessed Jul 2022.

possible that a mental illness leads to the development of substance misuse, or that substance misuse leads to a mental illness. It is also possible that mental illness and substance misuse are endured as two unrelated disorders, which then interact, with each exacerbating the other. Furthermore, it is also important to note that other factors may influence either condition (e.g., physical health problems).[36]



1.5.1 Mental Health Problems Leading to Substance Misuse

Certain mental health disorders (e.g., bipolar disorder, antisocial and schizotypal personality disorders, and anxiety disorders) are risk factors for developing a substance misuse disorder. It is commonly hypothesised that people with mild to severe mental health disorders may misuse drugs as a form of self-medication. Drugs and alcohol may be misused to cope with experiences directly caused by mental health disorders or its consequences. This is supported by research suggesting that psychoactive substances are likely misused as a self-regulation strategy to alleviate distress.[37]

Research has shown that having a mental health disorder in childhood or adolescence can increase the risk of later drug misuse and the development of a substance misuse disorder. This may include untreated/internalised disorders such as ADHD, depression, and anxiety.[38]

1.5.2 Substance Misuse Leading to Co-existing Mental Health Problems

Heavy, prolonged, and frequent misuse of drugs and alcohol can result in physical and mental health problems. For example, the evidence indicates that alcohol misuse follows a causal model and likely leads to depression, rather than depression being the reason for misusing alcohol (i.e., self-medication).[39] The effects of substance misuse are similar to symptoms associated with psychiatric disorders, which makes substance misuse related changes in mental health status difficult to distinguish from clinical mental health changes (e.g.,

[36] NICE. Guideline Scope: Severe mental illness and substance misuse (dual diagnosis): community health and social care services. Accessed Mar 2023.
[37] Smith et al. (2017). Exploring the Link Between Substance Use and Mental Health Status: What Can We Learn from the Self-medication Theory? Accessed Jun 2022.
[38] NIH – National Institute on Drug Abuse. (2020). Common Comorbidities with Substance Use Disorders Research Report. Accessed Jun 2022.
[39] Boden & Fergusson. (2011). Alcohol and depression. Accessed Jun 2022.

depression). The after-effects of substance misuse (e.g., hangovers and comedowns) may also have a detrimental and powerful effect on mental health. Hangovers from alcohol misuse can cause a depressant effect on mood, and alcohol withdrawal may cause a state of confusion, anxiety and psychosis.[40] Withdrawal from drugs, such as amphetamines, can also lead to depression and in severe cases can lead to suicide.[41]

Substance misuse has been known to worsen existing mental health conditions, including anxiety, depression, bipolar disorder, and other psychotic disorders (e.g., schizophrenia). For example, the results from a prospective study show that those who misused cannabis while suffering from schizophrenia experienced exacerbated symptoms of delusions and hallucinations.[42] It is thought that people with poorly managed mental health conditions may choose to ingest substances in an attempt to cope or self-medicate their symptoms. However, although this may provide temporary relief, in the long-term it can increase the length of time the mental health condition will last and the severity of the symptoms, as well as increase dependence on the given substance.[43] In addition to this, the misuse of certain substances has been known to interfere with the effectiveness of mental health medications taken for pre-existing mental health conditions. For example, using MDMA or cocaine alongside taking a course of antidepressants can cause an overproduction of serotonin (serotonin syndrome) that in some instances can be fatal.[44]

1.5.3 Substance Induced Mental Health Conditions

Mental health conditions that occur only in association with substance use are specified as 'substance-induced' and may develop in the context of intoxication or withdrawal. Affective, or mood disorders, reported to have been substance-induced include bipolar disorder and depressive disorders.[45] Substances most frequently associated with inducing mood disorders include alcohol, cocaine, and recreational opioids such as heroin. Additionally, although originally prescribed by medical professionals, iatrogenic substances such as interferons or corticosteroids can also induce mood disorders in certain cases.[46]

The most essential feature of treatment for a substance-induced mood disorder should be abstinence. Clinicians can offer supportive care whilst observing the patient in a safe environment during the withdrawal period. However, in more severe cases, clinicians have been known to treat the active mood disorder with medication, even though the mood disorder is known to have been caused by ingesting a substance. As keeping off the substance(s) in question is so important, certain lifestyle factors that promote sobriety will increase the likelihood of remission (e.g., financial stability, support from family and friends, and medication compliance).[47]

A currently unexplained complication to the existence of substance-induced mental health links to suicide. Data suggests that suicide attempts are more common in individuals with substance-induced mood disorders rather than independent mood disorders. One study found

[40] Bayard et al. (2004). Alcohol Withdrawal Syndrome. Accessed Jun 2022.
[41] Shoptaw et al. (2009). Treatment for amphetamine withdrawal. Accessed Jun 2022.
[42] Hides et al. (2006). Psychotic symptom and cannabis relapse in recent-onset psychosis. Prospective study. Accessed Jan 2024.
[43] Smith. (2023). Drugs and Mental Health. Accessed Jan 2024.
[44] Dobry et al. (2013). Ecstasy use and serotonin syndrome: a neglected danger to adolescents and young adults prescribed selective serotonin reuptake inhibitors. Accessed Jan 2024.
[45] Tolliver & Anton. (2015). Assessment and treatment of mood disorders in the context of substance abuse. Accessed Jan 2024.
[46] Patten & Barbui. (2004). Drug-induced depression: a systematic review to inform clinical practice. Accessed Jan 2024.
[47] Revadigar & Gupta. (2022). Substance-Induced Mood Disorders. Accessed Jan 2024.

that in a group of people who had attempted suicide, substance-induced depression was identified in 60% of attempters, whereas independent depression was identified in only 13% of attempters.[48]

1.5.4 Underlying Factors Leading to Both Substance Misuse and Mental Health Disorders

There are a number of factors which can lead to both substance misuse and mental health disorders. These include genetic factors, environmental factors, trauma and stress, and behaviours. Genetics are estimated to be responsible for a large proportion of an individual's likelihood of developing substance misuse disorders. For example, the inheritability of alcohol misuse disorders ranges between 40 to 60%.[49] Most of this is due to complex interactions among multiple genes and genetic interactions with environmental influences.

Higher levels of stress have been shown to impact on brain activity in ways that lead to decreased behavioural control and increased impulsivity, which can make individuals more likely to start misusing drugs and have less self-control over stopping misuse. Mental health disorders and substance misuse can also impair a person's ability to deal with stress. People with mental health disorders often misuse drugs as self-medication to lower the levels of stress. This can create a cycle of worsening substance misuse and mental illness where people self-medicate with substances to deal with stress. Furthermore, this can often make stress more difficult to cope with. Finding measures to relieve stress in dual diagnosis patients, such as mindfulness-based stress reduction, can help prevent such a cycle from occurring.[50]

1.5.4.1 Specific Associations between Mental Health and Substance Misuse

Several specific associations between mental health and substance misuse include:

- Substance misuse, self-harm and suicidal behaviour.
- Substance misuse, mood disorders and anxiety.
- Substance misuse and personality disorders.
- Substance misuse and severe mental illness.
- Substance misuse and PTSD.

1.6 The National Picture

1.6.1 Prevalence of Dual Diagnosis

In England and Wales (2022-23), an estimated 9.5% of the population (aged 16-59 years) and 17.6% of young people (aged 16-24 years) were thought to have used 'any type of illicit drugs' during the previous 12 months. Furthermore, 3.3% of the population (aged 16-59 years) and 6.4% of young people (aged 16-24 years) had misused Class A drugs during the same period.[51]

According to a 2016 report from the independent Mental Health Taskforce to the NHS, 1 in 4 people experience mental health issues each year in England.[52] Additionally, 1 in 6 working-age adults have symptoms associated with mental ill health.[53]

[48] Conner et al. (2014). Substance-induced depression and independent depression in proximal risk for suicidal behaviour. Accessed Jan 2024.
[49] Wang et al. (2012). The genetics of substance dependence. Accessed Jun 2022.
[50] NIH – National Institute on Drug Abuse. (2020). Common Comorbidities with Substance Use Disorders Research Report. Accessed Jun 2022.
[51] ONS. (2023). Drug misuse in England and Wales: year ending March 2023. Accessed Jan 2024.
[52] NHS. (2016). The Five Year Forward View for Mental Health. Accessed Jan 2024.
[53] NHS. (2014). Mental Health and Wellbeing in England. Accessed Jan 2024.

Rich datasets exist nationally for both substance misuse and mental health. However, there is a relative lack of data on dual diagnosis. National surveillance from the Office for Health Improvement and Disparities (OHID) on drugs and alcohol treatment include statistics on the need for mental health treatment and treatment received.[54] This represents the most comprehensive national data available on dual diagnosis. However, we acknowledge that these data are not as sophisticated as the dataset on substance misuse, which includes indicator categories for prevalence and unmet need, client characteristics, substance misuse profile, access to services and treatment outcomes.[55] Therefore, we are not able to fully understand the epidemiology of dual diagnosis and draw conclusions on the effectiveness of dual diagnosis treatment with the same confidence as for substance misuse. Despite these limitations, data are presented on dual diagnosis from the National Drug Treatment Monitoring System (NDTMS) and from the Fingertips data (OHID) throughout this report.

A large systematic review published in 2009 synthesised the available evidence on dual diagnosis prevalence within the UK.[56] The review focused on comorbid alcohol and drug misuse rates in people with psychosis in different mental health and addiction settings in the UK, as well as variations in such rates between different population groups. The results revealed wide variations in reported drug and alcohol misuse rates in psychosis patients across the UK, with rates of 20-37% in mental health settings, and 6-15% in addiction settings. Rates were found to be especially high in inpatient and crisis team settings (38-50%) and forensic settings. Rates were also found to be highest in inner city areas within the UK. This research provides a useful reference to dual diagnosis prevalence in different settings within the UK. However, the findings were somewhat inconsistent with national surveillance data.

1.6.2 Drug Treatment Data

According to NDTMS data for England (2021-22), there were 52,673 individuals receiving treatment for drug and alcohol misuse who also had a mental health need identified.[57] This represents 81.0% of the total number of new presentations (n=66,263). Of the individuals with a mental health need identified, 13,555 (25.3%) did not receive treatment or refused treatment for mental health. The total number of people receiving any treatment for mental health was 40,118 (74.7%).

[54] OHID. Adult Substance Misuse Treatment Statistics-2020-to-2021-Report Accessed Jul 2022.
[55] NDTMS. National Drug Treatment Monitoring System Accessed Apr 2024.
[56] Carra & Johnson. (2009). Variations in rates of comorbid substance use in psychosis between mental health settings and geographical areas in the UK. Accessed Jul 2022.
[57] NDTMS. National Drug Treatment Monitoring System Accessed Apr 2024.

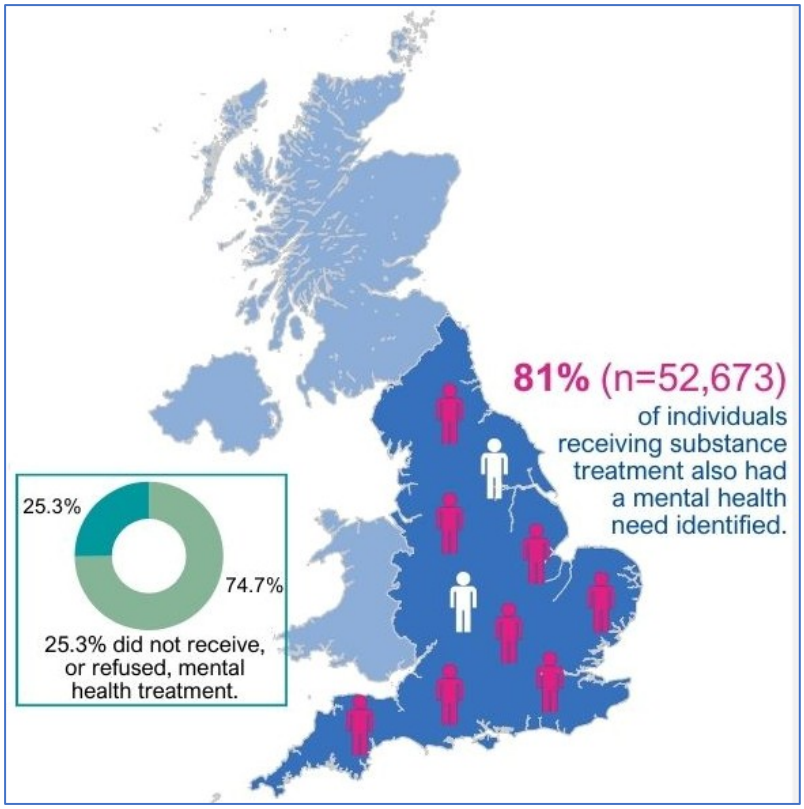


Figure 4: Proportion of Individuals in England with a Mental Health Need Identified Who Were Not Receiving Mental Health Treatment whilst in Substance Misuse Treatment (2021-22).

Source: NDTMS.[57]

In 2021-22, there were 66,123 new presentations for drugs and alcohol in substance misuse services in England, of which 79% of individuals had a mental health need identified (n=52,673). 76.2% of those identified with a mental health need were receiving mental health treatment (n=40,118) and 23.8% were not (n=12,555). Furthermore, there were 56,724 new presentations for alcohol only, of which 70% of individuals had a mental health need identified (n=39,707). 83.3% of those identified with a mental health need were receiving mental health treatment (n=33,058), and 16.7% were not (n=6,649).[58]

Of the 92,380 individuals with a mental health need identified, 79.2% were already receiving or engaging in mental health treatment pathways (n=73,176). Most individuals were receiving mental health treatment from their GP, ranging from 73.4% of drug and alcohol clients (n=29,439) to 80.2% of alcohol only clients (n=26,514). This suggests that primary care is an essential pathway for individuals experiencing dual diagnosis for receiving mental health support. Furthermore, a large percentage of individuals were already engaged with mental health services before treatment began, ranging from 28.8% for drug and alcohol clients (n=11,573) to 21.5% for alcohol only clients (n=7,099). (Table 3)

[58] OHID. Adult Drug Commissioning Support Pack: 2023-24 Report: Key Data. Accessed Internally.

Table 3: Number and Proportion of Individuals receiving Mental Health Treatment in England, by Drug/Alcohol Category (2023-24).

Mental Health Treatment	Drugs and Alcohol	%	Alcohol Only	%
Receiving mental health treatment from GP	29,429	73.4%	26,514	80.2%
Receiving mental health services	11,573	28.8%	7,099	21.5%
Engaged with IAPT (Improving Access to Psychological Therapies)	873	2.2%	873	2.6%
Receiving a NICE recommended intervention for treatment of a mental health problem	819	2.0%	522	1.6%
Has an identified health-based place of safety for mental health crisis	420	1.0%	293	0.9%
Total individuals receiving mental health treatment	**40,118**	**100%**	**33,058**	**100%**

Source: Adult Drug Commissioning Support Pack via NDTMS.[59]

1.6.3 Premature Mortality and Severe Mental Illness

A report published by the Office for Health Improvement and Disparities (2023), recognised that physical health is poorer among people with severe mental illness. People with severe mental illness are at a greater risk of chronic conditions, which can increase the risk of premature death.

While the severe mental illness may not be recorded as a cause of death, it may have influenced a person's risk of developing chronic conditions, accessing healthcare and their ability to manage their physical health. It is estimated that among people with severe mental illness, two thirds of deaths are from preventable physical illnesses. People with severe mental illness are five times more likely to die before 75 years, than those without.[60]

In England, there were 120,273 premature deaths in adults with severe mental illness (2018-20), which equated to 103.6 per 100,000. This was lower than in Birmingham, where the rate was 147.8 per 100,000 deaths during this time (n=2,705).[61]

The latest data shows that premature mortality (before 75 years) is higher for males (124 per 100,000) than females (84 per 100,000) with severe mental illness. The rate of premature mortality is also higher in the most deprived areas (200 per 100,000) compared to the least deprived areas (53.9 per 100,000).[62]

It has been suggested that in England, 26,727 adults with severe mental illness die prematurely (before 75 years) each year. Adults with severe mental illness are 2.3 times more likely to die prematurely from cancer, 4.1 times from cardiovascular disease, 6.5 times from liver disease, and 6.6 times from respiratory disease.[63] This estimate is based on an annual

[59] OHID. Adult Drug Commissioning Support Pack: 2022-23: Key Data. Accessed Internally.
[60] OHID. (2023). Premature mortality in adults with severe mental illness (SMI). Accessed May 2023.
[61] OHID. Premature mortality in adults with severe mental illness (SMI). Accessed Feb 2024.
[62] OHID. (2023). Premature mortality in adults with severe mental illness (SMI). Accessed May 2023.
[63] Royal College of Psychiatrists. Over 26,000 adults with severe mental illness die prematurely from preventable illness each year. Accessed Feb 2024.

figure, rather than the three-year cumulative figure from Fingertips (n=120,273), mentioned in a preceding paragraph.

In 2018-20, premature mortality due to cancer in adults (aged 18 to 74) with severe mental illness was calculated at 20.2 per 100,000, followed by cardiovascular disease (18.9) and respiratory disease (12.2). However, this data only contains adults with diagnosed cases of severe mental illness. Premature deaths within the general population are higher (i.e. cancer deaths (160.5 per 100,000), cardiovascular deaths (90.4) and respiratory deaths (41.3).[64] However, this data includes adults with severe mental health (both diagnosed and undiagnosed).

1.6.4 Premature Mortality and Substance Misuse

In 2022, there were 4,907 deaths related to drug poisoning in England and Wales, which equated to 84.4 deaths per million population. The majority of these deaths (66%) were among males (n=3,240), with the remaining 1,667 deaths among females (34%). The majority of the drug-poisoning deaths (n=3,127) were identified as drug misuse (64%). The age group with the highest number of deaths relating to drug misuse was among those aged 40 to 49 years, which equated to 130.8 deaths per million population. Opiates accounted for the largest drug category (46.1%) of drug-poisoning deaths.[65]

Research investigating the major causes of death among people with a history of opioid misuse in England (2001-18), found that 33.1% of deaths observed were due to drug poisoning, while the majority (66.9%) were due to other causes. Among the main causes of death, cancers were responsible for 13.2% of deaths, followed by digestive diseases (12.2%), external causes (10.3%), respiratory disease (9.4%), circulatory disease (8.7%), infections (3.7%) and nervous system diseases (1.2%). The most common causes of death from single conditions within these categories were from liver disease (9.6%), COPD (5.2%) and suicide (4.9%).[66]

Research from Sweden, showed that premature mortality among a cohort of 1,405 patients admitted to a detoxification unit for substance misuse disorders, was almost 6 times higher than among the general population. Among the cohort, two thirds of deaths were drug related, with opiates being the single strongest predictor. Predictors of deaths by overdose (defined as a death occurring shortly after taking illicit drugs and where the death is directly related to the intake) included being male, using opiates, being young when first admitted, and having mood and anxiety disorders. Predictors of deaths by intoxication (defined as a death occurring shortly after taking licit drugs and where the death is directly related to the intake) included misuse of licit drugs, being male, having psychosis, mood and anxiety syndromes.[67]

1.7 National Strategies and Guidance

This section outlines key legislation, government strategies, NICE guidance, reports and documents relating to dual diagnosis. The link between mental health and substance misuse has been recognized across many government strategies over the years, signaling an understanding of the high risk of comorbidity between these conditions. The high risk among people with experience of homelessness and those in contact with the criminal justice system

[64] OHID. Severe Mental Illness. Accessed Feb 2024.
[65] ONS. 2023. Deaths related to drug poisoning in England and Wales: 2022 registrations. Accessed Feb 2024.
[66] Lewer. (2022). Causes of death among people who used illicit opioids in England, 2001-18. Accessed Feb 2024.
[67] Fridell. (2019). Prediction of psychiatric comorbidity on premature death in a cohort of patients with substance use disorders: a 42 year follow-up. Accessed Feb 2024.

are also highlighted. While NICE guidance provides recommendations for health and social care, there appears to be a lack of guidance to support children and young people aged below 14 years with co-existing substance misuse and mental health issues. Despite efforts to integrate treatment, care continues to be disjointed for many, further complicated by separated commissioning pathways.

1.7.1 Legislation

The ***Misuse of Drugs Act (1971)*** is intended to prevent the non-medical use of classified drugs. It controls medicinal drugs as well as drugs with no current medical use which are accountable to a series of offences including unlawful supply, unlawful possession, intent to supply, import and export, and unlawful production.[68] The ***Drugs Act (2005)*** brought in new police powers, including the power to test for drugs on arrest. This identification of misusers of specific Class A drugs among offenders could allow more individuals to access treatment.[69] This new legislation was intended to make provision in connection with controlled drugs and for the making of orders to supplement anti-social behaviour orders, in cases where behaviour is affected by drug misuse or other prescribed factors.[70] The ***Psychoactive Substances Act (2016)*** introduced new legislation placing a blanket ban on all psychoactive substances not already controlled under the *Misuse of Drugs Act*.[71] Exemptions were given for nicotine, alcohol, caffeine and medicinal products.[72]

The ***Mental Health Act (1983)*** sets out the assessment, treatment and rights of people with a mental health disorder. This Act allows people to be detained when they are at risk of harm to themselves or others, commonly termed being 'sectioned'. When a person is on short-term leave or discharged from a hospital where they have been treated under the Mental Health Act, they may be placed under a Community Treatment Order which sets out conditions, which if not met, could result in the individual returning to hospital.[73]

The ***Care Act (2014)*** introduced a new unified law on care and support for adults in England and placed new responsibilities on local authorities.[74] The Act sets out processes for ascertaining an adult's need for care and whether the person is eligible for publicly funded care and support. While the Act doesn't refer specifically to dual diagnosis, it does stipulate that adults will be eligible for care and support if they have care and support needs that are a result of a physical or mental health condition.[75] The Act also introduced a statutory entitlement to support for the carers of adults with care and support needs. Local authorities are mandated to carry out a carer's assessment to ascertain whether the carer is eligible to access support. This should evaluate the impact of caring on the carer's mental and physical health, their ability and willingness to care, and what the carer wishes to achieve in their daily life. The ***Children and Families Act (2014)*** provides statutory guidelines for support for young carers and parents of disabled children.[76]

[68] GOV.UK. (1971) Misuse of Drugs Act. Accessed Apr 2024.
[69] Secretary of State for the Home Department. (2010). Memorandum to the Home Affairs Committee Post-Legislative Assessment of the Drugs Act 2005. Accessed Aug 2022.
[70] Legislation.gov.uk. Drugs Act 2005. Accessed Jul 2022.
[71] Legislation.gov.uk. Misuse of Drugs Act 1971. Accessed Jul 2022.
[72] Legislation.gov.uk. Psychoactive Substances Act 2016. Accessed Jul 2022.
[73] NHS. Mental Health Act. Accessed Jan 2023.
[74] GOV.UK. (2014). Care Act 2014. Accessed Mar 2023.
[75] Department of Health and Social Care. (2016). Care Act Factsheets. Accessed Mar 2023.
[76] Local Government Association. (2022). Carers and safeguarding: a briefing for people who work with carers. Accessed Mar 2023.

1.7.2 Government Strategies

No Health without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages (2011) was published by the Department of Health and covers all ages. The Strategy adopted an approach to promote mental health and wellbeing, prevent mental illness, and identify and intervene as soon as mental illness arises. The Strategy acknowledges that dual diagnosis is associated with a wide range of problems and highlights the importance of appropriate services being available locally, including the provision of fully integrated care when it is appropriate to meet the breadth of need.[77]

The ***Government's Alcohol Strategy (2012)*** promotes measurable, evidence-based prevention activities at a local level and national ambitions to reduce alcohol-related harm. This included a minimum unit pricing, which was subject to a U-turn in 2013 (i.e. not implemented in England) and there has been no alcohol specific strategy since. Other commitments included a consultation concerning a ban on the sale of multi-buy alcohol discounting and piloting of innovative sobriety schemes to challenge alcohol-related offending. The Strategy draws attention to the 'clear association between having a mental illness and increasing risk of alcohol dependence' and suggested that recovery must include tackling wider factors that reinforce dependence, including housing needs and employability.[78]

The ***Drug Strategy (2017)*** included four key principles: reducing demand, restricting supply, supporting recovery, and driving action on a global scale. The Strategy identifies that individualised and integrated mental health care will reduce the risk of substance misuse, and it reiterates the need for services to work together to facilitate recovery.[79] Following on from the *Drug Strategy*, the Government published ***From Harm to Hope: a 10-year Drugs Plan to Cut Crime and Save Lives (2021).*** This document recognised that the methods implemented to date had not been effective in combating drug misuse. Throughout the Strategy there is recognition of the damaging effects of comorbid substance misuse and mental health issues, and it highlights that drug dependence often co-exists with other health disparities, like poor mental health and homelessness. On this basis, there is a pledge to ensure the physical and mental health needs of people with drug addictions are addressed.[80] In this 10-year drugs strategy, the Government indicate that they will implement key recommendations from the **Dame Carol Black Report** (see Section 1.7.4 for further details) to reduce harm and support recovery. The document lays out a long-term strategy where drug misuse is seen as a problem for the whole of society, rather than solely as a law enforcement issue, and is clear that addiction is a chronic health condition requiring long-term follow-up; that addiction is often driven and accompanied by trauma and mental ill health and that for those with dual diagnosis, addiction and mental ill health are co-morbidities.[81]

1.7.3 NICE Guidance and NHS

The NICE Guideline ***Depression in Children and Young People: Identification and Management (2019) [NG134]*** refers to children and young people aged 5-18 years. It notes that professionals should enquire about the use of alcohol and drugs when assessing children and young people with depression. Depression in children and young people is managed

[77] Department of Health and Social Care. (2011). No health without mental health: a cross-government outcomes strategy. Accessed Jul 2022.
[78] HM Government. (2012). The Government's Alcohol Strategy. Accessed Jul 2022.
[79] Home Office. (2017). Drug Strategy. Accessed Jul 2022.
[80] HM Government. (2021). From harm to hope: a 10-year drugs plan to cut crime and save lives. Accessed Jul 2022.
[81] Department of Health and Social Care. (2021). Review of drugs: phase two report. Accessed Jul 2022.

through a stepped-care model, allowing those with differing needs to access appropriate levels of support.[82]

The NICE Guideline ***Psychosis and Schizophrenia in Children and Young People: Recognition and Management (2013) [CG155]*** notes that children and young people (anyone under 18 years) with psychosis or schizophrenia should be routinely treated by a single multidisciplinary team without being passed between teams unnecessarily or undergoing multiple unnecessary assessments. When experiencing a first episode of psychosis, children and young people should be asked about their alcohol and drug history.[83]

The NICE Guideline ***Drug Misuse Prevention: Targeted Interventions (2017) [NG64]*** refers to targeted interventions to prevent misuse of drugs in children, young people (aged 10 to 18 years, and up to 25 years for those with special educational needs or disability) and adults who are most at risk of misusing drugs, or who experimentally or occasionally misuse drugs. Prevention activities can be delivered through existing services such as primary care, community mental health services, sexual health services and school nursing services. Routine appointments e.g., GP appointments, school nurse contact or contact with the criminal justice system in the community can be opportunities to assess vulnerability to drug misuse.

Young people assessed as vulnerable to drug misuse may benefit from skills training such as making healthy behaviour choices, managing stress or conflict resolution. This can be offered to parents and carers also. For looked after children and care leavers, skills training may also focus on coping with feelings of exclusion. For adults assessed as vulnerable to drug misuse, information and advice on drugs and their impact, including information on local services should be provided. This can be given alongside a plan for a follow-up after the assessment.[84]

Other relevant NICE quality standards for children and young people include:

- NICE Quality Standard [QS48] – Depression in Children and Young People (2013).[85]
- NICE Quality Standard [QS102] - Bipolar Disorder, Psychosis and Schizophrenia in Children and Young People (2015).[86]
- NICE Quality Standard [QS165] - Drug Misuse Prevention (2018).[87]

The NICE Guideline ***Coexisting Severe Mental Illness (Psychosis) and Substance Misuse: Assessment and Management in Healthcare Settings (2011) [CG120]*** recognises the importance of building a non-judgmental, trusting relationship with adults and young people (aged 14+) with psychosis and coexisting substance misuse. Professionals should consider the link between these conditions, stigma and discrimination and that some individuals may attempt to hide one or both of their conditions. People may also hold fears such as being detained, or having children removed from their care. Primary healthcare professionals should refer all adults and young people to secondary mental health services or Child and Adolescent Mental Health Services (CAMHS) where a) a person with psychosis or suspected psychosis also has suspected coexisting substance misuse, and b) a person with substance misuse or suspected substance misuse has suspected coexisting psychosis. Healthcare professionals in substance misuse services should be able to recognise the

[82] NICE. (2019). Depression in children and young people: identification and management. Accessed Jan 2024.
[83] NICE Guideline [CG155]. (2013). Psychosis and schizophrenia in children and young people: recognition and management. Accessed Jan 2024.
[84] NICE Guideline [NG64]. Drug misuse prevention: targeted interventions. Accessed Jan 2024.
[85] NICE Quality Standard [QS48]. (2013). Depression in children and young people. Accessed Jan 2024.
[86] NICE Quality Standard [QS102]. (2015). Bipolar disorder, psychosis and schizophrenia in children and young people. Accessed Jan 2024.
[87] NICE Quality Standard [QS165]. (2018). Drug misuse prevention. Accessed Apr 2025.

symptoms of psychosis and assess for mental health needs. Professionals in secondary mental health services should consider taking supervision, advice, consultation and training from substance misuse service professionals.[88]

The NICE Guideline ***Alcohol-use Disorders: Diagnosis, Assessment and Management of Harmful Drinking (High-risk Drinking) and Alcohol Dependence (2011) [CG115]*** makes recommendations about harmful drinking and alcohol dependence in adults and young people aged 10-17 years. For people who misuse alcohol and have a significant comorbid mental health problem, or are at high risk of suicide, a referral for psychiatric assessment should be made for further assessment and treatment. All children aged 10-15 with alcohol misuse associated with physical, psychological, social or emotional problems, and/or comorbid drug misuse should be referred to CAMHS. Young people aged 16-17 should be assessed against adult criteria when being considered for a referral to these services.[89]

NICE Guideline ***Service User Experience in Adult Mental Health: Improving the Experience of Care for People using Adult NHS Mental Health Services (2011) [CG136]*** highlights what makes a good experience for adults using NHS mental health services.[90] One of the guideline's recommendations is that when providing care for people using mental health services, continuity of individual therapeutic relationships should be maintained wherever possible. Research shows that this relationship continuity not only leads to increased satisfaction among patients, but also among staff as well.[91]

The NICE Guideline ***Coexisting Severe Mental Illness and Substance Misuse: Community Health and Social Care Services (2016) [NG58]*** relates to people aged 14 years+. Since 2013, separate funding streams have been in place for mental health and substance misuse services. Mental health services are funded by Integrated Care Boards (ICBs; previously the clinical commissioning groups), and substance misuse services are funded by local authorities. This guideline notes that health and social care services need to be adapted to meet the needs of people with dual diagnosis, but that specialist dual diagnosis services may not be needed. This guidance aims to support in the provision of a range of coordinated services that address people's wider health and social care needs, as well as other issues (e.g., housing and employment).

This guidance recognises that people with coexisting severe mental illness and substance misuse can experience fragmented care. Joint pathways can help ensure continuity of care, particularly where individuals experience transition between services (e.g., moving between children and adult health or social care services), but also in other situations (e.g., where commissioning contracts are due to expire). Having a key contact can support continuity of care. Furthermore, this guideline recommends the consideration of joint training between substance misuse and mental health services which could support a consistent approach across services.[92]

[88] NICE Guideline [CG120]. (2011). Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings. Accessed Jan 2024.
[89] NICE. Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence. Clinical Guideline [CG115]. 2011. Accessed May 2022.
[90] NICE. (2011). Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services. Accessed May 2023.
[91] King's Fund. (2010). Continuity of care and the patient experience. Accessed May 2023.
[92] NICE. Overview | Coexisting severe mental illness and substance misuse: community health and social care services. Clinical Guideline [NG58]. Accessed Jul 2022.

The ***NICE Quality Standard: Coexisting Severe Mental Illness and Substance Misuse (2019) [QS188]*** sets out quality standards for the assessment and care of persons aged 14 and over with coexisting severe mental illness and substance misuse. It states that anyone aged 14+ with suspected or confirmed severe mental illness should be asked about their drug or alcohol use. It also emphasises the importance of not excluding someone from mental health or substance misuse services due to the existence of both conditions, and that any missed appointments should be followed up rather than discharged. Furthermore, it purports that a person with dual diagnosis should have a care coordinator from mental health services, where it is recognised that the person requires treatment from secondary care mental health services.[93]

The ***Care Programme Approach*** has been outlined in NICE guidance whereby individuals with dual diagnosis receive a care coordinator from mental health services, who alongside being a key contact for that individual, should develop a care plan.[94] This practice guidance highlights that a whole system approach should support this Care Programme Approach through integrated care pathways, information sharing, joint working and that commissioners should ensure that a range of services are available to meet needs and choices.[95]

The ***Community Mental Health Framework* (2019)** proposed a replacement to the Care Programme Approach for community mental health services. The Framework aims to update guidance in line with more recent legislation and to enable a more flexible approach to care. It is recognised that people living with dual diagnosis may experience discontinuity in their care, which can occur due to a lack of competences whereby people are excluded from mental health or substance misuse services due to the co-existence of the other. The framework attempts to overcome this issue through the principle of inclusivity. A need to embed expertise that provides support for those with dual diagnosis is recognised and may be delivered through the 'new community-based offer' set out in the *Long Term Plan*. Formal links should be in place between mental health and drug and alcohol services.[96]

The ***NHS Long Term Plan (2019)*** set out the ambition for new community-based support for adults and older adults with severe mental illness. Part of this new offer is support for those with coexisting substance misuse through a reorganisation of core community mental health teams into place-based and multidisciplinary services aligned with primary care networks.[97]

The '***Review of International Clinical Guidelines on Mental Health and Substance Misuse' (2021)*** looked at guidelines published between 2010-20 on mental health disorders and substance misuse, evaluating the extent to which these guidelines address such co-existing disorders. This research looked at substance misuse disorder and severe mental illness (encompassing psychosis and other types of schizophrenia and bipolar). All of the NICE guidelines reviewed in this work noted the link between mental illness and substance misuse and how each can worsen the other. This research illustrated some variance in awareness and advocacy of the coexistence of substance misuse and mental illness, and also where some guidelines may have gaps in recommendations.[98]

[93] NICE Quality Standard. (2019). Coexisting severe mental illness and substance misuse. Accessed Mar 2023.
[94] NICE (2016). Coexisting severe mental illness and substance misuse: community health and social care services. Accessed Mar 2023.
[95] Department of Health. (2008). Refocusing the care programme approach. Accessed Mar 2023.
[96] NHS. (2019). The Community Mental Health Framework for Adults and Older Adults. Accessed Mar 2023.
[97] NHS. (2019). The Long-Term Plan. Accessed Mar 2023.
[98] Alsuhaibani et al. 2021. Scope, quality and inclusivity of international clinical guidelines on mental health and substance abuse in relation to dual diagnosis, social and community outcomes. Accessed Feb 2023.

The ***Improving Access to Psychological Therapies (IAPT) Manual (2023)*** is a national programme developed to promote access to evidence-based psychological therapies from the NHS. IAPT does not provide drug or alcohol interventions and should only be delivered to a person using substances where their use will not hinder engagement. In circumstances where the substance use prevents engagement (e.g., misusing substances), this should be treated before the mental health concerns. IAPT recommend routine assessment of drug and alcohol use and where this is identified, IAPT and substance misuse services may work together to support the individual's needs. Reciprocal training is one way that collaborative working protocols can be developed.[99]

The ***Core20PLUS5 model*** is an NHS England approach to reducing health inequalities at national and local levels. The Core20PLUS5 approach has several elements and is comprised of:

- 'Core 20' – the most deprived 20% of the national population, defined by the Index of Multiple Deprivation.
- 'PLUS' – PLUS population groups are groups which have been identified to be affected by health inequalities for each local area.[100] PLUS also include 'inclusion health groups' which describes people who are socially isolated and have overlapping risk factors for poor health.[101]
- '5' – there are five national clinical areas of focus which require improvement. These differ for adults and for children. For adults, these are maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, and hypertension. For children, these are asthma, diabetes, epilepsy, oral health and mental health.

1.7.4 Key Reports and Guidelines

The ***Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide (2002)*** was published by the Department of Health. It summarised the emerging policy framework and good practice on the topic of mental health provision and services for people with mental health problems and problematic substance misuse. A key message in the document is that mental health services should take the lead responsibility for the care of people with severe mental health and substance misuse problems (known as 'mainstreaming'). This way of working, with clear pathways for individuals, was to reduce the likelihood of clients being shunted between services and losing contact with their service providers. Specialist support, consultancy and training should also be offered to mental health teams and substance misuse agencies, to improve integrated service provision and care.

Figure 5 is a quadrant model that explores associations between substance misuse and mental health problems. Each quadrant represents a different combination of 'high' and 'low' severity of substance misuse and mental health problems. By categorising patients into one of the four quadrants, it may provide more clarity over who should lead on treatment. For example, in the instance a patient has high severity of both substance misuse and mental health problems, their lead provision should be from acute mental health or joint working. If a patient has low severity of substance misuse but high severity of mental health problems, they should seek help from mental health services or joint working. If a patient has both low severity

[99] NHS. (2023) The Improving Access to Psychological Therapies Manual. Accessed Mar 2023.
[100] NHS England. Core20PLUS5 (adults) – an approach to reducing healthcare inequalities. Accessed Dec 2022.
[101] NHS England. Inclusion Health Groups. Accessed Jan 2023.

of substance misuse and mental health problems, they should seek help from their GP or through joint communication with drug and alcohol services. And finally, if a patient has high severity of substance misuse but low severity of mental health problems, they should seek help from drug and alcohol treatment services.

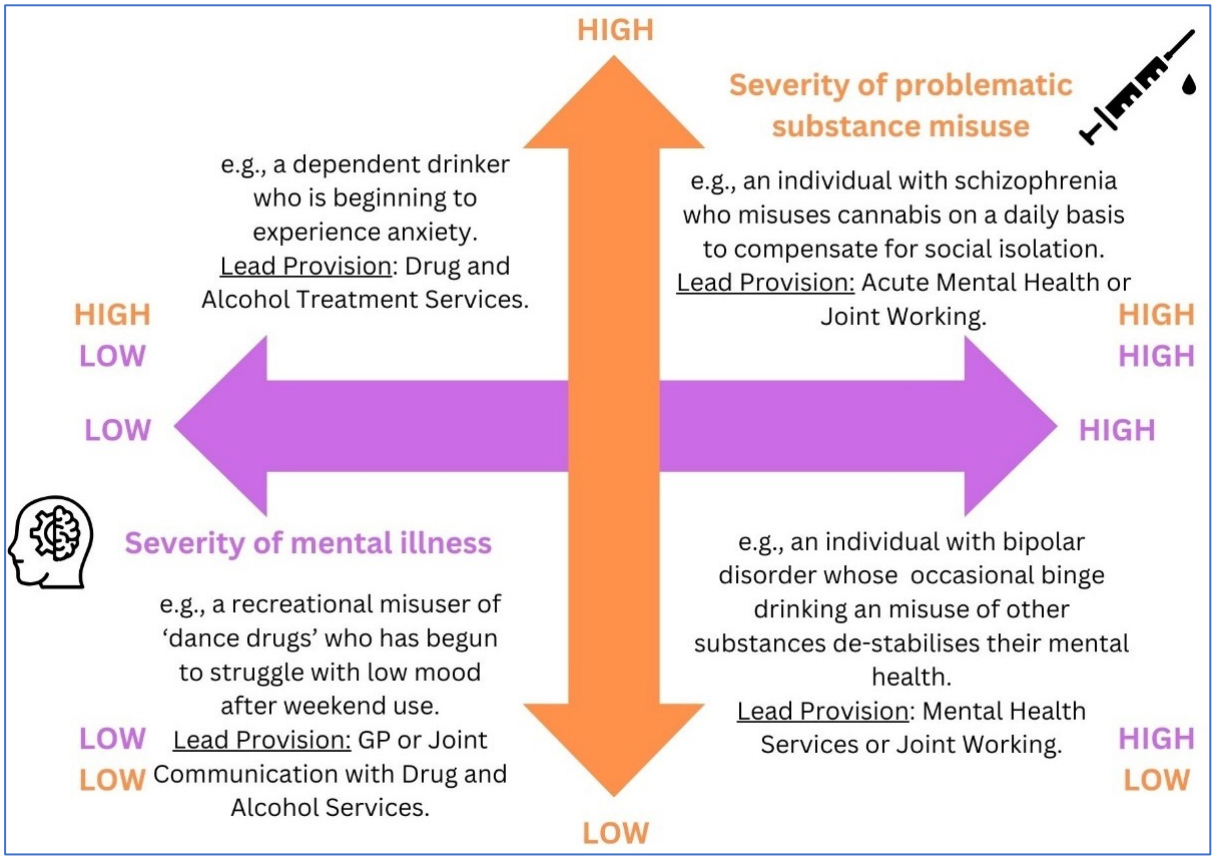


Figure 5: The Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide.[102]

Source: Created internally.

The Department of Health published the ***Dual Diagnosis in Mental Health Inpatient and Day Hospital Settings*** document in October 2006 and refers to all mental health provision, except those for children and young people with learning disabilities. One of the main aims and a key theme that underpins the guidance is the integration of drug and alcohol expertise and training in mental health service provision. A fundamental message communicated is that dealing with substance misuse is a core competence required by healthcare professionals in mental health service roles. Inequalities related to dual diagnosis are also recognised, with women and ethnic minority groups being cited as often being poorly served by mental health and drug and alcohol services.[103]

Published by the Department of Health and Ministry of Justice in March 2009, ***A Guide for the Management of Dual Diagnosis for Prisons*** recognises that dual diagnosis has a higher prevalence in prisons than in the general population. This document also acknowledges that the responsibility for dual diagnosis overlaps a number of the health and social care services

[102] Department of Health. (2002). Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide. Accessed Feb 2024.
[103] Department of Health. (2006). Dual diagnosis in mental health inpatient and day hospital settings. Accessed Jul 2022.

provided in prisons. The guidelines are therefore intended to be used as a framework that can be adapted by individual establishments to provide coordinated services to the client group in prisons.[104] Movement towards this approach can be seen in the latest iteration of the ***Service Specification for Integrated Substance Misuse Treatment Service Prisons in England (2018).***[105] Integrated service provision is at the core of this service specification.

Guidance for Improving Continuity of Care between Prison and the Community (2018) recognises the importance of an integrated care pathway from prison to the community to reduce rates of reoffending and support those in recovery from addiction. One of the ways this is monitored is through data showing the proportion of adults who have a substance misuse treatment need who engage with community treatment following release from prison. This has increased over time from 30.3% in 2015-16 in England (15.1%, Birmingham), to 42.6% in 2022-23 in England (36.7%, Birmingham).[106] Recommendations to improve continuity of care between prison and community settings included developing a standard referral form for use between prison and community settings, agreeing a referral protocol, contact from community providers with clients before their release from prison, reviewing the community provision, and improving links with relating services in order that referrals can be jointly coordinated.[107]

Public Health England published ***Better Care for People with Co-occurring Mental Health and Alcohol/Drug Use Conditions: A Guide for Commissioners and Service Providers (2017)*** to support the implementation of the *Five Year Forward View for Mental Health* recommendations. The guide aimed to support local areas in responding more effectively to people with dual diagnosis of all ages, primarily through encouraging co-working between commissioners and service providers. The main proposed benefit of this approach was that access to services for people with dual diagnosis would be improved. The document was underpinned by two key principles. The first was that tackling dual diagnosis is 'everyone's job', meaning that services should work together to reach shared solutions. The second principle was that there is 'no wrong door', meaning that service providers should have an open-door policy for people with co-existing mental health and substance misuse problems (i.e., that treatment for any of the co-occurring conditions is available through every contact point). The guide also highlights the importance of supportive care for carers of people living with co-occurring mental health and substance misuse conditions. It instructs practitioners to identify carers and family members who have 'unmet needs' and make relevant referrals for support (i.e., care assessments and/or family support services).[108]

The ***Drug Misuse and Dependence: UK Guidelines on Clinical Management (2017)*** acknowledge the high prevalence of co-occurring mental health problems in drug treatment and user populations. The authors stated that the co-existence of a drug problem should not preclude a service user from accessing the recommended treatment provided by mental health services. It is a necessity for some users to undergo treatment that includes a dual focus on substance misuse and mental health issues in an integrated treatment package. However, concerns are raised over the availability and implementation of specific dual-focused treatments. To overcome potential limitations, it is suggested that management of co-existing

[104] Department of Health. (2009). A Guide for the Management of Dual Diagnosis for Prisons. Accessed Oct 2023.
[105] NHS England. (2018). Integrated Substance Misuse Treatment Service Prions in England. Accessed Jul 2022.
[106] Public Health England. (2022-23). Indicator: Adults with substance misuse treatment need who successfully engage in community based structured treatment following release from prison (Persons, 18+ yrs). Accessed Nov 2023.
[107] Public Health England. (2018). Guidance for improving continuity of care between prison and the community. Accessed Nov 2023.
[108] Public Health England. (2017). Better care for people with co-occurring mental health, and alcohol and drug use conditions. Accessed Jul 2022.

mental health issues will need to be provided from mental health services using an integrated or parallel model.[109]

Young People Commissioning Support: Principles and Indicators (2018) recognised that many young people attending drug and alcohol services present with a range of vulnerabilities, with the most common substances being cannabis and alcohol. Young people's services should be aware of the links between alcohol and drug misuse with child sexual exploitation and abuse, and targeted prevention work should support those at risk of sexual exploitation. Services should continue to attempt engagement where a young person does not attend appointments, and clear working arrangements between mental health and substance misuse services should be in place for young people. Effective handovers to adult services, where required, should be carried out with a review involving the young person and the young people and adult service professionals.[110]

The Dame Carol Black Review (2020-21) was an independent review of drugs which informed the Government's approach in tackling harm caused by drugs and alcohol misuse. It examined the challenges posed by drug supply and demand and highlighted the declining quality and capacity of drug treatment services, with disproportionate premature death and entrenched drug misuse associated with deprivation.[111] The involvement of young people and children in drug supply and county lines were recognised, and has been associated with child poverty, school exclusions, and children in care. The number of children using drugs has increased over time and these children often have complex needs (including mental health needs) which require specialist treatment.

The second part of the review, commissioned by the *Department for Health and Social Care*, focused on prevention, treatment and recovery. It made a series of 32 recommendations for government, local government and other organisations. The review made direct reference to mental health, stating that '*for many people, mental health problems and trauma lie at the heart of their drug and alcohol dependence'*. The report stated that the workforce in both services should be trained to respond better to co-existing drug and mental health problems and ensure that individuals do not fall between the cracks.[112]

The briefing report ***Multiple Disadvantage and Co-occurring Substance Use and Mental Health Conditions (2022)***, informed by individuals across Making Every Adult Matter (MEAM) approach and Fulfilling Lives networks, focuses on the difficulty in access to support for people who have multiple disadvantage and dual diagnosis.[113] Multiple disadvantage manifests in a combination of experiences including homelessness, substance misuse, domestic violence, contact with the criminal justice system and mental ill health. For many these circumstances are the cumulation of long-term experiences of poverty, deprivation, trauma, abuse and neglect, racism, sexism and homophobia.[114] While there is no specific prevalence, it is known that dual diagnosis is common among people experiencing multiple disadvantage.

Research has estimated that most people undergoing drug (70%) or alcohol (86%) community treatment experience mental ill-health, and that 44% of community mental health patients

[109] Department of Health and Social Care. Drug misuse and dependence: UK guidelines on clinical management. Accessed Oct 2023.
[110] Public Health England. Young people commissioning support: principles and indicators. Accessed Mar 2023.
[111] Home Office. (2020). Review of drugs: phase one report. Accessed Jul 2022.
[112] Department of Health and Social Care. (2021). Review of drugs: phase two report. Accessed Jul 2022.
[113] MEAM. (2022). Multiple disadvantage and co-occurring substance use and mental health conditions. Accessed Nov 2023.
[114] MEAM. About Multiple Disadvantage. Accessed Apr 2024.

report drug or alcohol misuse.[115] Among those sleeping rough, evidence suggests that 82% have a mental health vulnerability, and 60% have a substance misuse need.[116]

Professionals reported on barriers to accessing support for people with dual diagnosis. Common reasons for inaccessibility and discharge from mental health services included not being eligible for mental health support until the substance misuse needs were addressed, missing appointments, attending appointments while intoxicated, and anti-social behaviour. Mental health professionals noted that treatment may be inaccessible due to complex behaviour of an individual, rather than their substance misuse itself, and mental health services can feel their offer is not suitable or able to meet a person's needs. In this case, people can be left between community services, where they may be thought of as too complex, but unable to access acute specialised services. This is further exacerbated by a lack of coordination between primary and secondary mental health care. There can also be additional barriers for different people linked with gender, sexuality, race or deprivation. The role of trauma was reported to be not considered enough among those with dual diagnosis, including a lack of trauma-informed care among services.

This report also highlighted enablers of access to support. One of these are specialist roles and teams, rather than mainstream service. Examples include dual diagnosis practitioners and mental health staff working with homeless people, who are able to take a holistic and flexible approach to support people. However, it was recognised that these roles are often only temporarily funded, often overstretched, and can reinforce exclusion from mainstream services for people with dual diagnosis. Another enabler to accessing services was cross-placements of staff in mental health and substance misuse services. Additionally, cross-sector training, joint commissioning, and system flexibility (e.g., allowing substance misuse services to refer people to mental health services without GP involvement) were also cited as enablers.[117]

The ***Substance Use Mental Health Resource Pack (2021)*** was published by Turning Point. This is a good practice guide for practitioners, which acknowledges the difficulties for those with dual diagnosis in receiving joined up support, often due to exclusion from mental health services. The Good practice guidance begins with engagement, involving an effective referral process (including a 'No Wrong Door' approach), and an early and joint assessment, which is of high quality. The guidance suggests that early and joint assessments are important for engaging individuals in treatment. Different examples of how this may work are outlined in this report, including having a Community Mental Health Team assessor joining the local substance misuse services for joined assessments, or having a Dual Diagnosis Nurse Consultant work with both substance misuse and mental health teams to provide a step-model of care, assessing clients for a step-up into specialist settings, or step-down into community settings.

Successfully supporting behaviour change involves supervision, training, expert advice, care co-ordination, joined treatment, continuity of care (particularly at key points of transition) and clear safeguarding procedures in place. Clear roles and responsibilities of those involved in the person's care should be confirmed, with information sharing agreements and a named

[115] Weaver et al. (2003). Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. Accessed Nov 2023.
[116] Ministry of Housing, Communities and Local Government. (2020). Understanding the Multiple Vulnerabilities, Support Needs and Experiences of People who Sleep Rough in England. Accessed Nov 2023.
[117] MEAM. (2022). Multiple disadvantage and co-occurring substance use and mental health conditions. Accessed Nov 2023.

care coordinator. Fundamental to this is the need for professionals who are equipped with the skills to support people with dual diagnosis. Those working in Improving Access to Psychological Therapies (IAPT) services may benefit from training to improve understanding of drugs and alcohol and the impact on mental health, because this workforce may be particularly well placed to support people with less severe mental health needs.

This guide also takes account of particular demographics, such as women with experience of intimate partner violence and sex workers and notes the importance of culturally appropriate services. Furthermore, the report recognises that separate funding has led to disjointed services and that there is a joint responsibility to meet the needs of citizens with dual diagnosis. Therefore, the guide recommends focusing on improving integration, rather than the creation of separate dual diagnosis services, which involves delivering treatment to address both the mental health and substance misuse needs simultaneously, in a joined-up package of care.[118]

In 2023, Turning Point launched a new online training resource which raises the awareness and understanding of co-existing substance misuse and mental health problems. This is a free training resource which is available to anyone, regardless of their level of knowledge or experience.[119]

1.8 Birmingham Strategies and Guidance

Local strategies are set out below, which set out Birmingham's commitment to tackling health inequalities and providing a strong evidence base to support commissioning of services. This strategic landscape ambitiously sets out to ensure the health and wellbeing of citizens, including improving wider determinants of health.

1.8.1 Birmingham's Levelling Up Strategy (2021)

Birmingham's Levelling Up Strategy (2021) is the city's contribution to the Government's goal of levelling up the country and recognised long-term and widespread inequalities within the city. It outlined the placed-based levelling up model, with East Birmingham's Inclusive Growth Strategy to link local and regional bodies and national government to address poor health, educational attainment, congestion and air population and to bring forward new homes and employment sites. The Levelling Up early intervention and prevention approach addresses inequalities people face. This includes the expansion of the neighbourhood networks and prevention first approaches to services including housing, to a wider population of adults aged 18-49 living with mental health conditions, among other health conditions and disabilities. Other actions include investment in community hubs, to connect citizens with resources and investment in digital inclusion.[120]

1.8.2 Birmingham Housing and Economic Needs Assessment (2022)

Birmingham's *Housing and Economic Needs Assessment* (2022) reported that in 2020 there were 445,275 dwellings in Birmingham, 55% of which were owner occupied housing. This is lower than the national average, with Birmingham having higher rates of social and private housing. This needs assessment included a survey of 1,800 local householders. 36.5% of all households reported that a member of the household had a disability (159,100 households). Of this 36.5%, the disability category 'mental health' represented 14.6% of responses (28,808 people) and was the second most common disability category after 'physical non-wheelchair'

[118] Turning Point. (2021). The SUMH Resource Pack. Accessed Dec 2023.
[119] Turning Point (2023). Turning Point launches Dual Diagnosis Training. Accessed Jan 2024.
[120] Birmingham City Council. Birmingham's Levelling Up Strategy. Accessed Nov 2022.

(49.4%). This survey also asked about childhood disability in Birmingham households, of which 3.9% of households responded 'yes'. Of this 3.9%, 10.7% of childhood disabilities related to mental health (2,993 children). Mental health was the second most common disability category after 'learning disability', which accounted for 37.9% responses of childhood disability.[121]

1.8.3 Birmingham Substance Use Needs Assessment (2022)

In 2021, Birmingham City Council developed a health needs assessment on drug and alcohol misuse, aiming to establish an evidence base to support the 2021-22 treatment planning process. The recommendations acknowledged the relationship between substance misuse and mental health and included making substance misuse a part of future needs assessments and deep dives on mental health, as well as enhancing pathways between substance misuse and mental health services. This needs assessment provided a necessary update on the 2013-14 publication[122] and lays the foundation for future strategic documents aiming to tackle the problems associated with dual diagnosis. This latest Substance Use Needs Assessment is yet to be published. However, the previous needs assessment on Substance Use from 2014 is available online.[123]

1.8.4 Triple Zero Strategy (2022)

Birmingham City Council developed a strategy in collaboration with public sector, local community and voluntary sector partners to reduce deaths and overdoses linked to drug and alcohol misuse by 2030. The draft strategy went out to public consultation in the summer of 2021. While the final strategy has not yet been published, a copy of the draft is available online.[124] The final *Triple Zero City Strategy* is due to be overseen by the *Health and Wellbeing Board*, and is based on three aspirations for the city; zero deaths due to drug or alcohol addiction, zero overdoses due to drug or alcohol addiction, and zero people living with any addiction without the support needed to manage it.

The authors accept that the aspirations are very ambitious, and many would argue impossible to achieve. However, rather than being targets, these statements are aspirational aims. Aiming for anything less would be a disservice to citizens and individuals, family and friends affected by addiction. The five themes of the Strategy are: Prevention and early intervention; Treatment, support and recovery; Children and young people; Additional challenges and complex needs; and Data and evidence.

Dual diagnosis primarily falls within the *additional challenges and complex needs* theme where a deep dive is suggested, alongside other potential approaches. These include additional targeted training and awareness to support engagement and referral for people accessing mental health or housing services, and the enhancement of pathways between substance misuse services and other services, such as the secondary mental health services.

[121] Birmingham City Council. Birmingham Housing and Economic Development Needs Assessment (HEDNA) Final Report. Accessed Nov 2022.
[122] Birmingham City Council. Public Health Birmingham Drugs and Alcohol Needs Assessment 2013-14. Accessed Jul 2022.
[123] Birmingham City Council. (2014) Public Health Birmingham Drugs and Alcohol Needs Assessment. Accessed Jun 2024.
[124] Birmingham City Council. Triple Zero City Strategy. Accessed Jul 2023.

1.8.5 Birmingham Joint Health and Wellbeing Strategy (2022-30)

The Health and Wellbeing Strategy is Birmingham's high-level plan for reducing health inequalities and improving health and wellbeing across the city.[125] There are five themes within the strategy:

- Healthy and Affordable Food
- Mental Wellness and Balance
- Active at Every Age and Ability
- Contributing to a Green and Sustainable Future
- Protect and Detect

These themes run along the life course, and they all aim to close the gap in inequalities. The Strategy recognises the significant gaps experienced by people living with mental health conditions and is committed to creating a mentally healthy city, where every citizen is supported to achieve good mental wellness and balance to navigate life's challenges. The aims of the core theme 'Mental Wellness and Balance' are to:

- Reduce the prevalence of depression and anxiety in adults to less than 12% by 2030.
- Reduce the suicide rate in the city to be in the lowest ten places in England by 2030.
- Reduce the emergency intentional self-harm rate to be within the lowest ten places in England by 2030.

1.8.6 A Bolder and Healthy Future for People of Birmingham and Solihull (2023-33)

This strategy sets out the vision of the Integrated Care Partnership and the priority areas for improvement over the 10 year period. Mental health was identified as one of the five clinical condition areas of focus in this strategy, along with circulatory disease, infant mortality, respiratory disease, and cancer. These clinical areas have been chosen as key conditions which affect life expectancy in Birmingham and Solihull. This strategy noted that in Birmingham and Solihull, 25 GP practices had a care plan in place for over 90% of patients with severe mental health issues, but also that 74 GP practices had care plans in place for under 50% of patients with severe mental health issues.[126]

[125] Birmingham City Council. Creating a Bolder, Healthier City (2022 to 2030). Accessed Nov 2022.
[126] Birmingham and Solihull Integrated Care System. 'A Bolder, Healthier Future for the People of Birmingham and Solihull'. . Accessed Aug 2023.

2 The Birmingham Picture

This section reviews the available data on Birmingham citizens living with dual diagnosis. Comprehensive prevalence data for dual diagnosis was not available for the local area. Therefore, an estimated prevalence was calculated, based upon the number of people in substance misuse treatment in Birmingham in 2023-24 who had a mental health condition (67.6%). To gain an understanding of the true prevalence in Birmingham (including unmet need), these figures were applied to those not in treatment, but estimated to need treatment. There were an estimated 30,409 citizens in Birmingham with a drug or alcohol misuse problem. Of these, 21,578 were not in treatment, including 14,587 citizens living with dual diagnosis. This estimated population of citizens living with dual diagnosis with an unmet need equates to 2.6% of citizens in Birmingham aged 15 years and over. The calculated prevalence estimates (including unmet need) do not include tobacco, as these were not included in the organisations' definitions of dual diagnosis the data were obtained from.

While an accurate local life expectancy is not known, research has suggested a reduction in life expectancy of between 15-20 years for those living with dual diagnosis. This estimate was applied to the 2020-22 life expectancy for Birmingham's general population, suggesting a reduction in life expectancy for all citizens with dual diagnosis to 60 to 65 years. There were over 1,157 deaths a year between 2014-22 in Birmingham where a dual diagnosis code was noted in the causes of death, with over two thirds of these citizens being male. Where a dual diagnosis code appeared on the death certificate, the most common main causes of death were mental health due to alcohol misuse, accidental poisoning from narcotics and psychodysleptics and liver diseases.

2.1 Methods for Estimating Prevalence

Dual diagnosis prevalence data is currently not available. Therefore, this research team used two methods to estimate prevalence. The first method calculated the number of people currently in substance misuse treatment with an identified mental health issue, providing a picture of the 'known need'. However, the second method estimated prevalence by looking at the 'unmet need' of drug misuse, identifying an overall estimate of substance misuse prevalence for the adult population and then applying the known percentage of identified mental health problems to the overall adult population.

2.2 Prevalence of Mental Health Conditions in Substance Treatment Services

The Diagnostic Outcomes Monitoring Executive Summary (DOMES) that is published by NDTMS was used to identify the number of Birmingham citizens in treatment for substance misuse, who also had an identified mental health condition (2023-24).[127] This equated to 67.6% of those in substance misuse treatment having a known mental health need (Table 4).

[127] DOMES Reports (2023-24). NDTMS - National Drug Treatment Monitoring System. Accessed Dec 2024.

Table 4: Percentage of Birmingham Citizens in Treatment with an Identified Mental Health Condition (2023-24).

Substance Group	Citizens in Treatment	Identified Mental Health Condition	Percentage
Opiate	3,605	2,226	61.7%
Non-opiate	1,096	687	62.7%
Alcohol	2,736	1,894	69.2%
Alcohol & non-opiate	1,394	1,166	83.6%
Total	**8,831**	**5,973**	**67.6%**

Source: NDTMS.[128]

2.3 Estimated Unmet Need

Local prevalence of unmet need was estimated using the most recent Alcohol and Drug Misuse and Treatment Services data (2020-21)[129] and Opiate and Crack Cocaine Use prevalence data (2020-21).[130] The overall prevalence of substance misuse in the Birmingham population aged 15 years and over was estimated to be 3.7%. When applied to Birmingham's 2021 Census data, this suggested that 30,409 citizens misused drugs and/or alcohol. Applying the prevalence of mental health conditions in substance misuse services (the 'known' need' (Table 4)) to the estimated drug and/or alcohol misuse population in Birmingham, suggested that there are 14,587 citizens living in Birmingham with dual diagnosis with an unmet need, equating to 2.6% of citizens aged 15 years and over. However, this estimate is only based upon drugs misuse in 15-64 year olds and alcohol misuse in over 18s.

2.4 Birmingham Children's Trust

During 2021-22, Birmingham Children's Trust carried out 14,185 care assessments led by social workers to gather information about the child and their family, to determine their needs and any risks to the child. During these assessments, 17,745 risk factors were identified. Risk factors linked to mental health and substance misuse are outlined in Table 5. Please note that multiple risk factors may be identified during an assessment.

Table 5: Risk Factors Identified in Birmingham Children's Trust Assessments (2021-22).

Risk Factor	Number
Mental health (parent)	2,182
Drug misuse (parent)	890
Alcohol misuse (parent)	799
Mental health (child)	587
Mental health (person)	278
Drug misuse (child)	185
Drug misuse (person)	162
Alcohol misuse (person)	89
Alcohol misuse (child)	65

Source: Birmingham City Council.[131]

[128] DOMES Reports (2023-24). NDTMS - National Drug Treatment Monitoring System. Accessed Dec 2024.
[129] GOV.UK. Alcohol and drug misuse and treatment statistics - GOV.UK (www.gov.uk) Accessed Mar 2023.
[130] GOV.UK. Opiate and crack cocaine use: prevalence estimates by local area Accessed Mar 2022.
[131] Birmingham City Council. JSNA Children and Young People. Accessed May 2024.

2.5 Contact with the Criminal Justice System

The Guidance for Improving Continuity of Care between Prison and the Community (2018) report recognises the importance of an integrated care pathway from prison to the community to reduce rates of reoffending and support those in recovery from addiction.[132] One of the ways this is monitored is through data showing the proportion of adults who have a substance misuse treatment need who engage with community treatment following release from prison. This proportion has increased in Birmingham from 15.1% in 2015-16 to 36.7% in 2022-23. In England this proportion has also risen from 30.3% in 2015-16 to 42.6% in 2022-23.

2.6 Life Expectancy

Unfortunately, it is not currently possible to accurately calculate life expectancy for Birmingham citizens who are living with dual diagnosis.

In Canada, Public Health Ontario estimated that their citizens with a co-morbidity of drug dependency and mental health have a life expectancy of 60 years.[133] In 2021, the Northern Ireland Assembly, whilst not giving a definitive age, suggested that life expectancy was between 15 to 20 years less than a person within the wider population without these conditions.[134] This was based on data from all of the UK nations, meaning that it reflects a national decrease in life expectancy for people with dual diagnosis. Based on the findings from a UK study, it is estimated that the life expectancy of people with mental health problems is reduced by 15-20 years and by 9-17 years in those with alcohol and drug misuse disorders.[135] If we apply the Northern Ireland Assembly findings to the 2021-23 ONS data for Birmingham, then the estimated life expectancy for men in Birmingham would decrease from 76.6 years (general population) to between 56.6 years to 61.6 years for male citizens living with dual diagnosis. The life expectancy for women in Birmingham would decrease from 81.3 years (general population) to between 61.3 to 66.3 years for female citizens living with dual diagnosis (Figure 6). Using 2020-22 estimates, the combined life expectancy for both genders would decrease from 80.1 years (general population) to between 60 and 65 years for citizens living with dual diagnosis.

[132] Public Health England. (2018). Guidance for improving continuity of care between prison and the community. Accessed Nov 2023.
[133] National Consortium of Consultant Nurses in Dual Diagnosis & Substance Use. Dual Diagnosis and Life Expectancy. Accessed Apr 2022.
[134] Black. (2021). Mental ill health and substance misuse: dual diagnosis. Accessed Apr 2022.
[135] Hayes et al. (2011). Associations between substance use disorder sub-groups, life expectancy and all-cause mortality in a large British specialist mental healthcare service. Accessed Jul 2022.

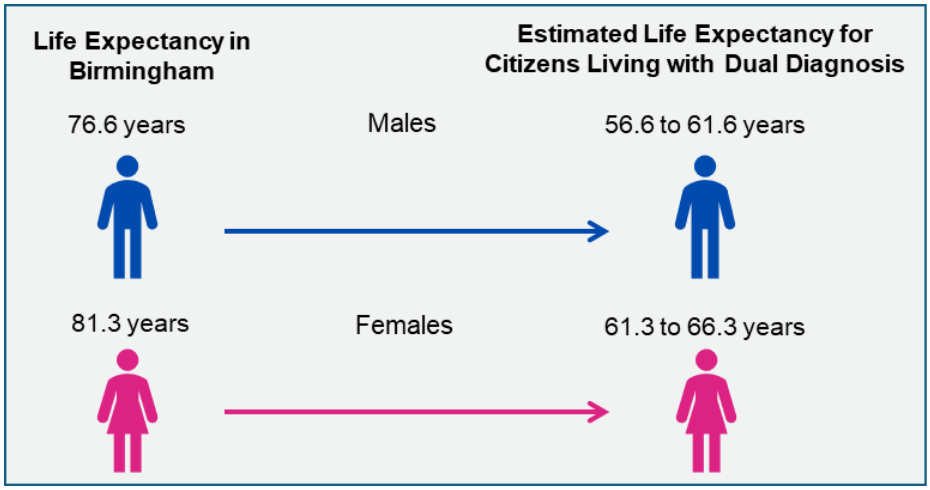


Figure 6: Estimated Life Expectancy for Birmingham Citizens Living with Dual Diagnosis.

Source: Internal estimates based on Northern Ireland Assembly[136] findings and Birmingham ONS data.[137]

2.7 Mortality Data

ICD codes provide two types of recorded deaths for dual diagnosis patients. These are codes F10 – F19, with cause of death code included in the registration, and codes X60 – X69 for patients who take their own life. These codes can appear as one of the causes of death in the case of a patient with dual diagnosis. However, this does not automatically mean that patients who take their own life would also have had a mental health condition. The codes F10 to F19 include tobacco among other substances, in line with the definition of dual diagnosis used in this report of co-occurring substance misuse and mental health conditions. As noted in section 1.4.1., we recognise that other organisations may not include tobacco in their definition of dual diagnosis.

Figure 7 provides a summary of dual diagnosis deaths between 2014-22, but only where the F code for dual diagnosis was referred to in causes of death in Birmingham. Over the 9-year period, there were a total of 1,157 deaths where a dual diagnosis code was mentioned in the causes of death, of which 170 included the dual diagnosis code as main cause of death. During this period, males consistently comprised over two thirds of deaths where dual diagnosis codes were included. It should be noted that Figure 7 only reflects the dual diagnosis codes and not all mental health conditions.

[136] Black. (2021). Mental ill health and substance misuse: dual diagnosis. Accessed Apr 2022.
[137] Department of Health and Social Care. Fingertips. Accessed Apr 2024.

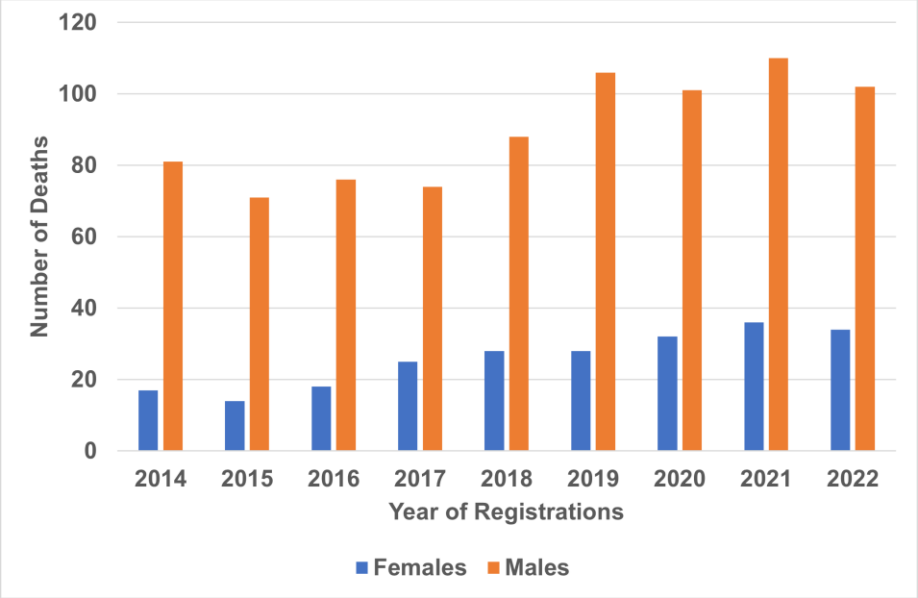


Figure 7: Birmingham Deaths where Dual Diagnosis ICD Codes (F10-F19) were Identified as Causes of Death, by Gender (2014-22).

Source: Internally calculated based upon data from NOMIS and NHS Digital (May 2024).

Table 6 highlights the main substance listed in deaths which included dual diagnosis as a cause between 2014-22, where alcohol is identified as the main form of substance misuse. In cases where dual diagnosis was listed as the main cause of death, alcohol again accounted for the highest proportion (77%).

Table 6: Main Substance mentioned as Cause of Death (2014-22).

Dual Diagnosis Causes of Death in Birmingham	Number of Deaths	Percentage
Mental health due to alcohol misuse	891	77.1%
Mental health due to tobacco misuse	101	8.7%
Mental health due to multiple drug use	93	8.0%
Mental health due to opioids misuse	26	2.2%
Mental health due to cocaine misuse	23	2.0%
Mental health due to cannabinoids misuse	19	1.6%
Mental health due to misuse of cocaine	2	0.2%
Mental health due to stimulant misuse	1	0.1%

Source: Internally calculated based upon data from NOMIS and NHS Digital (2024).

Table 7 summarises dual diagnosis deaths by age group during 2014-22. During this period, the majority of deaths in Birmingham for dual diagnosis occurred in the 35 to 64 age group (57.2%), whereas 32.3% of deaths occurred in the 65+ age group. This is significantly different to the average mortality age of the general population.

Table 7: Birmingham Deaths where Dual Diagnosis was Recorded, by Age Group (2014-22).

Age Groups	Number of Deaths	Percentage
15 to 24	23	2.0%
25 to 34	98	8.5%
35 to 44	180	15.6%
45 to 54	255	22.0%
55 to 64	227	19.6%
65 to 79	240	20.7%
80+	134	11.6%

Source: Internally calculated based upon data from NOMIS and NHS Digital (May 2024).

Table 8 provides a summary of the top ten causes of death for citizens with codes F10 to F19 (dual diagnosis) included in their death registration certificates. Mental Health due to alcohol misuse was the most common main cause of death (11.5%), with accidental poisoning by and exposure to narcotics and psychodysleptics the second most common main cause of death (8.8%). In Birmingham, premature deaths accounted for 82.3% of the deaths among citizens (aged under 75) with a dual diagnosis code on their death certificate.

Table 8: Top 10 Causes of Death in Birmingham where Dual Diagnosis Appeared on the Death Certificate (2014-22).

Main Causes of Death where F10 to F19 were included as a Cause	Number of Deaths	%
Mental health due to alcohol misuse	133	11.5%
Accidental poisoning by and exposure to narcotics and psychodysleptics (hallucinogens)	102	8.8%
Liver diseases	98	8.5%
Alzheimer's disease	57	4.9%
COPD	56	4.8%
Parkinson's disease	50	4.3%
Accidental poisoning by and exposure to alcohol	49	4.2%
Falls	48	4.1%
CHD	40	3.5%
Liver disease	35	3.0%

Source: Internally calculated based upon data from NOMIS and NHS Digital (April 2024).

2.8 Data Limitations

Throughout the process of researching this deep dive on dual diagnosis, the research team explored available data sources (including national and local data, both published and unpublished) to help build an accurate picture of need within Birmingham. Some limitations to the data presented in this deep dive report are discussed below, and these are drawn upon in the report's Key Finding 2: *There is currently insufficient data to allow a full understanding of dual diagnosis prevalence in Birmingham and the associated health and wellbeing needs.* Recommendations to build upon these limitations and support future data analysis to better identify citizens with dual diagnosis and associated inequalities are outlined in section 6.4.

Improving the data that is collected and analysed is essential to supporting an evidence-based approach. This data then needs to be shared and made available for public health research to further shape future commissioning priorities.

The data contained within this document has originated from several sources. However, much of the data that the research team has located is based on citizens currently in treatment and does not provide a defined prevalence of the overall Birmingham population, who have both a drug and alcohol problem. Consequently, defining local prevalence has been a major difficulty to this research.

National prevalence for those with dual diagnosis (drug and mental health problems) is provided at various age ranges but does not provide an overall prevalence. NICE guidelines highlight that this is in part made difficult to ascertain by varying definitions of dual diagnosis in the literature, meaning that there are also no clear prevalence figures for different types of diagnoses, ethnicity groups or other demographics (e.g., LGBTQ+ and ethnic minorities). NICE recommend that longitudinal representative research is required to establish the prevalence of dual diagnosis and the epidemiology, in relation to social determinants, treatment and outcomes.[138]

There is a need for an accurate prevalence of dual diagnosis to be calculated and monitored to enable both 'known', and 'unmet' need to be identified, at both a national and local level, for all ages. Strategies to support this include:

- Consistent recording of citizens with dual diagnosis in GP routine data by establishing a read code which may be triggered when a mental health condition and substance misuse are both detected on a patient's record. This may support the accurate identification of local prevalence and enable access to services and support where needed.
- Recording of citizens living with dual diagnosis who have experience of other adversity (e.g., domestic abuse, homelessness, sex working) within GP routine data, to enable identification of unmet need and make relevant referrals for support.
- Creation of a dual diagnosis identification code which could be used consistently across health services.

Projected data around citizens with dual diagnosis, including projections of 'known' and 'unmet' need, would be helpful to commissioners, public health and others by providing an estimation of size and type of need. However, this is currently lacking at both the local and national level. If available, this information would support public health in predicting future numbers of residents who would need to utilise both the drugs and mental health services, thus enabling more effective service planning to meet this need. Therefore, there is a need for projections to be developed at both a national and local level to effectively plan services for citizens living with dual diagnosis.

The authors of this deep dive had access to qualitative data relating to parents with dual diagnosis who were undergoing treatment. However, there was no data available to provide an understanding of the needs of parents and their children who were not in contact with services, which has led to an incomplete picture of need. It is understood that while this information may be stored in the case notes of children in care, this data is not easily accessible, and therefore was not available for this deep dive research. Consistent recording

[138] NICE. (2011). Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings. Accessed Mar 2023.

of parental status of citizens with dual diagnosis, as well as their carers and family members by GPs may enable a more accurate identification of these individuals, enabling access to services and support where needed.

3 Health and Wellbeing Needs of Citizens Living with Dual Diagnosis

Health inequalities are the differences in health status between different groups of the population and are often avoidable. Citizens living with dual diagnosis face significant health inequalities and stigma, which can exacerbate the detrimental effects of co-existing mental health and substance misuse disorders. These inequalities may include barriers in access to health care and inadequate care that is not inclusive of their needs. Citizens living with dual diagnosis are also more likely to face difficulties with education, employment, accommodation, sexual abuse, personal relationships and general health compared to people with a single diagnosis of mental health issues or a substance misuse problem.[139]

3.1 Drug Classes and Uses

Drugs are classified as Class A, B, or C, according to an assessment of their relative harms. These classifications are coupled to a hierarchy of sanctions, with harsher prison sentences and fines for criminal offences involving drugs in higher classifications.[140] Class A includes cocaine, heroin, MDMA, LSD, morphine and some Class B drugs prepared for injection. Class B includes oral amphetamines, ketamine, barbiturates, cannabis and codeine. Class C includes most benzodiazepines, anabolic steroids, khat, gabapentin and pregabalin.

Many different types of substances are relevant to this deep dive. They include, cannabis, club drugs, cocaine, opioids, anabolic steroids, psychoactive substances, khat, prescription medication, alcohol and substances used in chemsex.

There are many reasons as to why people may use substances and subsequently may develop a substance misuse disorder. These can be categorised under two main themes: positive reinforcement (the pursuit of pleasure) and negative reinforcement (escape from pain). Examples of positive reinforcement include alleviating boredom, thrill seeking and feeling like part of a community if you otherwise feel socially excluded. Examples of negative reinforcement include reducing physical pain and using substances as a coping mechanism for stressful and difficult situations (e.g., domestic abuse or homelessness).[141]

There are also different types of substance use, that have varying impact on a person's daily life:

- Socially acceptable use – this is viewed as 'normal' consumption and behaviour.
- Functioning use – this might be viewed as problematic from the outside, but the individual can still function day to day.
- Experimental – this is when a person will begin to explore different drugs, what reaction they may have to them and the social aspects of drug use.
- Recreational – this type of substance use is when drug taking becomes part of a person's lifestyle. For example, the use of ecstasy and other 'dance drugs' on weekends.
- Binge – this is when a person will consume a large amount of drugs in a short period of time but often less frequently than those who use drugs regularly.

[139] Banerjee et al. (2002). Co-existing Problems of Mental Disorder and Substance Misuse. Accessed Jul 2022.
[140] GOV.UK (1971) Misuse of Drugs Act. Accessed Jul 2022.
[141] Turning Point. Substance Use and Mental Health Training. Accessed Jan 2024.

- Polydrug – this term refers to using more than one drug or type of drug at the same time or one after another.
- Dependent (physical or psychological) – this is when a person continues to use drugs in order to avoid unpleasant withdrawal symptoms.[142]

3.1.1 Smoking and E-Cigarettes

National treatment statistics show that the prevalence of smoking is higher in both men and women accessing substance misuse treatment, irrespective of the substance they are misusing, compared to the general population. For those starting treatment in 2021-22, 53% had smoked tobacco in the previous month. In comparison, smoking rates in the general population are 15.8% for men and 12.1% for women.[143] Smoking has also been shown to be higher among those with severe mental illness than in the general population. Data for 2022 showed that 12.6% of adults in Birmingham smoked, which was higher than across England (12.7%).[144] Data from 2014-15 showed that 40.4% of adults in Birmingham with a serious mental illness smoked.[145] More recent data from 2022-23 showed that in England, 25.1% of adults with a long-term mental health condition smoked.[146]

Electronic cigarettes are also known as 'vapes' or 'e-cigarettes'. In 2022, young people aged 16-24 years were most likely to report daily or occasional vaping (15.5%), with the rate decreasing as the age range rose (i.e., 25-34 years (10.6%), 35-49 years (9.5%), 50-59 years (8.5%) and those aged 60+ (4.4%)).

In 2021, 9% of school pupils in England reported being current e-cigarette users, and 22% reported ever having used them. There was a relationship between smoking and vaping, whereby pupils who had ever smoked were more likely to have used e-cigarettes.[147]. A systematic review found vaping was associated with depression, suicidality, disordered eating, impulsivity, perceived stress, in addition to ADHD among young people. Children and young people have also been suggested to be more vulnerable to illegal vapes which do not comply with safety regulations in the UK. E-cigarettes also raise concerns about renormalising smoking, increasing the uptake of smoking and becoming a gateway to traditional tobacco consumption among young people. However, there has been mixed evidence whether this is occurring.[148]

Although there is evidence of lower health risks associated with e-cigarettes compared with traditional cigarettes, the World Health Organisation have warned of adverse health impacts of vaping among children, adolescents and pregnant women.[149] Therefore, vaping is not recommended for children and young people or non-smokers, due to the recognition that any smoking can be harmful and that the long-term effects of vaping are yet to be determined.[150]

While it is illegal to sell vapes to anyone under 18 years, there is evidence that the use of vapes among children and young people is rising. In 2023, 11-17 year olds reported that the most common way to access vapes was through shop purchases (48%) and being given

[142] Turning Point. Substance Use and Mental Health Training. Accessed Feb 2024.
[143] OHID. (2022). Adult substance misuse treatment statistics 2021 to 2022: report. Accessed Mar 2024.
[144] OHID. Smoking prevalence in adults (18+) – current smokers (APS). Accessed Mar 2024.
[145] OHID. Smoking prevalence in adults (18+) with serious mental illness (SMI) 2014/15. Accessed Mar 2024.
[146] OHID. Smoking prevalence in adults with a long term mental health condition (18+) – current smokers (GPPS). Accessed Mar 2024.
[147] NHS Digital. (2022). Smoking, Drinking and Drug Use among Young People in England, 2021. Accessed Mar 2024.
[148] House of Commons Library. (2024). Vaping and Health. Accessed Mar 2024.
[149] House of Commons Library. (2024). Vaping and Health. Accessed Mar 2024.
[150] NHS. Vaping to quit smoking. Accessed Mar 2024.

vapes (46%). Disposable vapes were the most frequently used device by young people (69%), which has risen significantly since 2021 (7.7%), creating a waste problem due to containing single use plastics which require proper disposal.[151] In early 2024, the Government announced new plans to tackle the use of vapes among children and young people. These include a ban on disposable vapes in the UK, a restriction on vape flavours and the use of plainer packaging. New fines are also planned for shops in England and Wales which sell vapes illegally to children.[152]

The Royal College of Paediatrics and Child Health note that paediatricians have a role in discouraging young people from using vapes and to take preventative action against its uptake.[153] NICE guidance [NG209] recommends that e-cigarettes should be included in schools' curriculum on tobacco, alcohol and drug misuse. The use of e-cigarettes should be discouraged, and clear information should be provided explaining why children and young people who are non-smokers should avoid e-cigarettes.[154]

Action on Smoking and Health released national vaping guidance for schools in 2022, stating that vaping is not for children and those who do not smoke should not vape. Despite this, children who have used vapes may have also tried smoking and vaping is less harmful than smoking. School curriculums should be informed by the evidence, showing that young people aged 16-18 years are most likely to take up vaping. Young people should not be excluded from schools for vaping or smoking alone and those under 18 should be asked about how they sourced these. Vapes may be one way in which vulnerable children may be exploited and staff should be aware of this.[155]

3.2 Risk Factors for Dual Diagnosis

This section reviews factors which may lead to or exacerbate mental health and substance misuse problems. Some demographics within the population may be more likely to experience poor mental health or substance misuse, and although these factors are not deterministic at an individual level, at a population level there may be a higher risk of experiencing dual diagnosis for these people. There are also wider determinants of health (e.g. housing) which may interact with a person's mental health or substance misuse in differing ways, because these may be both causes and consequences of poor health and wellbeing but may also provide a positive effect.

3.2.1 Age

In 2022, drug misuse data for England and Wales showed that young people (aged 20-24) represent the highest percentage of drug users. The data also shows a steady decrease in drug use associated with increased age. For example, the oldest age group (55-59 years) represented the lowest percentage of drug users (Figure 8).[156]

[151] Royal College of Paediatrics and Child Health. (2023). Policy Briefing: Vaping in young people. Accessed Mar 2024.
[152] Gov.UK, (2024). Disposable vapes banned to protect children's health. Accessed Mar 2024.
[153] Royal College of Paediatrics and Child Health. (2023). Policy Briefing: Vaping in young people. Accessed Mar 2024.
[154] NICE guideline [NG209]. (2021). Tobacco: preventing uptake, promoting quitting and treatment dependence. Accessed Mar 2024.
[155] ASH. (2022). New national vaping guidance for schools released by Action on Smoking and Health. Accessed Mar 2024.
[156] Office for National Statistics. Drug misuse in England and Wales: June 2022. Accessed Feb 2023.

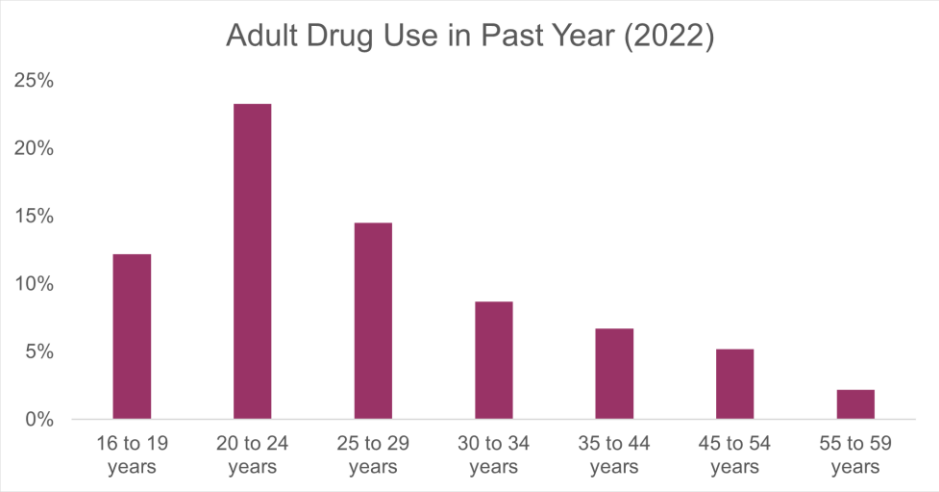


Figure 8: Proportion of Adults Who Reported Using a Drug in the Last Year by Age (England and Wales, 2022).

Source: ONS.[157]

According to WHO, one in seven 10-19 year olds experiences a mental disorder. The risk of dual diagnosis in adulthood is increased by substance misuse or mental health issues during adolescence.[158] Another estimate, from 2023, reported that in England, one in 5 children and young people (8-25 years) had a probable mental health disorder.[159] This is higher than previous estimates suggesting that one in nine children aged 5-16 years had a probable mental health disorder in 2017 increasing to one in six in 2020.[160] In 2016, 19% of 11-15 year olds had smoked, 44% had drunk alcohol and 24% had taken drugs.[161]

Hospital admissions due to self-harm appear to be higher among young people aged 15-19 years (641.7 per 100,000) compared with 10-14 years (307.1 per 100,000) and those aged 20-24 years (340.9 per 100,000).[162]

The research on dual diagnosis has been limited for older people, focusing on younger age groups. Studies have shown that dual diagnosis in older adults is underdiagnosed, despite high rates of co-morbidity.[163] The potential for underdiagnosis may create a 'hidden population' of older adults with co-occurring mental health and substance misuse disorders.[164] ONS statistics show that age specific alcohol-related death rates were highest for those aged 55 to 59 and that the highest rate of drug-related deaths was in those aged 45 to 49 years.[165]

Drug misuse is a concern for older people, with more prescribed medicines than other age groups leading to a higher rate of exposure to potentially addictive medications and the potential for accidental misuse. A study of older adults showed common mixing of prescription medicines, non-prescription drugs, and dietary supplements, with around 1 in 25 at risk for a major drug interaction. Another study of patients aged 50+ found that over a quarter who

[157] Office for National Statistics. Drug misuse in England and Wales: June 2022. Accessed Feb 2023.
[158] Subodh et al. (2019). Age of onset of substance use in patients with dual diagnosis and its association with clinical characteristics, risk behaviours, course, and outcome: A retrospective study. Accessed Jul 2022.
[159] NHS England. (2023). One in five children and young people had a probable mental disorder in 2023. Accessed Apr 2024.
[160] NHS Digital. (2020). Mental Health of Children and Young People in England, Accessed May 2024.
[161] NHS Digital. (2017). Smoking, Drinking and Drug Use Among Young People in England – 2016. Accessed Mar 2023.
[162] OHID. Children and Young People's Mental Health and Wellbeing. Accessed Feb 2024.
[163] Searby et al. (2020) Improving Care Provision to Older Adults with Dual Diagnosis: Recommendations from a Mixed-Methods Study. Accessed Jul 2022.
[164] Searby et al. (2015). Dual Diagnosis in Older Adults: A Review. Accessed Jul 2022.
[165] ONS. (2022). Alcohol-specific deaths in the UK: registered in 2020. Accessed Jul 2022.

misuse prescription opioids or benzodiazepines expressed suicidal ideation, compared to 2% who do not use them.[166]

3.2.2 Gender

In 2020, drug misuse in the previous 12 months was reported to be higher among men (11.9%) than women (6.9%) in England. Figure 9 shows the gender breakdown, by type of drug misused.[167]

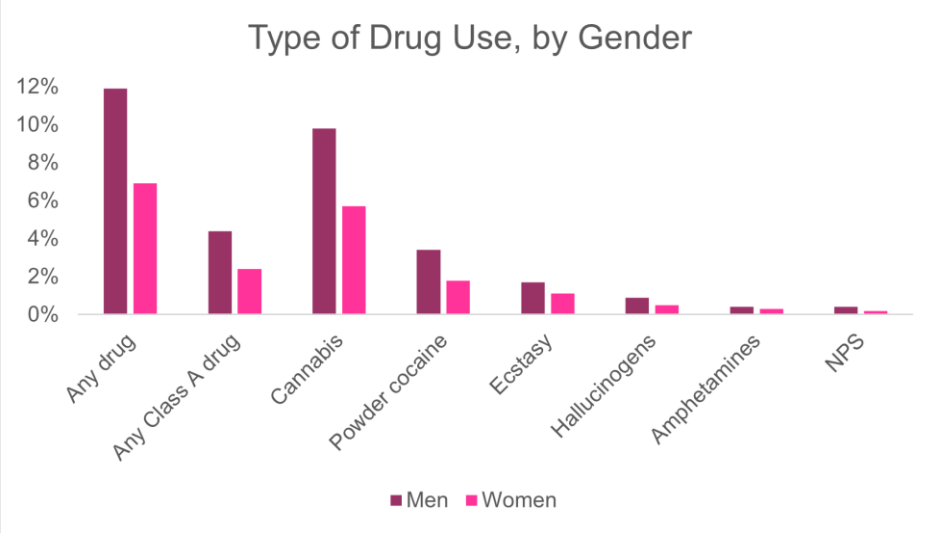


Figure 9: Proportion of Adults (Aged 16 to 59) Who Reported using a Drug in the Last Year, by Type of Drug and Gender (England and Wales (2020).

Source: ONS.[167]

Figure 10 contains ICD-10 mental health data on Birmingham patients by gender. In total, there were 11,631 patients who entered hospital in Birmingham with a mental health condition between April 2018 and March 2023. The majority of the patients were male (52.8%; n=6,137) and 47.2% were female (n=5,494).

The most common mental health condition among male patients were disorders due to substance use (n=2,654), representing 43.2% of male patients. The majority of patients in this category were male (74.5%), while 25.5% were female. The most common condition among females were organic mental disorders (n=1,440), representing 20.7% of female patients. Females accounted for 59% of patients with organic mental health disorders. while males accounted for 41%.

[166] NIH National Institute on Drug Abuse. Substance Use in Older Adults Drug Facts. Accessed Jul 2022.
[167] Office for National Statistics. Drug misuse in England and Wales: March 2020. Accessed Feb 2023.

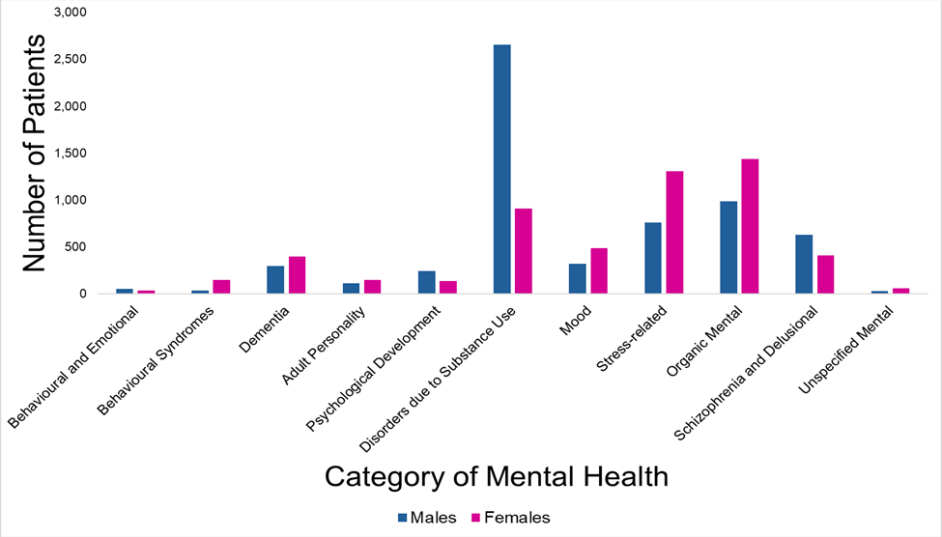


Figure 10: Patient Gender Split, by Mental Health Groups (ICD10) 2018-23.

Source: Internally calculated from NHS HES Inpatients data.

Figure 11 contains ICD-10 mental health data on Birmingham hospital admissions, by gender. Please note that this data represents hospital admissions where mental health conditions were the main cause of admission, and is therefore not representative of all admissions where the patient had mental health conditions in their secondary causes for entry into hospital. In total, there were 13,370 hospital admissions for mental health conditions between April 2018 and March 2023. This number is higher than the number of patients, because patients may have had more than one admission during this period. The majority of admissions were for male patients (54%; n=7,265) and 46% were for female patients (n=6,105). The largest mental health category for male admissions was mental health disorders due to substance use (n=3,510), representing 48% of male admissions. The largest category for female admissions were organic mental health conditions (n=1,511), representing 25% of female admissions.

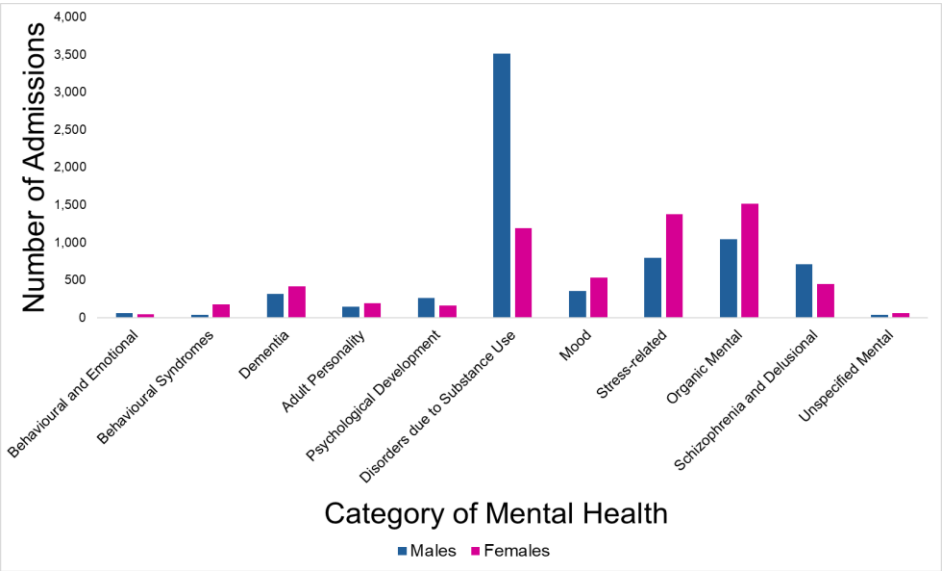


Figure 11: Admissions Gender Split, by Mental Health Groups (ICD10) 2018-23.

Source: Internally calculated from NHS HES Inpatients data.

Research published in 2019 focused on the mental health needs of prisoners in the UK and gender differences. Female prisoners were significantly more likely to report a prior mental

health diagnosis and be in contact with mental health services, compared to males. Overall, females showed higher rates of comorbidity (e.g., multiple disorders) than males. Furthermore, males were more likely to be identified as having a gap in unmet mental health need (through reporting a mental health need, but having no contact with mental health services), than females.[168]

An example of an all-female residential facility is Ophelia House located in Oxfordshire. Ophelia House is a facility offering abstinence-based residential substance misuse treatment with the aim for residents to create healthy attachments, provide positive peer support, strengthen self-expression, and help women develop skills. The female only model has been designed and developed using evidence and best practice around trauma-informed care. Staff are trained to recognise and respond to signs of trauma, for example, if a woman has been subjected to intimate-partner violence or sexual abuse.[169]

3.2.3 Children, Young People and Families

The topic of dual diagnosis with respect to children and young people is complex. Children are vulnerable to harms associated with dual diagnosis if their parent(s)/carer(s) has co-existing mental health and substance misuse problems. Dual diagnosis issues can begin in childhood, with mental health issues and trauma causing significant challenges that can extend throughout their lives.[170,171] Children with parents who have co-existing mental health and substance misuse problems are at higher risk of entering care earlier and staying in care for longer,[172] suffering abuse and neglect, and developing their own mental health, substance misuse and behavioural problems.[173]

Based on national estimates (2022-23), 12,418 young people in England (aged under 18 years) were in contact with treatment services for substance misuse. This is a 10% increase from the previous year (n=11,326) but a 13% reduction in the number in treatment since 2019-20 (n=14,291). The percentage of younger children (children under the age of 14) in treatment was 10% (n=1,188 young people). Of immediate concern is that 48% of young people in England starting their substance misuse treatment between 2022-23 declared having a mental health treatment need. This continues a rising trend, having risen each year since 2018-19 (32%). 71% of young people who had mental health treatment need received some form of treatment, usually from a community mental health team. 59% of young people were already engaged with a mental health service at the start of their substance misuse treatment. However, 29% of young people that had a mental health need identified didn't receive treatment or refused treatment. Data on mental health needs also show sex-specific differences, with a higher proportion of girls accessing substance misuse treatment reporting a mental health treatment need (74%) than boys (69%).[174] In comparison to young people, adults in substance misuse treatment who had a mental health need were more likely to be receiving any treatment for this (79% vs 71%).[175]

[168] Tyler et al. (2019). An updated picture of the mental health needs of male and female prisoners in the UK: prevalence, comorbidity, and gender differences. Accessed Feb 2023.
[169] Phoenix Futures. Ophelia House. Accessed Jan 2024.
[170] St Mungo's. Lived experience of dual diagnosis. Accessed Aug 2022.
[171] Cullen & Norton. (2021). Chicken or egg: A dual diagnosis narrative. Accessed Aug 2022.
[172] Semidei et al. Substance abuse and child welfare: clear linkages and promising responses. Accessed Jul 2022.
[173] Hegarty. (2005). Supporting children affected by parental dual diagnosis. Accessed Jul 2022.
[174] GOV.UK. (2023). Young people's substance misuse treatment statistics 2021 to 2022: report. Accessed Feb 2024.
[175] OHID. (2023). Adult substance misuse treatment statistics (2022 to 2023 report). Accessed May 2024.

3.2.4 Childhood Adversity

Adverse childhood experiences are preventable and potentially traumatic experiences and have been described widely in the literature. Originally, categories of adverse childhood experiences were narrow and included abuse (physical, emotional or sexual), neglect (physical or emotional), or household challenges (e.g., mental illness, divorce or substance abuse). However, adverse childhood experiences are not limited to these categories. Research has suggested that children experiencing multiple childhood adversities may be at an increased risk of mental ill-health and substance misuse later in life.[176] While understanding the impact of childhood adversity is important, it is also necessary to understand factors which can minimize it. These include educational opportunities and the development of life skills that support young people in coping with negative emotions and stress, in addition to the provision of interventions, such as counselling, family programmes which work with parents and families to build skills and nurture relationships.[177]

3.2.5 Sexual Orientation and Gender Identity

The diversity of user experiences with regards to dual diagnosis should be recognised and cared for, particularly for marginalised groups such as people in sexual minority groups. Individuals with dual diagnosis who identify as lesbian, gay, bisexual, transgender, queer or questioning (LGBTQ+) may experience additional stress and stigma as they face society's prejudice towards them. Furthermore, the social rejection, judgement, victimisation, and isolation often felt by the LGBTQ+ community may be implicated in the pathogenesis of dual diagnosis.[178]

In 2018, Stonewall conducted a large-scale survey which found that just over half of LGBT people had experienced depression in the previous year. This survey also showed that trans people had a higher likelihood of reporting that they had thought about taking their own life in the previous year (46%) in comparison to lesbian, gay or bisexual non-trans people, which also remained high (31%). This report highlighted the often-neglected health needs of LGBT persons by healthcare professionals, with 13% of respondents having experienced unequal treatment due to being LGBT, rising to 32% for trans people. This highlights that negative experiences and lack of trust of healthcare providers are barriers to accessing these services for this group. Alcohol consumption was higher among older LGBT people compared to younger people. 33% of those aged over 65 said they drank almost every day, compared with 7% of those aged 18 to 24 years. Drinking was higher among gay, bisexual and trans men (20%) compared to LGBT women (13%) and non-binary people (11%). However, drug misuse was higher among younger age groups. For example, 13% of those aged 18-24 years reported taking drugs at least once a month, and this was 1% among those aged 65+.[179]

[176] Birmingham Children's Trust. (2023). Practice Model Handouts v05.05.23. Accessed Internally Oct 2023.
[177] Public Health Wales. Tackling Adverse Childhood Experiences (ACEs). State of the Art and Options for Action. Accessed Oct 2023.
[178] Lee et al. (2016). Discrimination, Mental Health, and Substance Use Disorders Among Sexual Minority Populations. Accessed Jul 2022.
[179] Stonewall. (2018). LGBT in Britain: Health Report. Accessed Feb 2023.

"There is a lot of alcohol flowing around within the community. And a lot of drugs. It seems like when people meet to socialise whether it's the weekend or midweek, it's focused on alcohol."

Birmingham LGBTQ+ Citizen with Dual Diagnosis

"At 14-15 I was hit with the realisation that I was attracted to the same sex. I had nowhere to go or nobody to speak to about it. I started drinking at home when I was around that age."

Birmingham LGBTQ+ Citizen with Dual Diagnosis

3.2.6 Ethnicity

Data from 2014 in England shows that more black (11.7%) and white British adults (8.9%) had used illicit drugs in the previous year than Asian adults (3.4%).[180] Other data from 2014 reported that black women (29.3%) were more likely to report a common mental health disorder than other women, followed by 'mixed other' (28.7%), Asian women (23.6%), white British (20.9%) and other white ethnic groups (15.6%). However, the differences in the prevalence of common mental health disorders among men from different ethnic groups were smaller. The highest prevalence was reported among black (13.5%) and white British (13.5%), followed by white other (13.1%), Asian (12.9%) and 'mixed other' (10.5%).[181]

The use of the Mental Health Act has been shown to be disproportionately used among black Caribbean, black African and black British people. It has been suggested that people from an ethnic minority background may be more likely to encounter structural inequalities, which interact with risk factors for mental health problems. These structural inequalities include experiencing poorer housing, socioeconomic deprivation, experiences of racism and substance misuse.[182]

3.2.7 Neurodivergence

Neurodivergence is a noun that identifies cognitive functioning that is considered different to the predominant neurotype (i.e., that some people think and process information in a different way to others). Someone whose brain functions differently to what is typical may be described as 'neurodivergent', which is an adjective that describes people that have neurodivergence. Neurodivergent people may have conditions such as attention deficit hyperactivity disorder (ADHD), autism, dyscalculia, dyslexia and dyspraxia.[183-184]

ADHD is a neurodivergent condition that impacts on behaviour and concentration.[185] A bi-directional link between ADHD and substance misuse disorder has been reported, with increased rates of substance misuse disorders within ADHD populations and increased rates of ADHD within substance misuse disorder populations.[186] ADHD is associated with increased risks of psychiatric disorders, including mood and anxiety disorders, personality disorders and substance misuse disorders.[187]

[180] Gov.UK. (2017). Illicit drug use. Accessed May 2024.
[181] Gov.UK. (2017). Common mental disorders. Accessed May 2024.
[182] UK Parliament Postnote. (2022). Mental Health Act Reform – Race and Ethnic Inequalities. Accessed Feb 2023.
[183] NHS Dorset. Language Guide. Accessed Nov 2024.
[184] The Brain Charity. Neurodivergent, neurodiversity and neurotypical: a guide to the terms. Accessed Nov 2024.
[185] NICE. (2021). Clinical Knowledge Summaries. Attention deficit hyperactivity disorder. Accessed Jul 2022.
[186] Huntley et al. (2012). Rates of undiagnosed attention deficit hyperactivity disorder in London drug and alcohol detoxification units. Accessed Jun 2022.
[187] Sobanski. (2006). Psychiatric comorbidity in adults with attention-deficit/hyperactivity disorder (ADHD). Accessed Jul 2023.

3.2.8 Learning Disabilities

Mental health problems are particularly common among people living with learning disabilities. Data from GP records indicate that the prevalence of severe mental illness is significantly higher for people living with learning disabilities (7.5%), compared to the general population (0.9%).[188] Research has found that having a mental health problem is a risk factor for developing a 'substance related problem' among people with learning disabilities. Other risk factors include living independently, having a mild learning disability, and being young and male.[189] It has also been suggested that those with mild learning disabilities may be most likely to misuse alcohol or drugs compared with more severe learning disabilities. Despite evidence suggesting that the prevalence of substance misuse is lower among people with learning disabilities than the general population, it has been suggested that those who do (particularly with alcohol use) may be at an increased risk of developing a problem.[190]

3.2.9 Armed Forces and Veterans

Rates of alcohol misuse and post-traumatic stress disorder (PTSD) are higher among veterans than the general public. In a UK sample, 1.8% met the criteria for both alcohol misuse and PTSD.[191] Alcohol misuse is associated with PTSD and other mental health problems and can have a significant impact on treatment. In a sample of nearly 400 male veterans, two thirds of whom were unemployed, over half of the treatment-seeking veterans reported hazardous or harmful alcohol misuse. Additionally, this group were more likely to report dependence on alcohol and alcohol-related harms when compared with both a group of UK Armed Forces and the general population. Among the veterans, higher levels of hazardous consumption and alcohol dependence were linked to being single, whereas being older and unemployed was associated with reduced alcohol misuse and hazardous consumption. Meeting the criteria for PTSD and having other mental health problems was associated with higher alcohol misuse and dependence.[192]

3.2.10 Criminal Justice System

According to Wright and colleagues,[193] patients with dual diagnosis are more likely to have a lifetime history of offending and violence than patients with psychosis only. Individuals with dual diagnosis may also come into contact with the criminal justice system as victims. Research has shown that people with dual diagnosis are more likely to have been a victim of violence (60% vs 11%), property crime (58% vs 30%), and vandalism (21% vs 14%) than the general population.[194]

Despite the recognition of dual diagnosis being a key challenge for criminal justice systems, there is still a lack of reliable dual diagnosis data within the prison system. Detection rates of

[188] NHS digital. Health and care of people with learning disabilities. Accessed Dec 2021.
[189] Taggart et al. (2006). An exploration of substance misuse in people with intellectual disabilities. Accessed Mar 2022.
[190] Public Health England. (2016). Substance misuse in people with learning disabilities: reasonable adjustments guidance. Accessed May 2024.
[191] Head et al. (2016). Post-traumatic stress disorder and alcohol misuse: comorbidity in UK military personnel. Accessed Jul 2022.
[192] Murphy and Turgoose. (2019). Exploring patterns of alcohol misuse in treatment-seeking UK veterans: a cross-sectional study. Accessed Jul 2022.
[193] Wright et al. (2011). Mental illness, substance abuse, demographics and offending: dual diagnosis in the suburbs. Accessed Jul 2022.
[194] De Waal et al. (2017). Prevalence of Victimization in Patients with Dual Diagnosis. Accessed Jul 2022.

dual diagnosis in prisons have been found to be low, prompting researchers to suggest further screening is required.[195]

HMP Birmingham carried out a prisoner survey (n=194), published in 2023. 54% of respondents reported feeling depressed, 23% suicidal, and 37% with other mental health problems upon arrival to the prison. 25% reported having a drug or alcohol problem upon arrival.

Two thirds (66%) reported that they had a mental health problem in this survey, while 34% reported not having one. The majority of respondents reported that their mental health had worsened since arriving at the prison (57%), while 11% reported that it had improved and 31% reported no difference. Nearly one quarter reported having an alcohol problem (23%) and 37% reported a drug problem when arriving at the prison, while 77% and 63% did not, respectively. 7% reported developing a problem with illicit drugs, and 8% reported developing a problem with non-prescribed medication since being in the prison.

Almost a third of respondents (30%) reported not being due to receive help for drug or alcohol problems upon release from prison despite needing help for this, and this was 55% for physical or mental health support.[196] While this survey is useful in providing separate estimates of mental health and substance misuse needs among those at HMP Birmingham, it does not provide a prevalence of dual diagnosis within the prison. Consideration to presenting this additional data in future surveys may be valuable.

In 2022, the first Intensive Supervision Courts were piloted in England as part of the Government's drug strategy. These courts serve tougher community sentences for criminals who would otherwise be given short jail terms. Offenders maintain monthly contact with the same judge and receive support and supervision from the probation service in order to tackle substance misuse through contact with drug and alcohol services. Additionally, services to support housing and education needs are also included in this wrap-around support. One of these pilots is at Birmingham Magistrates' Court, with a focus on female offenders with complex needs, including substance misuse.[197] This pilot commenced in July 2023 and will last for 18 months, supporting women aged 18+ who would otherwise receive a custodial sentence of up to 6 months.[198]

[195] Baranyi et al. (2022). The prevalence of comorbid serious mental illnesses and substance use disorders in prison populations: a systematic review and meta-analysis. Accessed Dec 2023.
[196] HMP Birmingham. (2023). Prisoner survey methodology, results and analyses. Accessed Jan 2024.
[197] Gov.UK. (2022). New Problem-Solving Courts to combat drug and alcohol-fuelled crime. Accessed Mar 2023.
[198] Information supplied directly from West Midlands Police. Accessed Jun 2023.

From Prison to Work

90% of those leaving UK prisons have a mental health or substance misuse need. However, only 6% of prison leavers receive support to find competitive employment. A research project aimed to address this gap by trialing an Individual Placement and Support employment programme over 3 years, with prison leavers from nine prisons within the West Midlands.

128 prison leavers were referred to this project, of which 54 people actively engaged. These people received specialist employment support, focusing on finding paid roles and providing support to maintain the role. While embedding employment support within mental health support is a key part of Individual Placement and Support, most participants did not receive community mental health support during this project.

Overall, 21 people were supported into competitive work and further support around accommodation, mental health and benefits were also given. A lack of services for people leaving prison was noted, and many people reported the employment programme as the only source of support received during this time. This cost of the project was £1,508 per head, which was noted to be lower than a similar community service costing £2,700 per head.[199]

3.2.11 Domestic Abuse

Research has shown strong associations between domestic abuse and mental health disorders. One recent UK study showed that women who experienced domestic abuse were up to three times as likely to develop mental illness, compared to other women.[200] In terms of substance misuse associations, one review showed intimate partner violence prevalence rates may range between 25% and 57% among women in drug treatment, compared with rates of 1.5%-16% found in community-based surveys of women.[201] This suggests that intimate partner violence is a significant health problem among women in drug treatment.

"I have got a girlfriend; she understands me at the moment. But previously it has caused my relationships to fall apart, I have also been vulnerable and been assaulted by previous partners."

Birmingham Citizen with Dual Diagnosis and Experience of Homelessness

"I went through a lot of domestic abuse. This has all lead to depression and anxiety. I was drinking to cover it all up."

Birmingham Parent with Dual Diagnosis

Results from a survey investigating experiences of intimate partner violence in England from 2007, found that more women (27.8%) reported having experienced intimate partner violence, compared to men (18.7%). More women also reported having experienced physical violence (22%), compared to men (12%). The experience of intimate partner violence was strongly related to a range of psychiatric disorders in both gender groups. However, there were gender

[199] Centre for Mental Health. From Prison to Work. A New Frontier for Individual Placement and Support. Accessed Feb 2024.
[200] University of Birmingham. (2019). Women who are experiencing domestic abuse are nearly three times as likely to develop mental illness. Accessed Jul 2022.
[201] El-Bassel et al. (2005). Relationship between drug abuse and intimate partner violence: a longitudinal study among women receiving methadone. Accessed Jul 2022.

differences in psychiatric conditions, by type of intimate partner violence. Women who experienced physical intimate partner violence were more likely to experience common mental health disorders, PTSD and eating disorders compared to men, whereas experiencing physical intimate partner violence was related to substance, alcohol disorders, or psychosis for both men and women.[202]

3.2.12 Sex Workers

Research indicates that sex workers are likely to have higher rates of drug misuse than the general population, with sample studies finding rates from 29.4% up to as high as 100%.[203,204,205,206] Sex workers are also likely to experience a high prevalence of mental health conditions, ranging from 73% to 94% across several sample studies.[207] This suggests that sex workers are at significantly higher risk of developing dual diagnosis.

Sex workers are an extremely vulnerable group, often experiencing multiple and complex needs, such as homelessness, poor education, lack of qualifications, criminal behaviour, and mental health conditions. All these factors can reduce the chances of sex workers being able to find alternative employment outside of sex work. Those who experience the double stigma of sex work and addiction often have difficulty seeking support, leading to social exclusion. This may lead to feelings of helplessness, isolation, and believing that there is no alternative.[208,209]

3.2.13 Gambling

While gambling is highest among those who are employed and are less deprived, at-risk and problem gamblers are more likely to be younger and male. Harmful gambling is associated with unemployment and living in more deprived areas, which suggests a link to health inequalities. Gambling is associated with increased alcohol consumption and poor mental health is a strong predictor of at-risk gambling.[210] One UK study suggested that among people with bipolar disorder, moderate to severe gambling problems are four times higher than the general population.[211]

[202] Jonas et al. (2013). Gender differences in intimate partner violence and psychiatric disorders in England: results from the 2007 adult psychiatric morbidity survey. Accessed Feb 2023.
[203] Home Office. Paying the price: a Consultation Paper on Prostitution. London; 2004. Accessed Jul 2022.
[204] Yeo et al. (2022). Key risk factors for substance use among female sex workers in Soweto and Klerksdorp, South Africa: A cross-sectional study. Accessed Jul 2022.
[205] House of Commons Home Affairs Committee. Prostitution: Third Report of Session 2016-17. Accessed Jul 2022.
[206] Jeal & Salisbury. (2004). A health needs assessment of street-based prostitutes: Cross-sectional survey. Accessed Jul 2022.
[207] Pandiyan et al. (2012). Psychological morbidity among female commercial sex workers with alcohol and drug abuse. Accessed Jul 2022.
[208] Cardiff County Council Community and Adult Services Scrutiny Committee. (2012). A Review of Multi-Agency Approaches to Tackling Sex Work/ Prostitution. Accessed Jul 2022.
[209] UCL Institute of Health Equity. (2014). A Review of the Literature on Sex Workers and Social Exclusion. Accessed Jul 2022.
[210] Public Health England. (2021). Gambling-related harms evidence review summary. Accessed Jul 2022.
[211] Jones et al. (2015). Gambling problems in bipolar disorder in the UK: prevalence and distribution. Accessed Jul 2022.

3.2.14 Financial Problems and Debt

"[mental health and substance use] took away quality time, took away finances."

FDAC Parent with Dual Diagnosis in Birmingham

"Monthly pay doesn't work for me, so I work jobs where I can get paid weekly. I find it hard managing a monthly budget, so weekly works best for me."

Birmingham LGBTQ+ Citizen with Dual Diagnosis

Socioeconomic status is a powerful risk factor that may independently increase an individual's vulnerability to substance misuse and mental health disorders. Deprivation and poverty are linked to problematic drug use and a higher prevalence of substance misuse, with those at the 'margins' of society most at risk (e.g., in care, in the criminal justice system, in mental health services and homeless people).[212]

The *Money and Mental Health Institute* reported that nationally, nearly 1 in 5 people (18%) with mental health problems are in problem debt. This is significantly higher than for those without mental health problems (5%). Similarly, 46% of people in problem debt also have a mental health problem. 13% of those in problem debt had thought about suicide and 3% had attempted suicide in the past year, compared to 0.8% of those not in debt.[213]

One way in which people with dual diagnosis may experience financial disadvantage is through the disability pay gap. This applies for those whose mental health condition may constitute a disability (see 1.4.7 Disability and The Equality Act). In the UK in 2021, the disability pay gap was 13.8%, with disabled workers earning an average of £1.93 per hour less than non-disabled workers (£12.10 vs £14.03). The pay gap is highest for disabled women. The impairment categories with the five highest pay gaps can be seen below.

Figure 12 shows that people with autism experience the highest pay gap (33.5%) followed by severe or specific learning difficulties (29.7%), epilepsy (25.4%), mental illness or other nervous disorder (22.1%) and depression, bad nerves or anxiety (17.7%). In this survey, respondents were asked to select their main impairment.[214]

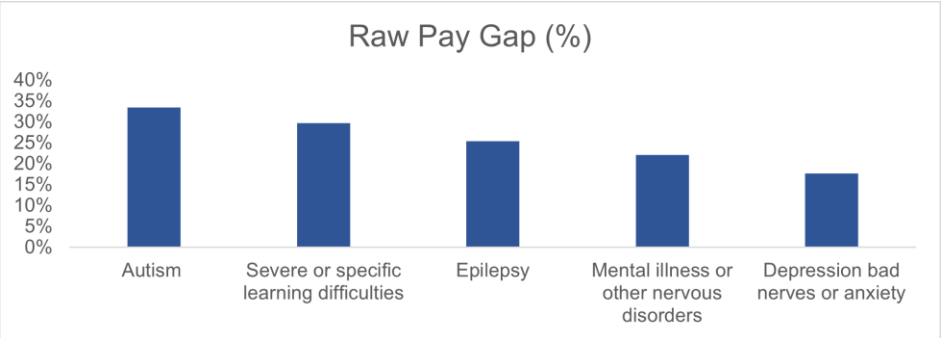


Figure 12: Disability Pay Gap, by Impairment Type (2021).

Source: ONS.[215]

[212] Shaw et al. (2007). Drugs and Poverty: A Literature Review. Accessed Jul 2022.
[213] Money and Mental Health Institute. (2019). Debt and Mental Health: A Statistical Update. Accessed Sep 2022.
[214] ONS. Disability pay gaps in the UK: 2021. Accessed Dec 2022.
[215] ONS. Disability pay gaps in the UK: 2021. Accessed Dec 2022.

For those receiving benefits, there are changes to their entitlement when entering the employment workforce. Some benefits may be discontinued, and others may remain available or become available (e.g., Access to Work grant). Different types of support in place for different groups and individuals in different circumstances, may mean the system is difficult to navigate.[216]

Cheetham et al. carried out research to understand the impact of Universal Credit on 33 claimants with complex needs, disabilities and health conditions, and 37 staff who were supporting these claimants. The claim process was described by claimants as 'complicated, difficult, demeaning, impersonal and punitive'. Many claimants had poor digital literacy and lack of digital access, leading to stress when trying to complete a claim. System errors resulted in payment delays, and these issues compounded the mental health problems of participants. Staff noted the negative impact of Universal Credit on claimants. Staff felt the system would not support the needs of those with complex needs, with one staff member saying *'… if you wanted to devise a system that discriminated against people with learning disabilities, this would be it … it absolutely particularly discriminates against people with mental health problems and people with learning disabilities'*.[217]

3.2.15 Stigma

Perceived stigma is associated with lower self-esteem, higher depression and anxiety and may lead to individuals being less likely to seek help.[218] There is also some evidence to suggest that stigma may indirectly affect treatment outcomes for patients seeking help for their substance misuse.[219]

[216] GOV.UK. Help with moving from benefits to work. Accessed Oct 2022.
[217] Cheetham et al. (2019). Impact of Universal Credit in Northeast England: a qualitative study of claimants and support staff. Accessed Nov 2022.
[218] Birtel et al. (2017). Stigma and social support in substance abuse: Implications for mental health and well-being. Accessed Mar 2023.
[219] Crapanzano et al. (2019). The association between perceived stigma and substance use disorder treatment outcomes: a review. Accessed Mar 2023.

3.2.15.1 Stigma within Ethnic Minority Communities

Within certain ethnic minority communities, there is public stigma that is experienced by those living with a mental health problem, those living with substance misuse or both. This public stigma can be defined as a set of negative attitudes or beliefs,[220] and for those living with mental health problems, this involves being avoided, feared and discriminated against.[221] Researchers reviewing stigma associated with mental health conditions and substance misuse among people from migrant and ethnic minority backgrounds found that this stigma was not only aimed at individuals living with substance misuse or mental health problems, but that this stigma was also directed at their families.[222] The study also found that among certain Asian communities, there was great importance held on protecting the family reputation from stigma resulting from mental health problems, because the family was also at risk of being excluded from social life, receiving unfair treatment and being shamed. In certain cases, this need to protect the family reputation leads to exclusion of individuals living with either substance misuse or mental health problems, and a narrative review on stigma in dual diagnosis suggests that this could involve keeping these individuals away from the community.[223]

The lived experience research that was commissioned for this deep dive included evidence of a Birmingham citizen undergoing dual diagnosis treatment away from their current community in Birmingham. A participant in the Lived Experience chapter (Chapter 5), researched by Change Grow Live with migrants living with dual diagnosis described a positive and supportive experience, due to the family paying for them to go back to their home country for rehab.

[220] Corrigan et al. (2012). Challenging the Public Stigma of Mental Illness. Accessed Mar 2023.
[221] Pescosolido et al. (2008). Rethinking theoretical approaches to stigma: A Framework Integrating Normative Influences on Stigma (FINIS). Accessed Mar 2023.
[222] Douglass et al. (2022). Exploring stigma associated with mental health conditions and alcohol and other drug use among people from migrant and ethnic minority backgrounds: a protocol for a systematic review of qualitative studies. Accessed Mar 2023.
[223] Balhara et a. (2016). Stigma-in-dual-diagnosis-A-narrative-review.pdf. Accessed Mar 2023.

Although the reason for doing so was not clear, *"Luckily my family were very supportive, and they paid for me to go back to Bangladesh to go to rehab. They did this twice and I stayed in rehab for 12 weeks each time. I did start using again when I came back because I was coming back to the same place, same people and same environment. Eventually I... stopped using and haven't looked back."*

3.2.16 Education

Mind reported on the association between secondary education and mental health in England. Over 2,800 young people and caregivers were involved in this research, finding that 68% of young people had some level of absence from school due to mental health.[224] Young people with mental health difficulties have been found to be twice as likely to not achieve five or more GCSEs at grade A*-C. While the relationship between poor mental health and poor academic achievement was stronger for males, it was found that females were more likely to experience poor mental health compared with males.[225]

A survey with secondary school students in 2021 found self-reported life satisfaction and wellbeing to be lower for pupils who had reported recently smoking, drinking alcohol and taking drugs (57%), in comparison to pupils who have not engaged in any of these (18%) and those who have engaged in one of these (35%).[226]

3.2.17 Employment

People with a severe mental illness have lower employment rates than people with any other group of health conditions.[227] The employment rate for people in contact with secondary mental health services is 67.4 percentage points lower than the overall rate.[228]

"I have lost my job and everything because of this, and now can't apply for jobs because as soon as they hear 'mental health', they think you're crazy. No point applying."

Birmingham LGBTQ+ Citizen with Dual Diagnosis

"Colleagues can be supportive. I'm quite open with people. Because I pull my weight and do a good job, colleagues are more likely to help me. Also, some colleagues I really enjoy talking to. I look forward to seeing people again on the next shift."

Birmingham LGBTQ+ Citizen with Dual Diagnosis

"My old employers weren't great – they were a small team and from a different culture and their attitude towards mental health was "pull yourself together." They didn't have the tools or experience to support their staff around mental health and it was horrible towards the end."

Birmingham Parent with Dual Diagnosis

Data on the Disability Living Allowance from 2018, shows that there were 40 Birmingham citizens claiming Disability Living Allowance due to alcohol and drug abuse. Additionally, there

[224] Mind. (2021). Young people failed by approach to mental health in secondary schools across England. Accessed May 2023.
[225] Smith et al. (2021). Adolescent mental health difficulties and educational attainment: findings from the UK household longitudinal study. Accessed May 2023.
[226] NHS Digital. (2022). Smoking, Drinking and Drug Use among Young People in England Accessed May 2023.
[227] NHS England. Individual Placement and Support offers route to employment for people with severe mental health conditions. Accessed Jul 2022.
[228] Public Health England. (2018). Health Matters: Reducing Health Inequalities in Mental Illness. Accessed Jul 2022.

were 910 claimants living with psychosis and 40 claimants living with a personality disorder.[229] (Table 9).

Table 9: Benefit Claimants, Disability Living Allowance by Condition (2018).

Claimants by Area and Gender	Psychosis (% of Total Claimants)	Personality Disorder (% of Total Claimants)	Alcohol and Drug Abuse (% of Total Claimants)	Total Claimants for All Conditions
England (total)	69,500 (4.9%)	4,650 (0.3%)	3,630 (0.3%)	1,425,330
England (males)	38,530 (5.0%)	2,090 (0.3%)	2,590 (0.3%)	768,590
England (females)	30,970 (4.7%)	2,560 (0.4%)	1,040 (0.2%)	656,740
Birmingham (total)	910 (3.3%)	40 (0.1%)	40 (0.1%)	27,220
Birmingham (males)	500 (3.4%)	20 (0.1%)	30 (0.2%)	14,890
Birmingham (females)	410 (3.3%)	20 (0.2%)	10 (0.1%)	12,340

Source: NOMIS.[229]

Dame Carol Black carried out an independent review into the effects of drugs, alcohol addiction (and obesity) on employment outcomes. This report noted that alcohol misuse could be a cause or a consequence of unemployment. Research has shown that employment improves the chances of an individual successfully completing drug treatment, and that completing treatment improves the chances of securing employment. Jobcentre Plus supports working age adults with substance misuse problems into employment. Recommendations from this review include that Jobcentres trial the use of individual placement and support approaches and co-location of Jobcentre staff in treatment centres. Improving the identification of those with substance misuse problems is important to ensuring the appropriate support can be put in place. The Dame Carol Black Review recommended that treatment recovery measures expand to include work and meaningful activity to allow people to move towards employment. Additionally, treatment and Jobcentre data was noted to need improvement. It was also suggested that a trial is run for claimants to engage in discussion with a healthcare professional about the impact of their health on their ability to work and any barriers this may present.[230] People living with dual diagnosis are at increased likelihood of unemployment[231] and NICE guidelines for community health and social care services for people with severe mental illness and substance misuse support the inclusion of education and employment opportunity considerations into a person's care plan. These activities can improve wellbeing and can support a person to feel a sense of purpose.[232]

Reasonable adjustments are a legal requirement for employers of people with disabilities or health conditions. This includes mental health, where this constitutes a disability. Reasonable adjustments ensure the person is not substantially disadvantaged in their role and includes changes to the recruitment process, flexible working hours, adaptations to the environment

[229] NOMIS. Benefit Claimants – Disability Living Allowance by Disabling Condition. Accessed Mar 2023.
[230] Black. (2016). An Independent Review into the impact on employment outcomes of drug or alcohol addiction, and obesity. Accessed Jul 2022.
[231] NICE. Guideline Scope. Severe Mental Illness and Substance Misuse (Dual Diagnosis): Community Health and Social Care Services. Accessed Aug 2022.
[232] NICE Guideline. (2016). Coexisting severe mental illness and substance misuse: community health and social care services. Accessed Aug 2022.

and more. Advice and support around reasonable adjustments can be sought from Disability Employment Advisors at Jobcentres.[233]

3.2.18 Housing

The mental health charity *Mind* recognise that there is an interactional relationship between poor housing and poor mental health, where each inequality can have a worsening effect on the other. Stress and anxiety can be exacerbated by insecure or crowded housing, and both housing conditions and mental ill-health can have an impact on sleep. Substance misuse can hinder a person's ability to find adequate housing. Financial difficulty can interact with both mental health and housing problems because mental health and housing problems may contribute towards difficulty maintaining employment, and these can be worsened by difficulty affording housing costs or organising housing benefits. Poor housing conditions can also worsen physical health through damp or cold environments, which can in turn affect mental health.[234]

National data shows that in 2021-22,[235] 11% of adults starting substance misuse treatment reported experiencing a housing problem, with 5% reporting an urgent housing problem. Supported housing is an alternative option for people with dual diagnosis, which may enhance feelings of independence and facilitate recovery. However, the level of provision in supported housing is not always sufficient and service users may be exposed to living environments that are detrimental to the recovery process, with crime and poor facilities that have negative impacts on the health of service users.[236, 237]

Houses in Multiple Occupancy (HMOs) have been linked with poor quality housing and may often house vulnerable tenants. HMOs may house those who are unable to afford other private rented accommodation and who are not priorities for social housing. Those living in HMOs may experience stigma, and poorer mental health.[238]

Supported exempt accommodation is also known as non-commissioned exempt accommodation or simply exempt accommodation. It is provided by a council, housing association, charity or voluntary organisation, and includes provision of care or support for claimants. These landlords are exempt from certain Housing Benefit restrictions, which allows them to yield rent levels at a higher rate than social sector rent or market rent. People living in exempt accommodation are often single adults who belong to marginalised groups, including individuals with mental health disorders, substance misuse issues, and leavers from addiction rehabilitation centres. Exempt accommodation is intended to provide these individuals with transitional accommodation, with a beyond minimal level of support, care, or supervision. The provision of this support is accounted for in the rent costs, which is why landlords are permitted to command higher rental rates.[239]

[233] Gov.UK. Reasonable adjustments for workers with disabilities or health conditions. Accessed Feb 2023.
[234] Mind. Housing and Mental Health. Accessed Mar 2023.
[235] Office for Health Improvement and Disparities. (2023). Adult substance misuse treatment statistics 2021 to 2022: report. Accessed Mar 2023.
[236] Cruce & Ojehagen. (2011). Recovery-promoting Care as Experienced by Persons with Severe Mental Illness and Substance Misuse. Accessed Jul 2022.
[237] Villena & Chesla. (2010). Challenges and struggles: lived experiences of individuals with co-occurring disorders. Accessed Jul 2022.
[238] Barratt & Green. (2017). Making a House in Multiple Occupation a Home: Using Visual Ethnography to Explore Issues of Identity and Well-Being in the Experience of Creating a Home Amongst HMO Tenants. Accessed Mar 2023.
[239] Spring Housing Association. (2019). Exempt from Responsibility? Accessed May 2023.

The support provided by exempt accommodation differs from services commissioned by grants (e.g., the Supporting People Grant) or regulated by the Care Quality Commission, and therefore is not subject to the same monitoring and standards. While exempt accommodation provides more than minimal support, there is no legal definition of care or support for this, nor any specification of how much support should be provided. Therefore, in some instances, there are concerns whether the support provided appropriately and adequately meets the needs of the occupants. Additionally, the lack of monitoring and governance has led to a proportion of poor quality accommodation and poor competency of landlords. A 2019 report also described the range of social injustices experienced by those inhabiting exempt accommodation in Birmingham, including social harm, lack of user voice, and barriers to employment and social integration.[240] Inter-related issues in Birmingham also include the disproportionate concentration of this type of accommodation in some areas of the city and the negative impacts on local communities, including anti-social behaviour.[241]

Birmingham took part in the Supported Housing Oversight Pilot, which aimed to improve the quality and standard of exempt accommodation through a Birmingham Quality Standard. This work began in late 2020, and in 2021 Birmingham undertook a public inquiry into exempt accommodation around the city. This recognised the need for good quality accommodation for vulnerable citizens and an acknowledgement of the lack of regulation and checks which had led to poor quality accommodation, poor competency of landlords and concerns about the

[240] Spring Housing Association. (2019). Exempt from Responsibility? Accessed July 2024.
[241] Birmingham City Council. (2021). Exempt Accommodation Report. Accessed May 2023.

impact on the surrounding communities. Birmingham's Draft Supported Housing Strategy (2020-25) estimated demand by client group, which can be seen in Table 10. This shows that citizens with mental ill-health represent the second largest client group (19.3%) while citizens with substance misuse or alcohol dependency represent the second smallest group (3.9%).[242]

Table 10: Demand for Supported Accommodation by Client Group.

Client Group Cluster	Estimate Need Units	Percentage of Overall Need	Upper Limit Estimate
Homeless with support needs	2,030	23.8%	2,550
Mental ill health	1,645	19.3%	2,025
Young people including care leavers	1,535	18.1%	1,850
Domestic abuse	1,355	15.9%	1,550
People with experience of the criminal justice system	805	9.5%	1,100
Physical disabilities	530	6.2%	600
Substance misuse or alcohol dependency	330	3.9%	400
Learning disabilities	275	3.2%	380
Estimate of total local supported housing need	**8,505**	**100%**	**10,455**

Source: Birmingham City Council.[242]

A £1 million supported exempt housing pilot in Birmingham led to the creation of a Charter of Rights with Spring Housing Association, to support tenants and families in awareness of the service they can expect. This pilot also included work with Birmingham Voluntary Services Council (BVSC) to design Quality Standards for all providers of exempt accommodation. Furthermore, a multi-disciplinary team of inspectors and social workers were employed to carry out more inspections of properties.[243]

The Charter of Rights mentioned above sets out the following statements:

- A right to feel safe and protected.
- A right to decent living conditions.
- A right to clear information on your support entitlement.
- A right to security of property.
- A right to seek advice and assistance, and to challenge.

The Quality Standards for supported exempt accommodation are focused on processes and practices, and not the physical condition of the building. Key areas for improvement are set out with a list of statements and examples on how to meet the standards. These standards provide non-commissioned exempt accommodation providers with recognition for good practice and consistent accommodation for residents. Quality Standard Awards are given as Gold, Silver, or Bronze and are valid for 2 years. In 2022, Spring Housing and the YMCA provider received Gold awards in Birmingham.[244]

[242] Birmingham City Council. Birmingham Supported Housing Strategy 2020-2025 Consultation Draft. Accessed Nov 2022.
[243] Birmingham City Council. Supported Exempt Accommodations. Accessed May 2023.
[244] Birmingham City Council. Quality Standards for Supported Exempt Accommodation. Accessed May 2023.

3.2.19 Homelessness

Research shows that almost three quarters of people who have slept rough in the UK have experienced a drug or alcohol need during their life, either historically or still actively misusing or dependent on them.[245] 'Need' refers to those who consider themselves dependent, have been in treatment, or have high levels of misuse.

Rates of mental health and substance misuse disorders have been found to be considerably higher in the homeless, compared to the general population. Whilst the prevalence of dual diagnosis in the general population may be less than 1% of individuals, it is estimated that between 18-42% of homeless people may have dual diagnosis.[246]

> "I have had spells of unstable accommodation, rough sleeping and this has affected both my using and mental health. I use more when I'm not housed."
>
> Birmingham Citizen with Dual Diagnosis and Experience of Homelessness

> "When you're homeless, you get completely consumed by drugs to cope. It's a cycle. You're so focused on it, before you know it 5 years have gone past, and nothing has changed. It's even the same when you're living in shared houses, you just focus on getting drugs and trying to cope that way."
>
> Birmingham Citizen with Dual Diagnosis and Experience of Homelessness

Despite suffering worse health than the general population, homeless people often struggle to access healthcare and support services or maintain engagement. Services should be specialised and accessible, with early prevention and treatment of mental health and substance dependence and joined-up social support, if the cycle of homelessness is to be broken. The Advisory Council on the Misuse of Drugs (ACDM) recommend:[247]

- Local services adopt a tailored approach to tackling the specific needs of homeless citizens who misuse drugs in their area.
- Integrated and targeted services, outreach, and peer mentors to engage and retain homeless people in proven treatments.
- Raising awareness among service providers of the levels of stigma experienced by homeless individuals who misuse drugs and ensure they are treated with respect.
- Involving people with experience of homelessness and substance misuse in the design and delivery of the service provision for substance misuse and homelessness services.

3.2.19.1 Hospital Inpatients of Citizens Living with Dual Diagnosis and Homelessness

Hospital inpatient data during a 7-year review period (2014-21) from Birmingham shows that there were 390 hospital admissions by 246 homeless people with a dual diagnosis code on their inpatient records. 206 of the patients were male (84%) and 40 were female (16%), which is comparable with overall admissions, whereby male patients were admitted 334 times (86%) and female patients 56 times (14%).

[245] ONS. Deaths of homeless people in England and Wales: 2019 registrations. Accessed Aug 2022.
[246] Jones. (2017). Socioeconomic deprivation and psychopathology: associations at the global and local level. Accessed Jul 2022.
[247] Cooper et al. (2017). A typology of modern slavery offences in the UK. Accessed Aug 2022.

Data also shows that 95.9% of homeless admissions with dual diagnosis codes during this period were recorded as emergencies and 3.8% were recorded as planned. This differs significantly from other patients with a dual diagnosis, where 65% of admissions were due to emergency and 28% were planned.

Between 2014-21, 108 patients were admitted with a singular dual diagnosis (44%), whereas 52 patients had two or more dual diagnosis code(s) (21%) and 86 patients had a dual diagnosis code(s) with MHC(s) (35%).

Analysis of the top causes of admissions for homeless patients with a dual diagnosis code shows that 'mental health due to misuse of alcohol' was recorded as the biggest cause (18%), followed by schizophrenia (8%), injuries (7%), musculoskeletal diseases (4%), and COPD (4%).

3.2.20 Community and Family Support

Social isolation may be a factor involved in both the cause and consequence of dual diagnosis.[248] Engaging with community assets can support the process of recovery for substance misuse.[249] Peer support has been shown to be helpful during recovery and is related to reduced relapse rates, as well as reduced rates of returning to homelessness.[250] Similarly, family members often play critical roles in the lives of individuals living with dual diagnosis, providing direct care, financial and psychological support and management of symptoms.[251,252,253]

[248] NICE. Severe mental illness and substance misuse (dual diagnosis): community health and social care services. Accessed Aug 2022.
[249] Collinson & Best. (2019). Promoting Recovery from Substance Misuse through Engagement with Community Assets: Asset Based Community Engagement. Accessed Aug 2022.
[250] Tracey & Wallace. (2016). Benefits of peer support groups in the treatment of addiction. Accessed Aug 2022.
[251] Townsend et al. (2006). Families of Persons With Substance Use and Mental Disorders: A Literature Review and Conceptual Framework. Accessed Aug 2022.
[252] Mueser & Fox. (2002). A family intervention program for dual disorders. Accessed Aug 2022.
[253] Brown et al. (2011). Likelihood of Asking for Help in Caregivers of Women With Substance Use or Co-Occurring Substance Use and Mental Disorders. Accessed Aug 2022.

3.2.21 Impact on Family, Carers and Professionals

3.2.21.1 Professionals Working with Individuals with Dual Diagnosis

> "If you could provide both mental health support and drug support, the barriers in place would diminish and we would be able to provide a more stable recovery journey for them."
>
> CGL Professional in Birmingham

NICE guidelines from 2011 state that professionals working within secondary mental health services should have the competence to recognise and treat people with coexisting psychosis and substance misuse.[254] NICE Quality Standards (2019) also suggest that support and training be provided for staff who work with people with dual diagnosis.[255] The guidance '*Better Care for People with Co-occurring Mental Health, Alcohol and Drug Conditions*' suggests that local areas carry out a training needs assessment to understand the local training needs of professionals.[256]

Staff wellbeing is an important factor for substance misuse and mental health services to consider. Three negative phenomena have been described among mental health professionals: secondary traumatic stress, vicarious trauma, and compassion fatigue. Secondary traumatic stress are behaviours and emotions which occur due to knowledge of a traumatic event and compassion fatigue is the reduced capacity or interest in being empathic. Symptoms of these can be similar to those of PTSD. Vicarious trauma describes an internal change in beliefs and thoughts that can occur after exposure to others' trauma and can include symptoms such as cognitive disruptions in trust, esteem or safety. The term secondary traumatic stress can be used as an umbrella term to describe all three concepts. Regular and supportive supervision, strong peer support, balanced caseloads, and organisational acknowledgement of these phenomena are all important factors for staff wellbeing. Researchers also found trauma specific training supported staff, including training in these concepts.[257]

Research has also shown that professionals working in drug and alcohol services are at risk of secondary traumatic stress and compassion fatigue.[258] A study carried out in Australia found that 20% of staff from alcohol and drug services (n=421) experienced some form of secondary traumatic stress. Factors such as having a workload high in traumatised clients, having less supervision and staff's own stress and anxiety levels were associated with this prevalence. These researchers noted that secondary traumatic stress may be a factor which increases a professional's stress and anxiety, or may be more likely among professionals with higher levels of stress and anxiety.[259]

[254] NICE. (2011). Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings. Accessed Mar 2023.
[255] NICE. (2019). Coexisting severe mental illness and substance misuse. Accessed Mar 2023.
[256] Public Health England. (2017). Better care for people with co-occurring mental health and alcohol/drug use conditions. Accessed Mar 2023.
[257] Sutton et al. (2022). The contribution of organisational factors to vicarious trauma in mental health professionals: a systematic review and narrative synthesis. Accessed Feb 2024.
[258] Huggard et al. (2017). A systematic review exploring the presence of vicarious trauma, compassion fatigue, and secondary traumatic stress in alcohol and other drug clinicians. Accessed Feb 2024.
[259] Ewer et al. (2014). The prevalence and correlates of secondary traumatic stress among alcohol and other drug workers in Australia. Accessed Feb 2024.

Staff training is a commonly used strategy to raise understanding of trauma and its impact. It can raise awareness of professionals' own symptoms of trauma, burnout and secondary trauma stress, as well as recognising this in their colleagues.[260]

3.2.21.2 Family and Carers

NICE guidance highlights the role that carers or family members may take when a person with severe mental illness and substance misuse has contact with health and social care. For example:

- The safeguarding needs of carers and wider family of a person with severe mental illness and substance misuse must be considered.
- The care coordinator within the mental health service can liaise with family or carers.
- Family or carers can be involved in care planning, where the individual wants this.
- Carers should be made aware of their entitlement to support and be offered a care assessment where appropriate.[261]

NICE guidance on supporting adult carers highlights that carers should be provided with information to support them as a carer, acknowledging that their role as a carer may change over time. Carers should be valued as expert partners by professionals and with the individual's consent they can be included in the care team. Professionals should work to identify carers of people with mental illness and substance misuse with the understanding that many people may not view themselves as carers.[262]

NICE Quality Standard QS200 is for supporting adult carers who provide unpaid care for any person over 16 years with health or social care needs. It includes five statements outlining high-quality care for areas of improvement.

- Statement 1: Identification of carers by health and social care and support in understanding their role and rights.
- Statement 2: Participation in decision making and care planning.
- Statement 3: Opportunity for a carer's assessment and discussion of own health and wellbeing needs, alongside work or education needs.
- Statement 4: Discussion with health and social care staff opportunities for respite.
- Statement 5: Offer of supportive working arrangements by workplaces.[263]

Adfam, a national charity supporting family and friends of people with substance misuse or gambling problems, carried out qualitative research in 2017-18, gathering the views of 54 family members of a person with dual diagnosis and 7 professionals working in mental health, substance misuse or family support services. Some family members reported that their support of a loved one with dual diagnosis could become very time consuming and could cause financial strain, where their loved one was dependent on them or had accumulated care costs or debts. Some families felt daily life and involvement in work and social activities were disrupted from supporting their loved one, which had a negative impact on their mental and physical health. Many family members were affected by 'kinship care', where they took on

[260] Scottish Government. (2023). Enablers and barriers to trauma-informed systems, organisations and workforces: evidence review. Accessed Feb 2024.
[261] NICE. Overview | Coexisting severe mental illness and substance misuse: community health and social care services. Clinical Guideline [NG58]. Accessed Jul 2022.
[262] NICE Guideline (NG150). (2020). Supporting Adult Carers. Accessed Apr 2023.
[263] NICE Quality Standard (QS200). (2021). Supporting Adult Carers. Accessed Apr 2023.

additional caring responsibilities, due to their loved one not being able to fulfil these, for example grandparents may take on the care of grandchildren.[264]

3.3 Health Inequalities

3.3.1 General Health

Individuals living with dual diagnosis endure poorer health than those without. NICE guidance shows that a person's physical health may be impacted by coexisting mental illness and substance misuse. Physical health needs should be monitored, reviewed and addressed where needed.[265] Whilst health inequalities can involve differences in access to care, quality and experience of care, behavioural risks to health, and wider determinants of health, this section focuses on differences in health status. NICE guidelines recommend that the physical health of adults and young people with both psychosis and substance misuse should be monitored. This monitoring should take place once per year at a minimum, but more frequently where a person has a significant physical illness, or there is a risk of this due to substance misuse.[266]

3.3.2 Physical Activity

Research suggests that aerobic exercise is associated with reduced substance misuse.[267] Physical activity has been suggested to support treatment and recovery from substance misuse disorders. A meta-analysis found that exercise can increase abstinence rates, reduce anxiety and depression, and reduce withdrawal symptoms.[268] Other research has found a positive effect of physical activity on the prevention of alcohol initiation, and a short-term effect of physical activity on drug and alcohol misuse. However, this review also suggested that further research was needed to understand these effects in more detail, due to risk of bias in the research and a lack of rigorous research.[269] Physical health has also been shown to have a positive impact on mental health, including reducing depressive and anxiety symptoms, and improving mood. Various mechanisms for this have been put forward, including the positive effects of increased self-efficacy, social interaction and release of endorphins.[270]

3.3.3 Cardiovascular Disease

Cardiovascular disease is purportedly the most frequent cause of premature mortality in people with severe mental health disorders, such as depressive disorder, bipolar disorder and schizophrenia.[271] Drug and alcohol misuse may further increase the risk of developing cardiovascular disease in those with mental health disorders. Lifestyle factors, such as poor nutrition and physical inactivity in addition to substance misuse can further exacerbate adverse effects on cardiovascular function. Unhealthy lifestyle choices are more common among people with mental health disorders.[272]

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[264] Adfam. Families, substance use and mental health. Accessed Apr 2023.
[265] NICE. Overview | Coexisting severe mental illness and substance misuse: community health and social care services. Clinical Guideline [NG58]. Accessed Jul 2022.
[266] NICE. (2011). Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings. Accessed Mar 2023.
[267] Smith et al. (2012). Exercise as a Potential Treatment for Drug Abuse: Evidence from Preclinical Studies. Accessed Jul 2023.
[268] Wang et al. (2014). Impact of Physical Exercise on Substance Use Disorders: A Meta-Analysis. Accessed Jul 2023.
[269] Thompson et al. (2020). Physical activity and the prevention, reduction, and treatment of alcohol and other drug use across the lifespan (The PHASE review): A systematic review. Accessed Jul 2023.
[270] Peluso et al. (2005). Physical Activity and Mental Health: The Association Between Exercise and Mood. Accessed Jul 2023.
[271] McIntyre et al. (2007). Medical comorbidity in bipolar disorder: re-prioritizing unmet needs. Accessed Jul 2022.
[272] Zaman et al. (2019). Lifestyle Factors and Mental Health. Accessed Jul 2022.

3.3.4 Respiratory Disease

The interaction of mental health and substance misuse disorders may cause people living with dual diagnosis to endure poorer respiratory health outcomes than those with a single diagnosis of either disorder, or the general population. In a large UK study, 90% of patients with schizophrenia and related psychosis had poor lung function, compared to 42% of the general population sampled in the study.[273] People with mental health problems are more likely to smoke, are less likely to adhere to treatment, and may have less motivation for self-management,[274,275] which may explain the high rates of respiratory morbidity among people living with mental health disorders. Drug users also have a significantly higher prevalence of respiratory diseases. A study, which included 18,570 patients, found that more drug misusers than non-drug users had a diagnosis of asthma (17.1% vs. 10.9%, respectively) or chronic obstructive pulmonary disease (2.4% vs. 0.8%, respectively) and were prescribed more chronic respiratory medications. These observations were seen even after adjusting for factors such as age, gender, deprivation and smoking status.[276]

3.3.5 Liver Disease

There are several types of liver disease and those which can be caused by alcohol include hepatitis and alcohol-related liver disease.[277] There are three main stages of alcohol-related liver disease including alcoholic fatty liver disease, alcoholic hepatitis and cirrhosis.[278] In 2022-23, the hospital admission rate for alcoholic liver disease was higher in Birmingham (59.1 per 100,000 population) compared to England (49.4 per 100,000 population).[279] Similarly, the mortality rate for those aged under 75 years from alcoholic liver disease was higher in Birmingham (16 per 100,000) than for England (11.6 per 100,000) in 2022.[280]

3.3.6 Cancer

Substance misuse disorders, including the misuse of alcohol and tobacco, can cause cancer. Research has consistently linked tobacco use with developing cancer, particularly lung cancer. Tobacco is known to be the number one cause of cancer and death from cancer.[281] Excessive and prolonged alcohol consumption is also highly detrimental to health, increasing the risk of cancers of the mouth, throat, oesophagus, colon, and breast cancer.[282]

3.3.7 Dementia

Dementia is a group of related symptoms (called a syndrome) which is associated with ongoing decline of cognitive functioning. Alzheimer's disease and vascular dementia are two conditions which make up the majority of dementia cases. In the UK, 1 in 14 people aged 65+ have dementia, while this figure is 1 in 6 for those aged over 80.[283] Age is a key risk factor for

[273] Filik et al. (2006). The cardiovascular and respiratory health of people with schizophrenia. Accessed Jul 2022.
[274] Lasser et al. (2000). Smoking and mental illness: A population-based prevalence study. Accessed Jul 2022.
[275] DiMatteo et al. (2000). Depression is a risk factor for noncompliance with medical treatment: meta-analysis of the effects of anxiety and depression on patient adherence. Accessed Jul 2022.
[276] Palmer et al. (2012). Prevalence of common chronic respiratory diseases in drug misusers: a cohort study. Accessed Jul 2022.
[277] NHS. Liver Disease. Accessed Apr 2024.
[278] NHS. Alcohol-related liver disease. Accessed Apr 2024.
[279] OHID. Hospital admission rate for alcoholic liver disease. Accessed Apr 2024.
[280] OHID. Under 75 mortality rate from alcoholic liver disease (persons, 1 year range). Accessed Apr 2024.
[281] Parkin. (2011). Tobacco-attributable cancer burden in the UK in 2010. Accessed Jul 2022.
[282] Boyle et al. (2003). European Code Against Cancer and scientific justification: 3rd version. Accessed Jul 2022.
[283] NHS. About Dementia. Accessed Jan 2023.

dementia, and female gender is a risk factor for Alzheimer's disease. However, there are also genetic and vascular risk factors such as hypertension, diabetes and smoking.[284]

Evidence suggests that a comorbidity of substance misuse and mental health disorders may lead to an increased risk of dementia. Research from New Zealand published in 2022, found that dementia was overrepresented among people with a mental health disorder, with 6.1% being diagnosed with dementia over the observation period, compared with 1.8% of individuals without a mental health disorder. Men with substance misuse disorders were 5.2 times more likely to develop dementia over the 30 year observational period, compared to those without a substance misuse disorder. For women with substance misuse disorders, their risk of dementia was 5 times more likely than those without a substance misuse disorder.[285]

3.3.8 Blood Borne Viruses

Human Immunodeficiency Virus (HIV) is a retrovirus that attacks and weakens the immune system which can be found in the blood and other body fluids. In the UK, it is most commonly contracted through unprotected sex with a person who has HIV but can also be contracted through drug misuse, where needles, syringes or other injecting equipment are shared. In Birmingham, Umbrella and Change Grow Live offer free testing and the Hepatitis C Trust team test in the community for HIV, Hep B and Hep C. Prevention options in Birmingham include access free condoms and pre-exposure prophylaxis through Umbrella's sexual health service and accessing Birmingham's needle exchange programme.[286]

A UK study has shown that for those living with HIV, there is a higher risk of living with a mental health illness. Nationally representative UK data showed that between 2000-20, people living with HIV were more likely to develop depression, anxiety and severe mental illness, compared to those without HIV.[287] Similarly, depression or anxiety can be common problems experienced by those living with chronic Hep C.[288]

3.3.9 Suicide

The rate of suicide and attempted suicide is high among people with substance misuse disorders[289] and people with mental health disorders.[290] Research has shown that the risk of suicide is associated with dual diagnosis to a greater extent than substance misuse disorders and mental health disorders alone.[291] Other disorders and comorbidities that are common in dual diagnosis patients may further increase the risk of suicide.

3.3.10 Continuity of Care

Poor adherence to treatment in individuals living with dual diagnosis is a common clinical problem,[292] and literature highlights continuity of care as one of the methods to help service users sustain treatment.[293] One qualitative meta synthesis of studies looking into patient's

[284] Van der Flier & Scheltens (2005). Epidemiology and risk factors of dementia. Accessed Jan 2023.
[285] Richmond-Rakerd et al. (2022). Longitudinal Associations of Mental Disorders with Dementia: 30-Year Analysis of 1.7 Million New Zealand Citizens. Accessed Jan 2023.
[286] Birmingham City Council. HIV. Accessed Feb 2023.
[287] Gooden et al. (2022). The risk of mental illness in people living with HIV in the UK: a propensity score-matched cohort study. Accessed Mar 2023.
[288] NHS. Symptoms: Hepatitis C. Accessed Mar 2023.
[289] Vijayakumar et al. (2011). Substance Use and Suicide. Accessed Jul 2022.
[290] Bradvik. (2018). Suicide Risk and Mental Disorders. Accessed Jul 2022.
[291] Restrepo et al. (2019). Suicide Risk Associated With Dual Diagnosis in General Population. Accessed Jul 2022.
[292] Maremmani et al. (2022). IJERPH | Free Full-Text | Substance Use/Dependence in Psychiatric Emergency Setting Leading to Hospitalization: Predictors of Continuity of Care (mdpi.com). Accessed May 2023.
[293] McCallum et al. (2015). Continuity of Care in Dual Diagnosis Treatment: Definitions, Applications, and Implications: Journal of Dual Diagnosis: Vol 11, No 3-4 (tandfonline.com). Accessed May 2023.

perceptions of continuity of care found information transfer and continuity of care (e.g., consistency of personnel and ongoing patient-provider relationship) to be two of the components of continuity of care that patients placed importance on.[294] This was similar to findings in a UK qualitative study exploring and comparing service users' and professionals' understanding of continuity of care in the organisation and delivery of mental health services. Researchers in the study found that service user participants identified infrequent 'staff changes', 'communication between staff' and not having to 'repeat your life history' as some of the positive components of continuity of care.[295]

3.4 Treatment and Recovery

It is recognised that different groups may have different views on what it means to be in recovery. For example, some groups (e.g., Alcoholics Anonymous) may favour abstinence from all drugs, whereas other groups such as Dual Diagnosis Anonymous may see the use of prescribed drugs as part of treatment.[296]

When working with people living with dual diagnosis, professionals should take a person-centred approach, taking time to build a trusting relationship, recognising that stigma and discrimination are associated with psychosis and substance misuse. Professionals should also recognise that some people may try and hide their conditions and may fear detainment, imprisonment or having children removed from their care.[297] NICE guidance recognises that people with coexisting severe mental illness and substance misuse can experience fragmented care. Joint pathways and a key contact can help ensure continuity of care, particularly where individuals experience transition between services.[298]

[294] Waibel et al. (2012). What do we know about patients' perceptions of continuity of care? A meta-synthesis of qualitative studies. Accessed May 2023.
[295] Sweeney et al. (2016). Defining continuity of care from the perspectives of mental health service users and professionals: an exploratory, comparative study.. Accessed May 2023.
[296] Milani. An Evaluation of the first UK Dual Diagnosis Anonymous pilot for individuals with co-existing mental and addictive disorders. Accessed Feb 2024.
[297] NICE. (2011). Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings. Accessed May 2023.
[298] NICE. Overview | Coexisting severe mental illness and substance misuse: community health and social care services. Clinical Guideline [NG58]. Accessed Jul 2022.

Nationally in 2021-22, a large majority of psychosocial treatments were delivered in the community, although a significant minority of those in the treatment groups 'non-opiate and alcohol' (28.8%) and 'alcohol only' (21.2%) were treated through prescriptions in inpatient settings. In terms of the length of time that people receiving prescribing interventions were in continuous prescribing treatment, there are differences between treatment groups. In the 'non-opiate and alcohol' group (86.8%), and the 'alcohol only' group (90%), the majority were in continuous treatment for under 12 months. Conversely, 27.7% of those in the 'opiate' group were in treatment for over 5 years while only 26.7% were in treatment for under 12 months. Data also shows that just over half of people leaving treatment among the groups 'non-opiate only', 'non opiate and alcohol', and 'alcohol only', exited treatment having completed treatment and being free of dependence. Conversely the most common treatment exit reason for patients in the 'opiate' group was treatment drop out (38.2%).[299]

"It's either waiting lists or you can't get in, or you have to do something else. Or phone at 8am to get an emergency appointment and you can't get through. It's so much effort to get through and you can't do it. You just get passed around, so I end up not doing it."

Birmingham Citizen with Dual Diagnosis, with no Formal Mental Health Diagnosis

"Things were getting way out of hand, and I couldn't cope."

Birmingham LGBTQ+ Citizen with Dual Diagnosis

"In the end, it was my children who motivated me to change. I had that motivation. Other people don't and only really have themselves to thinks about and change for. I think that's harder."

Birmingham Parent with Dual Diagnosis

"Parents are often declined forms of psychological therapy as they need to be clean before services will accept them, but this is part of the problem. Parents cannot achieve that without support."

FDAC Professional in Birmingham

"I don't think I would have got better if I hadn't had my child taken off me. I needed the space, so I had room to get myself sorted but I also needed the kick up the bum."

Birmingham Parent with Dual Diagnosis

"When I had my kids, I feel like my drug use and my mental health was much better than it is now. But since they've been taken away, I feel like it's made things worse. Having to deal with the emotions of not having my children is very difficult."

Birmingham Parent with Dual Diagnosis

The UK survey called 'Life in Recovery' (2015) showed benefits of recovery. Data from this survey showed that 18% of respondents reported losing custody of their children while in active addiction. Furthermore, 4.5% regained custody of their children during the first year of recovery. Additionally, 12.4% of those in 5 years of sustained recovery reported regaining custody of their children. Other benefits of recovery include physical health benefits, which can be shown by a reduced use of emergency services and being more likely to have returned to education and training, compared to those in active addiction.[300]

[299] GOV.UK. Substance misuse treatment for adults: statistics 2021 to 2022. Accessed Mar 2023.
[300] Best et al. (2015). UK Life in Recovery Survey 2015. Accessed Mar 2023.

3.4.1 Trauma-Informed Approach

An individual can experience trauma due to enduring a stressful or harmful event, a set of events or set of circumstances that they find difficult to cope with. Trauma may result from experiences like physical violence, intimate partner sexual violence or human trafficking. Trauma can happen at any age and can affect a person at any time, even a long time after the event has taken place.[301]

According to guidance from the UK government, trauma-informed practice or a trauma-informed approach is '*an approach to health and care interventions which is grounded in the understanding that trauma exposure can impact an individual's neurological, biological, psychological and social development*.' There are six principles of trauma-informed practice. These include safety, trust, choice, collaboration, empowerment and cultural consideration.[302] There are different tiers of support, provided by professionals, supporting a person-centred approach:

- Trauma-Informed Support: The entire workforce in dual diagnosis and related fields should be able to signpost citizens to self-help materials and provide psychoeducation.
- Trauma Skilled Support: Professionals such as recovery workers, nurses, non-medical prescribers and social workers should be able to provide guided self-help, routine enquiry, organise safety planning and give out non-specialist support.
- Trauma Enhanced Support: Counsellors, psychologists and psychiatrists, from a substance misuse perspective, should be able to provide survivor support groups, counselling and bridging psychological intervention, including symptomatic management.
- Trauma Specialist Support: Counsellors, psychologists and psychiatrists, from a mental health perspective, should be able to provide longer-term therapy at specialist services.[303]

3.4.2 Experts by Experience

In 2016, the Mental Health Taskforce, commissioned by NHS England, produced an independent report 'The Five Year Forward View for Mental Health'.[304] Throughout the report the taskforce highlighted the value of experts by experience in the design and development of services during the commissioning process. The taskforce also campaigned for co-production with service users to be a standard approach in mental health commissioning to make services more accessible and appropriate for people of all backgrounds. Recommendations focusing on mental health research and workforce strategy developing with involvement of experts by experience were accepted by the Government.[305,306]

Following publication of the Five Year Forward View for Mental Health report, the charity Rethink Mental Illness carried out an evaluation of the involvement of lived experience in mental health commissioning and shared their findings in a report.[307] Their research found that despite co-production having been shown to not only empower service users, increase quality and efficiency of service as well as improve clinical outcomes, co-production in mental health

[301] Mind. Trauma. Accessed Feb 2024.
[302] GOV.UK. Working definition of trauma-informed practice. Assessed Feb 2024.
[303] Turning Point. Substance Use and Mental Health Training. Accessed Feb 2024.
[304] Mental Health Taskforce. (2017). The Five Year Forward View for Mental Health. Accessed Nov 2023.
[305] UK Gov. (2017). The Government's response to the Five Year Forward View for Mental Health – January 2017. Accessed Nov 2023.
[306] NHS England. NHS England » NHS mental health dashboard. Accessed Nov 2023.
[307] NHS England. NHS England » NHS mental health dashboard. Accessed Nov 2023.

commissioning was not yet common practice. To tackle this, they put together recommendations to promote co-production in mental health commissioning.

Researchers in a UK study looking into the role of lived experience in mental health education and practice found that a key component to fully eliminate stigma and discrimination in mental health practice is the positive recruitment of individuals living with mental health problems.[308] This was due to the understanding and empathy that came with personal experiences of mental health problems whilst taking into consideration the need to maintain professional boundaries.

3.4.2.1 Fulfilling Lives

The Fulfilling Lives programme was a £112 million investment over 8 years by the National Lottery Community Fund to support 12 areas of England to build partnerships to support people living with multiple disadvantage. This programme used co-production and had three main aims:

- Support people with multiple disadvantage with person-centred, co-ordinated services.
- Services to be tailored and connected, with the possibility of involvement of service users in service design and delivery.
- Shared learning and improved measurement of outcomes.[309]

Birmingham Changing Futures Together

The Birmingham-specific branch of the 'Fulfilling Lives Programme' was led by BVSC but also had contributors such as Birmingham City Council and Birmingham MIND.[310] Regarding coproduction, in its evaluation this project was able to highlight some key learning points that could be applied to any piece of coproduction:

- A safe and welcoming environment should be created where experts by experience feel they can share their ideas without judgement.
- Accessible language should be used.
- Job titles/labels should be avoided as experts should feel their contribution is equally as important as the next person's.
- Project coordinators should be honest with experts about roles, parameters, time commitments and desired outcomes.
- Experts should be involved in coproduced projects from the beginning so they can help shape the work, rather than being consulted once decisions have already been made.
- Experts should be supported to understand what coproduction is and what it means in practice so their project contribution can be meaningful.
- Experts should be supported by a dedicated network, and they should be compensated for their time (but not necessarily financially).

[308] Stickley, T. (2012). "Wounded Healers": The role of lived experience in mental health education and practice. Accessed Nov 2023.
[309] Fulfilling Lives. The Fulfilling Lives Programme. Accessed Nov 2023.
[310] Fulfilling Lives Programme. Birmingham Changing Futures Together. Accessed Nov 2023.

After the end of this programme, several local areas have received additional funding through the Changing Futures programme, including Birmingham.[311]

3.5 Finance and Health Economics

3.5.1 Funding

In February 2023, it was announced that 150 local authorities in England will receive an extra £421 million government funding for drug and alcohol treatment and recovery.[312] This will support an increase in quality of provision, staff recruitment and support more prison leavers into services.

Table 11: Drug and Alcohol Treatment and Recovery, Birmingham Allocation.

Local Authority	Drug Strategy Allocation (2023-24)	Inpatient Detoxification Allocation (2023-24)	Indicative Drug Strategy Allocation (2024-25)	Indicative Inpatient Detoxification Allocation (2024-25)
Birmingham	£4,947,461	£285,216	£9,547,838	£285,216

Source: Department of Health and Social Care.[313]

Since 2015-16, NHS England has increased local funding for mental health in line with the increase in money available to Clinical Commissioning Groups (now termed ICBs). From 2019-20, a renewed commitment to the funding of mental health services with a ringfenced local investment fund of at least £2.3 billion a year by 2023-24. It is expected that by 2023-24, investment in mental health services will deliver:

- Expanded perinatal mental health services to allow 66,000 new and expectant mothers to access moderate, severe or complex perinatal mental health support.
- An additional 345,000 children and young people to access mental health services and school or college mental health support teams.
- All children and young people experiencing a mental health crisis to access crisis care 24 hours per day.
- Universal mental health crisis care, via NHS 111.
- Better quality care across primary and community teams for people with moderate to severe mental illnesses.[314]

3.5.2 Return on Investment

Research published in 2016 followed individuals who were in contact with the Drug Interventions Programme for a six-month period in the Northwest of England. In this programme, people who were arrested for certain offenses (including drug possession or dealing) were tested for cocaine and/or opiate metabolites whilst in police custody, and those who tested positive were then referred to drug treatment services. This aimed to effectively identify those involved with crimes associated with drug misuse and offer effective support through referral to drug misuse treatment. This evaluation found the programme to be cost-

[311] Fulfilling Lives. The Fulfilling Lives Programme. Accessed Nov 2023.
[312] Department of Health and Social Care. £421 million to boost drug and alcohol treatment across England. Accessed May 2023.
[313] Department of Health and Social Care. £421 million to boost drug and alcohol treatment across England. Accessed May 2023.
[314] NHS England. NHS Mental Health Dashboard. Accessed Jun 2023.

effective in reducing future crime, through engaging people in drug treatment and supporting people with housing and money advice. Among those who were followed in this programme, there was a 52% reduction in offending.[315]

Public Health England updated their commissioning support tool for mental health prevention in August 2017. This report summarises findings from modelling work which estimates the cost of investment in various interventions which aim to reduce the risk of mental health problems and promote good mental health. It is suggested that investing in these interventions can return cost savings to the NHS, due to poor mental health increasing the risk of poor physical health and difficulty managing physical health problems. However, cost savings extend beyond the NHS, because poor mental health can also reduce participation in work, education and community activities. The modelling found that the following programmes produced a return on investment estimated to be between £1.26 to £39 for every £1 spent on these interventions.

- School-based anti-bullying programmes.
- Workplace programmes.
- Interventions to support people with chronic physical problems in primary care.
- Programmes to support the use of psychosocial assessment for those attending A&E with non-fatal self-harm.

These savings were modelled for up to 10 years, thus providing evidence to support investment in mental health interventions.[316]

There is a lack of available health economics data relating to dual diagnosis, particularly for local authorities. This limitation is likely to be in part due to mental health and substance misuse treatment services being funded separately and managed by different entities (i.e., local authorities commission substance misuse treatment, whilst integrated care boards (ICBs) commission mental health services). Further research should investigate optimal pathways for dual diagnosis service provision to maximise social return on investment. Nevertheless, investing in mental health and substance misuse services shows a financial as well as social benefit.

[315] Collins et al. (2016). Assessing the effectiveness and cost-effectiveness of drug intervention programs. Accessed May 2023.
[316] Public Health England. (2017). Commissioning Cost-Effective Services for Promotion of Mental Health and Wellbeing and Prevention of Mental Ill-Health. Accessed May 2023.

4 Services

An extensive service-mapping exercise was carried out for this deep dive and services relating to mental health and substance misuse are reported here.

Since 2013, mental health and substance misuse treatment services have been funded separately, with commissioning responsibility sitting with different entities. Mental health services are funded by integrated care boards (ICBs) and local authorities commission substance misuse treatment, prevention and harm reduction (non-prescribed function of the Public Health Ring Fenced Grant).[317]

The Substance Use Mental Health Resource Pack (2021) and Multiple Disadvantage and Co-occurring Substance Use and Mental Health Conditions (2022) recognise that services should work jointly to support the needs of citizens with dual diagnosis, rather than creating separate dual diagnosis-specific services.[318,319] The Community Mental Health Framework recognises the discontinuity in care citizens with dual diagnosis may experience, and advocates for the principle of inclusivity to overcome this.[320] NICE Guidelines also note the importance of reducing multiple assessments and passing citizens between services,[321] and research supports the idea that continuity of care can benefit both patients and staff.[322]

4.1 Service Providers Commissioned by Birmingham City Council

Birmingham City Council commissions two service providers to support citizens living with substance misuse in the city. ***Aquarius*** support young people with substance misuse and ***Change Grow Live*** support adults.

In addition, ***the Needle Exchange*** is commissioned to provide a facility where people who inject drugs can obtain sterile injecting equipment and dispose of used needles in a responsible, hygienic, and safe manner. Needle exchange is a harm reduction method that is offered by many pharmacies in Birmingham. There is an extensive network of nearly 100 pharmacies and 6 specialist needle exchanges across Birmingham. Between January 2016 and September 2021, 7,138,340 needles were distributed by pharmacies.[323] There are three different types of packs:

- 1ml packs (containing 10 fixed needle syringes). These are usually 29G by 12mm and used directly into the vein (e.g., arms, feet, in between toes and fingers). Overall, 538,146 packs and 5,381,460 needles have been distributed, which is an average of 7,799 packs each month.
- Deep vein packs (containing 10 x 2ml syringes). Steroid needles need to be thick as they are going through muscle and tissue (groins, thighs, buttocks). Overall, 122,957 packs and 1,229,570 needles have been distributed, an average of 1,781 packs each month.
- Steroid packs (containing 10 x 2ml low dead space (reduces the risk of BBV's) syringe barrels, 10 x green needles (21G x 1.5") and 10 x blue needles (23g x 1.25")). The longer needle 1.5" will be used for drawing up (getting the liquid out of the vial) and the

[317] GOV.UK Public health ring-fenced grant financial year 2024 to 2025. Accessed May 2024.
[318] MEAM. (2022). Multiple disadvantage and co-occurring substance use and mental health conditions. Accessed Nov 2023.
[319] Turning Point. (2021). The SUMH Resource Pack. Accessed Dec 2023.
[320] NHS. (2019). The Community Mental Health Framework for Adults and Older Adults. Accessed Mar 2023.
[321] NICE. (2011). Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services. Accessed May 2023.
[322] King's Fund. (2010). Continuity of care and the patient experience. Accessed May 2023.
[323] Birmingham City Council. (2021). Birmingham Substance Use Needs Assessment. Accessed Jul 2023.

shorter needle (1.25”) to inject, so in effect there are 10 needles in a pack. Overall, 52,721 packs and 527,210 needles have been distributed, an average of 764 packs per month.[324]

In July 2022, a new ***Vulnerable Adults Pathway*** was commissioned by Birmingham City Council to support individuals who require regular help to manage their lives and wellbeing. It provides early intervention to prevent individuals reaching crisis point, supports resilience and the maintenance of independence. A lead worker will be assigned to each individual to provide support and advocacy, which can be available for up to two years. To provide stability, accommodation may be provided for up to two years and providers will develop move-on pathways to support the needs of the individual to reach their housing goals. These include step-down independent living and will include the Mental Health Trust and Forward Thinking Birmingham. Vulnerable adults should work towards achieving independent accommodation at the end of support, such as an independent tenancy or shared living. Providers will work closely with other organisations, including substance misuse services, GPs, pharmacies and secondary health care provision, as well as neighbourhood network schemes and other voluntary and community organisations. Individuals will be supported into education, employment and training opportunities as part of the PURE project, which is funded by the European Social Fund.

This will be available for five years until June 2027, with the possibility of a further two year extension, and has involved the commissioning of multiple providers. The commissioning for adults with mental health support needs involves lead worker services, (providing face to face support, both short and long term) and long term and emergency accommodation. Birmingham Mind, Home Group and Cranstoun have been commissioned to provide the lead worker services. Birmingham Mind, Home Group and Anvil House have been commissioned to provide the accommodation services. Individuals will be supported into education, employment and training opportunities as part of the PURE project, which is funded by the European Social Fund.[325]

4.2 Services for Children, Young People and Families

4.2.1 Aquarius

Birmingham City Council (non-prescribed function of the Public Health Ring-Fenced Grant) commissions a service to support young people living with substance misuse. This service is provided by Aquarius, who support young people across the West Midlands who are affected by alcohol, drugs and gambling. They provide a ***Young Person’s Service*** which supports children and young people with substance misuse, as well as children and young people who are affected by a parent or carer’s substance misuse. Available support includes information and advice, a drop-in service and structured interventions.[326]

The ***Aquarius CARES*** service supports children and young people who are looked after and misuse substances or alcohol, or who are affected by a parent or carer’s substance misuse. This service also supports care leavers (up to the age of 25) and kinship carers. This service supports children and young people through participation in the 12-week ***CHOICES Programme***. This aims to build resilience and coping skills, healthy relationships, support around substance misuse, and is tailored to meet the needs of the young person. For those

[324] Birmingham City Council. (2021). Birmingham Substance Use Needs Assessment. Accessed Jul 2023.
[325] Information emailed directly from Adult Social Care. Accessed Sep 2022.
[326] Aquarius. Young Peoples Services. Accessed May 2024.

aged under 16, support is available for the whole family and includes one-to-one support, as well as the opportunity to meet other families who may be experiencing similar situations. For those aged 16-25, there is additional peer mentoring and opportunities to engage with service development and qualifications through Aquarius projects.[327]

Derby Family Drug and Alcohol Safeguarding Service

The Family Drug and Alcohol Service in Derby was commissioned by Derby City Council in 2012, and delivered by Aquarius who work with families where there is parental substance misuse. This service supports parents on a 1-1 basis at home and in the community to improve outcomes for the whole family. Alongside this, the Choices Project supports young people in schools who are affected by parental substance misuse to build resilience, promote safety strategies, and build support networks to safeguard against parental substance misuse. The Family Drug and Alcohol Service also provides peri-natal parenting programmes, peer groups and family activities. Wider support is available to meet housing, debt and employment needs, and families are supported to identify protective factors against parental substance misuse, and identify positive social networks.

The Family Drug and Alcohol Service also runs a pre-proceedings intensive programme which is a specialist programme for parents where there is significant concern or high likelihood of escalation to Public Law Outline. This programme involves a whole family assessment and a 12-week programme of intensive support and interventions around substance misuse, home safety, parenting and building relationships. Families take part in the M-Pact Parenting Course which is a family programme building family wellbeing. This programme may also include referrals (e.g., child protection conferences), and consultations with social care teams.

Other support includes fortnightly pregnancy safeguarding meetings to discuss pregnant parents living with substance misuse, delivering the 6-week Parenting Prospective programme, attending locality vulnerable children's meetings, and delivering the training 'working with substance using parents' to professionals working with families in Derby.[328]

4.2.1.1 Client Characteristics

Aquarius are responsible for caring for young people (aged under 25) who are experiencing substance misuse problems in Birmingham. Table 12 provides trend data for young people who received treatment with Aquarius between April 2019 and March 2024. This shows a 30% decrease in young people receiving treatment during 2020-21 (n=82) due to the COVID-19 pandemic, followed by a rise in numbers since that date, including a 50% increase from 2022-23 to 2023-24. During the five years from 2019-20 to 2023-24, 1,170 young people received substance misuse assistance from Aquarius. 488 (41.7%) had a mental health need and 117 (24.0%) had been diagnosed with a mental health need and were receiving substance treatment.

[327] Aquarius. Aquarius CARES. Accessed Apr 2022.
[328] Aquarius, Family Drug and Alcohol Service. Information received internally. Accessed Mar 2024.

Table 12: Young People Receiving Substance Misuse Treatment with Aquarius (2019-24).

Group	2019-20	2020-21	2021-22	2022-23	2023-24	Total
Total young people misusing substances	273	191	188	207	311	1,170
Mental health need	109	81	66	88	144	488
Percentage of need	39.9%	42.4%	35.1%	42.5%	46.3%	41.7%
Diagnosed mental health	32	15	13	23	34	117
Percentage of need	29.4%	18.5%	19.7%	26.1%	23.6%	24.0%

Source: Aquarius.[329]

Table 13 provides an age summary of young people receiving substance misuse treatment with Aquarius, but also whether they were affected by parental substance misuse. Over the five year period, 85.2% of those in treatment with Aquarius misused substances themselves (n=997), with the highest percentage being among young people aged under 14 (95%). There were no clients who misused substances in treatment over 18 years of age and none were affected by parental substance misuse.

Table 13: Young People receiving Treatment from Aquarius by Age Group and whether Affected by Parental Substance Misuse (2019-24).

Age	Total	Young People Misusing Substances	Percentage	Young People Affected by Parental Substance Misuse	Percentage
Under 14	300	285	95.0%	15	5.0%
15-16	527	477	90.5%	50	9.5%
17-18	289	235	81.3%	21	7.3%
18+	54	0	0.0%	0	0.0%
Total	**1,170**	**997**	**85.2%**	**86**	**7.4%**

Source: Aquarius.[329]

Table 14 provides a gender summary of the categories above. This shows that there were a higher number of males in treatment who misused substances (n=706) than females (n=286), and that males were more likely to misuse substances (87.2%) than females (80.8%). However, the data also shows that females have a higher percentage who are affected by their parent's misuse of substances (8.8%).

Table 14: Young People receiving Treatment from Aquarius by Gender and whether Affected by Parental Substance Misuse (2019-24).

Gender	Total	Young People Misusing Substances	Percentage	Young People Affected by Parental Substance Misuse	Percentage
Female	354	286	80.8%	31	8.8%
Male	810	706	87.2%	54	6.7%
Unknown	6	*	83.3%	*	16.7%

Note: A field marked with '' suggests a figure of 5 or below.*

Source: Aquarius.[330]

[329] Information received directly from Aquarius via email. Email received April 2024.
[330] Information received directly from Aquarius via email. Email received April 2024.

Table 15 provides a summary of young people receiving substance misuse treatment with Aquarius, by ethnic group. This shows that the young people from a white background represent the ethnic group with the largest percentage in treatment (44.3%). However, whilst at an individual background level they are the highest, the data also shows that 55.7% (n=652) of young people are from black and ethnic minority groups.

Table 15: Young People receiving Treatment from Aquarius, by Ethnicity (2019-24).

Ethnicity	Total	Percentage
White	518	44.3%
Asian	208	17.8%
Black	225	19.2%
Mixed	174	14.9%
Any other ethnicity	24	2.1%

Source: Aquarius.[330]

Table 16 provides a summary of young people who have a substance problem themselves or are affected by parental substance misuse, by ethnic group. The 'any other ethnicity' group forms the largest proportion within an ethnic group of young people who misuse substances (95.8%; n=23). Young people from an Asian background form the next largest proportion within an ethnic group (92.3%; n=192). Young people from a white background have the largest proportion within an ethnic group who are affected by parental substance misuse (10.0%; n=52).

Table 16: Young People receiving Treatment from Aquarius by Ethnic Group and whether Affected by Parental Substance Misuse (2019-24).

Ethnicity	Total	Young People Misusing Substances	%	Young People Affected by Parental Substance Misuse	%
White	518	417	80.5%	52	10.0%
Asian	208	192	92.3%	10	4.8%
Black	225	195	86.7%	10	4.4%
Mixed	174	152	87.4%	11	6.3%
Any other ethnicity	24	23	95.8%	*	4.2%
Unknown	21	18	85.7%	*	9.5%

Note: A field marked with '' suggests a figure of 5 or below.*

Source: Aquarius.[331]

Table 17 provides data on young people who have transitioned into adulthood during the last five years whilst receiving treatment with Aquarius. This shows that during this period, there has been an increase in the number of young people in treatment transitioning into adulthood. It also shows that Aquarius have treated 87 young people transitioning into adulthood, which was 7.4% of all the young people they have treated.

[331] Information received directly from Aquarius via email. Email received April 2024.

Table 17: Young People in Treatment with Aquarius Transitioning into Adulthood (2019-24).

Group	2019-20	2020-21	2021-22	2022-23	2023-24	Total
Total young people	273	191	188	207	311	1,170
Young people in transition	7	5	10	6	59	87
Percentage	2.6%	2.6%	5.3%	2.9%	19.0%	7.4%

Source: Aquarius.[331]

4.2.2 Change Grow Live

Change Grow Live provide drug and alcohol services through hubs across the city: Central and West, South, East, and North Hub. Hubs are accessed by appointments.[332]

Change Grow Live Birmingham have a dedicated ***Women's Team,*** which offers a women's only space for service users. This team are involved in a number of projects including work with Heartlands, Good Hope and University Hospital Birmingham to support substance misuse midwives and women becoming mothers.[333] The Women's Team also works closely with Birmingham Children's Trust, including liaison with social workers, writing court reports and actively participating in child protection conferences and other meetings. A proportion of Family Drug and Alcohol Court clients are helped by the Women's Team, whose role is to support the service user through the process and with recovery. The Women's Team are working with Umbrella Health on the 'Healthy Pregnancies Workshop' pilot.[334]

4.2.3 Family Drug and Alcohol Court

"[FDAC provided] parenting insight on how to safeguard child [and] taught me how to control emotions positively."

FDAC Parent with Dual Diagnosis in Birmingham

"The challenges of FDAC include balancing the timescales of court and the children with the realistic timescales of parents' recovery from addiction. We often work with parents with high levels of trauma and complicated background history."

FDAC Professional in Birmingham

"It is difficult to tell children about drugs and alcohol in an appropriate way due to the sensitivity of the subject. Professionals often get nervous about this and so do not do the work with the child when it would actually be helpful as the child has lived through it."

FDAC Professional in Birmingham

In February 2021, the ***Birmingham and Solihull Family Drug and Alcohol Court (FDAC)*** launched a new programme aimed at reducing the number of children taken into care, by supporting parents with drug and alcohol addictions. This specialist court is provided in partnership by Birmingham Children's Trust and Solihull Metropolitan Borough Council and is overseen by judges, who work with parents to find solutions to substance misuse, domestic abuse and mental health problems.[335] Through this alternative model, parents are provided

[332] Change Grow Live. Drug and Alcohol Service – Birmingham. Accessed May 2024.
[333] Change Grow Live. May Bulletin - Birmingham. (2021). Accessed May 2022.
[334] Information received directly from CGL via email. Email received July 2022.
[335] Birmingham Children's Trust. Birmingham and Solihull Family Drug and Alcohol Court launches. (2021). Accessed May 2022.

with a 'trial for change', allowing them the best possible chance to overcome their problems.[336] Families see a judge every two weeks with the aim to address the problems and keep the family together.[337] Interventions and support provided to parents may include a mix of accessing local services and working with the FDAC team. Parents are generally supported with four areas, including abstinence, understanding and repair, strengthening relationships and a child-centred lifestyle.[338]

Evaluating long term outcomes of cases from the London FDAC, Harwin et al. found that the majority of cases cited 'neglect' as their primary cause of concern. Almost half of children involved in the cases had health conditions such as asthma, neonatal abstinence syndrome or sight problems. Many of the families experienced co-occurring mental health and domestic abuse problems alongside substance misuse. More of the children involved in the FDAC model were living with their parents or reunited at the end of care proceedings (37%), compared to those going through usual proceedings (25%). Mothers going through the FDAC model were more likely to have ended their misuse of substances (46%), compared to mothers who were going through usual proceedings (30%). Of those who had ceased their substance misuse, mothers within the FDAC model were more likely to have continued their abstinence at 5 year follow-up (58%), compared with mothers that went through usual proceedings (24%).[339]

An evaluation of this model found that children involved in FDAC were more likely to be reunified with their primary carer at the end of care proceedings (52.0%), compared with standard proceedings (12.5%). There was also a lower probability of children being placed in local authority care with FDAC (28.6%) than standard proceedings (54.7%). Additionally, there were higher rates of parents ceasing drug or alcohol misuse for those going through FDAC (33.6%), compared to standard proceedings (8.1%).[340]

4.2.4 Forward Thinking Birmingham

Forward Thinking Birmingham is the city's mental health partnership for citizens aged 0-25 years. This is a partnership between Birmingham Women's and Children's NHS Foundation Trust, Simplify Health, The Priory and The Children's Society.[341]

The *Core Community Hub* teams work across the city with children and young people who are in need of specialist mental health services. These teams provide assessment and treatment.[342] They also provide a Crisis team, an Early Intervention in Psychosis service (for under 35s), and a Home Treatment team. Community and inpatient services work together to support young people in need of admission.[343]

4.2.5 Youth First

Youth First is a specialist CAMHS service, run by Birmingham and Solihull Mental Health Foundation Trust for high-risk children and young people with complex needs. This team work with health, social care, youth offending teams and others, including youth justice. They

[336] Birmingham Children's Trust. Family Drug and Alcohol Court - Information for professionals. Accessed May 2022.
[337] Birmingham Children's Trust. Birmingham and Solihull Family Drug and Alcohol Court launches. (2021). Accessed May 2022.
[338] Birmingham Children's Trust. Family Drug and Alcohol Court - Information for families. Accessed May 2022.
[339] Harwin et al. (2018). Child and Parent Outcomes in the London Family Drug and Alcohol Court Five Years On: Building on International Evidence. Accessed May 2022.
[340] FDAC. Evaluation of Family Drug and Alcohol Courts: Implications for Policy and Practice. Accessed Aug 2023.
[341] Birmingham Women's and Children's NHS Foundation Trust. Forward Thinking Birmingham. Accessed Apr 2022.
[342] Forward Thinking Birmingham. Core Community Hubs. Accessed Apr 2022.
[343] Forward Thinking Birmingham. Hospital Admissions. Accessed Apr 2022.

provide early intervention to support young people with mental health needs and to prevent young people being escalated into youth custody or inpatient care.[344]

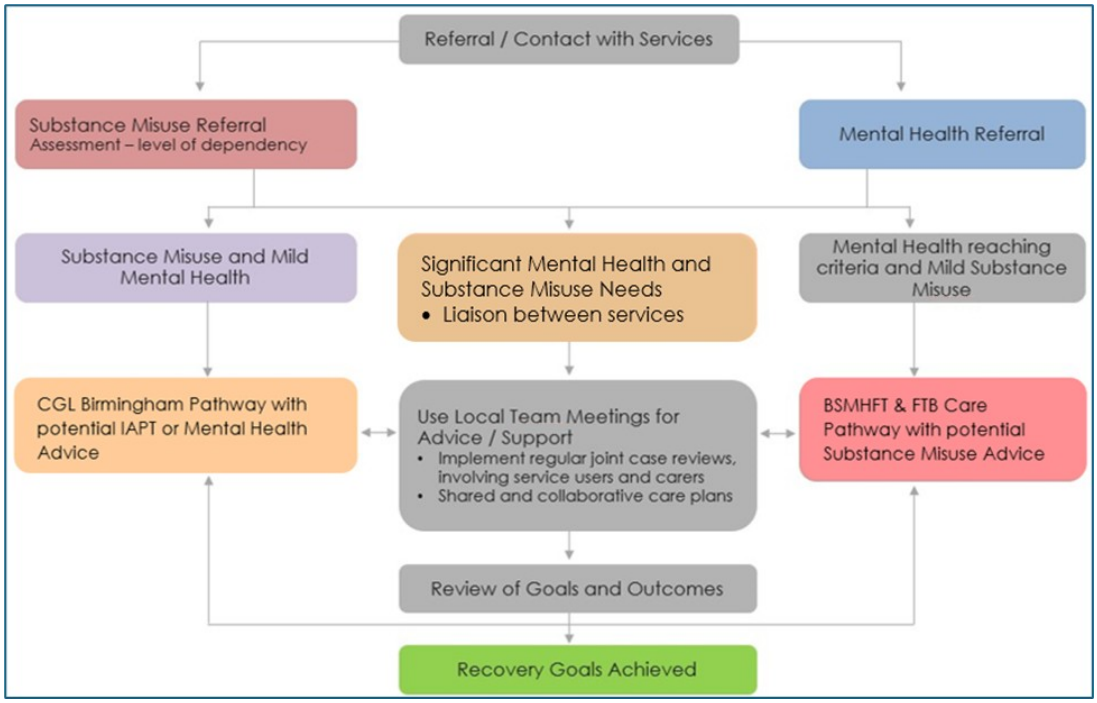
4.3 Services for Adults

4.3.1 Working Protocol for People with Co-existing Mental Health and Substance Misuse Disorders (Dual Diagnosis) (2024)

Birmingham's Dual Diagnosis Joint Working Protocol expands on the partnerships between Change Grow Live (CGL), Birmingham and Solihull Mental Health Trust (BSMHFT), and Forward Thinking Birmingham (FTB). Protocol partners include Aquarius, GPs, Public Health, Adult Social Care, Birmingham Children's Trust, Datus, Kikit, Intuitive Thinking Skills and Emerging Futures. The implementation of the joint protocol is overseen by the Joint Integrated Governance Group and is informed by the Community Mental Health Framework, implementing a principle of 'no wrong door'. Shared principles of the Protocol include:

- Forming positive and constructive relationships between agencies.
- No exclusion from mental health services due to the perception that the mental health need is substance induced.
- Encouraging the individual to take control over their treatment.
- Taking account of the person's family and responsibilities and the needs of carers.
- Clearly defining the roles of agencies to support the individual.

Figure 13: Pathways for the Management of Dual Diagnosis in Birmingham.



Source: Working Protocol for People with Co-existing Mental Health and Substance Misuse Disorders (Dual Diagnosis).[345]

Joint working relates to the involvement from CGL, BSMHFT and FTB to assess and support service users in treatment. Figure 13 (above) shows the pathways for the management of dual diagnosis in Birmingham.

[344] Birmingham and Solihull Mental Health Foundation Trust. Youth First. Accessed Jul 2023.
[345] Information supplied by CGL. Accessed 2024.

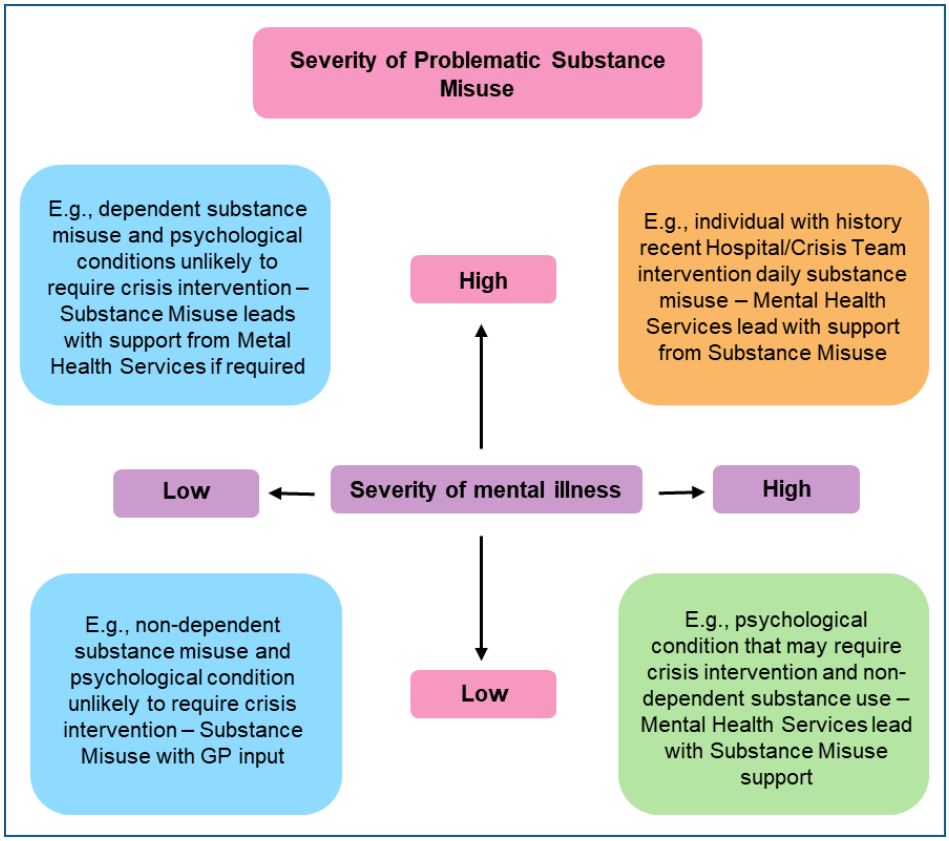


Figure 14: Diagram of Treatment Pathways for Citizens with Mental Illness and Substance Misuse.

Source: Working Protocol for People with Co-existing Mental Health and Substance Misuse Disorders (Dual Diagnosis).[346]

4.3.2 Dual Diagnosis Services

4.3.2.1 COMPASS Programme

COMPASS is a service within the Birmingham and Solihull Mental Health Foundation Trust whose primary function is to offer supervision, consultation and training to the mental health workforce within the trust in order to support their practice in delivering substance misuse orientated intervention to patients. In some instances, direct support is offered to patients through COMPASS for direct and time-limited intervention. This is for adults with a care coordinator within the trust who have a serious mental illness, who also have historic or current substance misuse and who consent to the referral. COMPASS use the term 'dual diagnosis' to refer to service users who present with severe complex mental health needs and drug misuse and/or alcohol misuse.[347]

4.3.2.2 Dual Diagnosis Anonymous

Dual Diagnosis Anonymous is a core group of members with experience of dual diagnosis who provide peer support for the management of mental health and substance addiction issues. Dual Diagnosis Anonymous run regular online meetings in the UK and also provide some in-person meetings, following a 12+5 Step model programme.[348] The additional 5 steps

[346] Information supplied by CGL. Accessed 2024.
[347] Information supplied by COMPASS. Accessed Mar 2024.
[348] Dual Diagnosis Anonymous. About Us. Accessed Mar 2023.

of the programme were created due to the additional difficulties that people living with dual diagnosis may experience, in comparison to those with a single diagnosis. Part of these steps is to recognise a difficulty with both substance misuse and mental health and being willing to accept help for both.[349]

During the COVID-19 pandemic, membership of Dual Diagnosis Anonymous grew around England, including in the Midlands. While this has increased the number of members accessing meetings, it is understood that most of this new membership has been online and that there is currently no in-person meeting availability in Birmingham.[350]

4.3.3 Substance Misuse Services

4.3.3.1 Change Grow Live

Change Grow Live (CGL) provide several adult drug and alcohol services across the city. Their services include information and advice, peer and group support, and alcohol and drug treatment options. CGL run the *Park House Inpatient Treatment Service* in Birmingham, which provides detoxification and stabilisation programmes to meet client's needs.[351]

Group Support is offered by CGL through a variety of groups which clients can attend. These run at different times and days across the city and include an LGBTQ+ group, Managing anxiety, Open recovery, Veterans group, Sleep hygiene and relaxation, IPS support.[352]

Since 2015, Birmingham City Council have commissioned CGL to provide substance misuse treatment services within the city. CGL have assisted in this research by providing treatment data for their client population in April 2022 (n=2,958). The majority of CGL's clients were male (72%).

At point of entry to CGL treatment, each client is asked to self-report whether they have a pre-existing mental health need. More female clients responded that they had a pre-existing mental health condition that required dual diagnosis treatment (73.8%), compared to male clients (55.9%). This trend is similar to that reported in the general population, with mental health problems more common among women (one in five women) than men (one in eight men).[353]

CGL clients are reviewed regularly and those with mental health needs are asked about changes experienced as a result of the treatment they are receiving. However, it should be noted that the initial question of having a mental health issue is a 'self-report' and as such, does not necessarily represent a clinical diagnosis. Table 18 shows a breakdown of total clients (n=2,958) as at April 2022, and the clients who self-reported mental health conditions at entry to CGL (n=1,804). The percentage of the total client database receiving mental health treatment currently is 44% of all clients. Whilst 54.9% of those clients who identified they had a mental health problem at time of entry into treatment are currently receiving mental health treatment, the data also shows that 17.7% of self-reporting clients (n=319) had not received a mental health diagnosis.

[349] Dual Diagnosis Anonymous. The DDA 12 Steps Plus 5. Accessed Mar 2023.
[350] Information received directly from Dual Diagnosis Anonymous.
[351] Change Grow Live. Park House Inpatient Treatment Service – Birmingham. Accessed Apr 2022.
[352] Change Grow Live. Drug and Alcohol Service Birmingham. Accessed Apr 2022.
[353] Mental Health Foundation. Men and Women: Statistics. Accessed May 2024.

Table 18: Treatment Status for Clients who Self-Reported Mental Health Condition at Entry to CGL.

Client status	Total Clients	Percentage of Clients	Self-Reported Clients	Percentage of Clients
Currently in mental health treatment	1,288	44.0%	990	54.9%
Received treatment for MH diagnosis in last 3 months	15	1.0%	37	2.1%
Received treatment for MH diagnosis previously (not in last 3 months)	223	8.0%	148	8.2%
Client did not identify whether they had received treatment	266	9.0%	129	7.2%
Never received any MH diagnoses	665	22.0%	319	17.7%
No reply given to question	501	17.0%	181	10.0%
Total	**2,958**	**100%**	**1,804**	**100%**

Source: CGL Client Database.[354]

In April 2022, the majority of CGL clients were from a white ethnic background (75%), followed by Asian (11%), mixed (6%), black (4%), unknown (2%) and 'other' (1%) ethnic backgrounds.

50% of CGL clients from a white background self-reported that they had a current mental health need or have experienced this sometime in the past. This compares to 36% of those from an Asian background and 53% of those from a mixed background. 33% of clients from an Asian background did not feel that they had ever had a mental health need.

Among CGL clients undergoing drug and alcohol recovery treatment who have a confirmed, current or past mental health condition and could therefore be classed as having a dual diagnosis, the mixed ethnic group contains the largest percentage undergoing treatment (53%), compared to those from a white (45%) or black (44%) background.

An analysis of self-reported drug misuse shows that opiate misuse was the most common form of substance misuse across all ethnic groups.

An analysis of CGL clients by age shows that the 35-44 age group represents the largest proportion of clients (45%). This is followed by those aged 45-54 years (26.9%), 25-34 years (18.2%), 55-64 years (7%), 18-24 years (1.5%) and 65+ (1.5%). The age group with the largest percentage of self-reported mental health need was the 18-24 age group (76.7%). However, clients within the 35-44 age group reported the lowest percentage of mental health need (56.9%).

Table 19: CGL Clients Self-Reporting Mental Health Need, by Age Groups (Apr 2022).

Age Groups	Total Clients	Percentage	Clients Self-Reported	Percentage of Clients	Percentage Self-Reporting
18-24	43	1.5%	33	1.8%	76.7%
25-34	538	18.2%	368	20.4%	68.4%
35-44	1,331	45.0%	757	42.0%	56.9%
45-54	796	26.9%	480	26.6%	60.3%
55-64	206	7.0%	140	7.8%	68.0%
65 and over	44	1.5%	26	1.4%	59.1%
Total Self-Reporting Clients	**2,958**	**100%**	**1,804**	**100%**	**N/A**

Source: CGL Client Database.[355]

[354] Information received directly from CGL via email. Email received Apr 2022.
[355] Information received directly from CGL via email. Email received Apr 2022.

While clients within the 35-44 age group reported the lowest percentage of mental health need (57%), this age group had the highest proportion currently receiving mental health treatment (41%). This age group also represented the largest group for those with previous mental health treatment (49%) and those not known (49%), whereas the largest group to have received treatment in the previous 3 months were those aged 25-34 years (53%).

Opiate misuse was the most frequent drug category among those aged 18-24 years, representing 48%. For those aged 25-34, the most frequent drug category was non-opiate (53%) and for those aged 35-44, this was opiate misuse (48%). For those aged 45-54 (31%) and 55-64 (20%), alcohol was the most frequent category.

4.3.3.1.1 Birmingham CGL Clients who are Parents

The majority of CGL clients who were in treatment in April 2022 were recorded as parents (n=1,920, 65%), while 35% were not parents (n=1,038). However, this data only relates to parents of children aged under 18, meaning that the data does not include adult children. Of those who were parents, only 11% lived with their children, whilst 87% were not living with them. The remaining parents (2%) were recorded as having some, but not all their children living with them.

Of the clients who were parents, 38% (n=731) self-reported that they had a current mental health need. 11% of these 731 parents were recorded as living with their children, whereas the majority of this group (89%) reported not currently living with their children. Of these 731 CGL clients (who were parents with a self-reported mental health need), there were a total of 689 children recorded. In the majority of cases, none of the client's children were living with them (69%). Furthermore, 18% of children lived with the parent who was a client of CGL and 6% of children lived with a parent who was a client of CGL but may have had other siblings who did not. 7% did not live with that parent client, due to no parental responsibility.

Of the 1,920 clients who were parents, 43.6% (n=838) had received a confirmed mental health diagnosis in the last 3 months and were currently receiving treatment. The majority of these 838 clients who had a confirmed mental health diagnosis and who were undergoing mental health treatment did not live with their children (n=738; 88.1%). 80 clients with a mental health diagnosis who were undergoing mental health treatment had all of their children living with them (10.8%) and 20 clients had some of their children living with them (2.7%).

4.3.3.1.2 CGL Clients With Mental Health Risks

In April 2022, the total CGL client base was 2,958 clients. Of these, 2,430 clients (82.2%) were recorded as having a diagnosed mental health condition and/or self-reported mental health concerns. Of the remaining 528 clients (17.8%), there were 108 clients (20.4%) recorded as having one or more of the following risks, but did not have a diagnosed mental health condition and/or self-reported mental health concern identified at the time of the assessment. 12 clients had current mental health risks, 8 had mental health risks in the past 3 months and 89 had mental health risks previously. These 108 clients equated to 3.7% of the total CGL client base.

The categories of mental health risk included: thoughts of suicide/ self-harm (n=54), attempted suicide (n=21), hallucinations (n=11), frequent and life-threatening self-harm (n=10), hospital admissions relating to mental health (n=5). A further three categories of mental health risk included psychosis, psychiatric/ previous crisis team intervention and current/ previous self-harm and these each contained 5 or fewer clients. This data implies that there are individuals undergoing substance treatment without a diagnosed mental health condition or self-reported

mental health concern, despite having a record of other mental health risks. Therefore, it is particularly concerning that there are individuals currently experiencing serious mental health problems, such as attempting suicide, self-harm and thoughts of suicide and self-harm, who have not been recorded as either having a diagnosed mental health condition nor a self-reported mental health concern. This evidence suggests that further psychiatric screening and assessment for mental health conditions would be beneficial for the clients of substance misuse service providers.

4.3.3.1.2.1 Clients With a Diagnosed Mental Health Condition or Self-Reported Mental Health Concerns Only

Of the total CGL client base (n=2,958), 1,288 clients were recorded as having a diagnosed mental health condition (43.5%), 1,142 clients self-reported mental health concerns (38.6%) and 837 were recorded as having both (28.3%). However, there were 1,038 clients who were recorded as having a diagnosed mental health condition only (35.1%), and 212 clients recorded as self-reporting mental health concerns only (7.2%). Whilst this is not intrinsically a cause for concern, it highlights the complexities in recognising and diagnosing mental health problems in clients who misuse substances. For the 212 clients who self-reported mental health concerns but did not have a diagnosed mental health condition, this may mean that they are awaiting an appointment to be assessed or possibly that they do not qualify as having a mental health condition from a clinical perspective. For the 1,038 clients with a diagnosed mental health condition but no self-reported mental health concerns, this suggests that these individuals are unable to evaluate their condition accurately or that they do not perceive their mental health condition as cause for concern, or do not wish to disclose it. The exact reasons for these discrepancies should be investigated for each client who has not been recorded as having both a diagnosed mental health condition and self-reported mental health concerns.

4.3.3.1.2.2 Types of Treatment Currently being Received for Mental Health

Of the 2,958 clients on the CGL database in April 2022, 74% (n=2,189) provided a response to the following question: 'Are you currently receiving any treatment for mental health?' There were seven potential responses to the question (Table 20).

Table 20: CGL Clients Currently Receiving Mental Health Treatment (April 2022).

Type of Mental Health Treatment Received	Clients	Percentage
Already engaged with the community mental health team	406	18.5%
Engaged with IAPT	<10	*
Receiving mental health treatment from GP	786	35.9%
Identified space in a health-based place of safety	168	7.7%
Receiving any NICE recommended interventions	<10	*
Need identified but no treatment	820	37.4%
No answer	759	34.7%
Client declined to commence treatment for their mental health	<10	*

Source: CGL Client Database.[356]

Note: A field marked with '' indicates where data has been supressed.*

The most frequent response was 'need identified but no treatment' (37.4%), followed by 'receiving mental health treatment from GP' (35.9%), 'already engaged with the community mental health team' (18.5%), then 'identified space in a health-based place of safety' (7.7%).

[356] Information received directly from CGL via email. Email received Apr 2022.

The other answers all received fewer than 10 responses. Responses were irrespective of the substance that the respondent was being treated for.

4.3.3.2 Turning Point

Turning Point are a social enterprise, supporting people with learning disabilities, mental health problems, and substance misuse problems. They provided health and social care support to over 171,000 people in 2022-23,[357] across 300 locations in England.

In 2021, Turning Point were involved in setting up a unique social prescribing service in Birmingham, supporting patients with complex social issues including homelessness, drug and alcohol misuse. Patients are referred from GPs to social prescribers (link workers), who are able to provide community based early support. A multidisciplinary team work with link workers, local services, and community organisations to support people in accessing support. It involves 25 GP practices and aims to reduce the experience of being passed between services, for those with multiple needs. Since the start of this work in August 2021, over 380 people have been supported, with engagement from services including Birmingham Healthy Minds, Barnardo's, SIFA Fireside and Housing Services (Birmingham City Council).[358] Across Birmingham and Shropshire (2021-22) over 580 people had been engaged with these services, including 70 people with learning disabilities, 151 with mental health problems and 185 with substance misuse. These services supported seven people into employment.[359]

4.3.3.3 KIKIT

KIKIT is based in Sparkbrook and predominantly supports those from black, Asian and ethnic minority communities. They are funded by Birmingham Public Health and CGL, and provide community-based activities and treatment programmes for those living with substance misuse and to address health and social wellbeing as well as community safety. They have a drop-in centre staffed by volunteers and health care professionals.[360] The KIKIT drugs and alcohol support is culturally sensitive, cultural and faith based. They work in partnership with Change Grow Live, to co-deliver a range of recovery services including support for Khat users. KIKIT also offer peer mentoring, outreach support and family and carer support, alongside their drug and alcohol recovery programmes.[361]

4.3.3.4 Birmingham LGBT

Birmingham LGBT offer counselling and psychotherapy for individuals identifying as LGBT who are experiencing issues with their sexuality, gender or sexual health.[362] They also offer a wellbeing support service for LGBT individuals to improve wellbeing and reduce isolation. Birmingham LGBT recognise that LGBT people may be at a higher risk of experiencing some mental health conditions, such as depression and anxiety, as well as self-harm, suicidal feelings and drug and alcohol misuse.[363] Birmingham LGBT also offer a Chemsex Support Service. *Chemfidential* is a free and confidential service for adults needing support around chems or chemsex, and is supported by the *Umbrella* sexual health service,[364] which is commissioned by Birmingham Public Health.

[357] Turning Point. About Us. Accessed Dec 2023.
[358] Turning Point. Annual Report 2022. Accessed Dec 2023.
[359] Turning Point. Annual Report 2023. Accessed May 2024.
[360] KIKIT. About Us. Accessed May 2022.
[361] KIKIT. KIKIT Drugs and Alcohol. Accessed May 2022.
[362] Birmingham LGBT. Counselling and Psychotherapy. Accessed May 2022.
[363] Birmingham LGBT. Wellbeing Support Services. Accessed May 2022.
[364] Birmingham LGBT. Specialist Services – Chemsex. Accessed May 2022.

4.3.3.5 Alcohol Care Team

Sandwell and West Birmingham Hospital NHS Trust commission *Alcohol Care Teams* within their acute hospitals, to provide specialist alcohol care for patients with alcohol dependence. The aims of these teams are to reduce preventable admissions to hospital, improve the management of acute withdrawal, improve education for staff and provide access for interventions for patients.[365] University Hospitals Birmingham also have in place Alcohol Care Teams.[366]

4.3.3.6 Narcotics Anonymous

Narcotics Anonymous is a community of people who support each other to achieve and maintain a drug free life. The only requirement for participation is a desire to stop using drugs.[367] There are a variety of Narcotics Anonymous meetings around Birmingham, at various times and locations.[368]

4.3.3.7 Alcoholics Anonymous

Alcoholics Anonymous is a fellowship where people share experiences and peer support for recovery from alcoholism. It is open to anyone who feels they have a problem with alcohol, regardless of the length of this problem.[369] Birmingham's Intergroup of Alcoholics Anonymous offers support for those wanting to recover from alcoholism. Meetings occur across the city at various locations and times, including local churches, community centres, and online.[370]

4.3.4 Mental Health Services

4.3.4.1 Birmingham Solihull Mental Health Trust

Birmingham and Solihull Mental Health Trust provide an array of mental health services throughout Birmingham and Solihull, both in the community and in hospitals. These include adult inpatient services across the city for those with mental health conditions who are experiencing acute psychiatric crisis[371] and community mental health teams who provide assessment, support and treatment for Birmingham citizens aged over 25 with functioning mental health problems.[372] Assertive outreach teams support citizens aged 25+ with severe and persistent mental health problems through therapeutic engagement to reduce hospitalisation and symptoms.

The Crisis Resolution and Home Treatment teams support those with severe mental health problems, some of whom also have co-occurring substance misuse and alcohol problems. This service is aimed at individuals aged 25+ and works to prevent the hospitalisation of those it supports.[373] Furthermore, Birmingham Healthy Minds is a free IAPT service for depression and anxiety, which is open to anyone aged 16+ who is registered with a Birmingham GP. People are able to self-refer and can access assessments and treatment.[374]

[365] Zero Suicide Alliance. Sandwell and West Birmingham Hospital Alcohol Care Team. Accessed May 2022.
[366] University Hospitals Birmingham. Alcohol Care Team. Accessed May 2024.
[367] Narcotics Anonymous UKNA Accessed Jul 2023.
[368] Narcotics Anonymous UKNA Meetings. Accessed Jul 2023.
[369] Alcoholics Anonymous. Who we are. Accessed Jul 2023.
[370] Alcoholics Anonymous. Birmingham Intergroup. Accessed Apr 2022.
[371] Birmingham and Solihull Mental Health NHS Foundation Trust. Adult Inpatient Services. Accessed Jul 2023.
[372] Birmingham and Solihull Mental Health Foundation Trust. Community Mental Health Teams. Accessed Mar 2024.
[373] Birmingham and Solihull Mental Health Foundation Trust. Home Treatment Teams. Accessed Feb 2024.
[374] Birmingham and Solihull Mental Health Foundation Trust. Birmingham Healthy Minds. Accessed May 2022.

4.3.4.2 Community-Based Mental Health Services

Birmingham Mind offer a variety of services supporting citizens with their mental health and wellbeing. Services include a helpline, supported accommodation, residential care and support in one's own home. Birmingham Mind are funded by the local authority or Birmingham ICB. [375] The Birmingham Mental Health and Wellbeing Hub is delivered by Mind and with Creative Support and operates four recovery hubs around the city. This service allows peer-led support networks and groups to take place and offers a blend of face-to-face and virtual sessions.[376]

Example of Good Practice - Mind

The branch of Mind in Bath, Somerset, in collaboration with Developing Health & Independence (DHI),[377] provide a dual diagnosis service. They support people who are working on recovery from substance or alcohol misuse by offering mental health support at the same time, in the form of emotional support, sharing information on coping strategies and signposting for other local mental health services.[378]

Telford Mind, Telford After Care Team, A Better Tomorrow and Telford and Wrekin Council deliver Dual Diagnosis Calm Cafes at two venues. These are staffed by mental health and substance misuse professionals and allow a space for people to engage socially with others and access mental health and substance misuse support.[379]

Based in Birmingham, *Living Well UK* provides free mental health services to Birmingham and Solihull residents. The Living Well Consortium has over 30 partnerships with third sector organisations, charities and social enterprises.[380] Available therapeutic services include walking therapy, interpersonal therapy, counselling for depression, and cognitive behavioural therapy.[381] Additionally they provide culturally sensitive support around housing, employment, welfare benefits, domestic violence, substance misuse and addiction support.[382] The Living Well Consortium is supported by Birmingham City Council, Forward Thinking Birmingham, The National Lottery and Children in Need.[383]

Sandwell African Caribbean Mental Health Foundation operates as a culturally responsive mental health charity for the black community in Sandwell and West Birmingham. It works in partnership with other local organisations to create change in mental health policy to reduce inequalities facing the black community.[384]

4.3.5 Local Hospital Inpatient Data

There are HES codes that specifically identify dual diagnosis patients, through reference to substance misuse with presence of a mental health condition (F10 to F19: mental and behavioural disorders due to psychoactive substance use). This group of codes indicate that the patient's dependence on these substances directly impacts upon their health, behaviour

[375] Birmingham Mind. What We Do. Accessed Jul 2022.
[376] Birmingham Mind. Mental Health and Wellbeing Hubs. Accessed Jul 2022.
[377] Developing Health & Independence. Get Help. Accessed Dec 2023.
[378] MIND Bath. Dual Diagnosis Service. Accessed Dec 2023.
[379] Telford Mind. Dual Diagnosis. Accessed May 2024.
[380] Living Well UK. Consortium Members. Accessed May 2022.
[381] Living Well UK. Types of Psychological Therapies. Accessed Feb 2024.
[382] Living Well UK. Support Services. Accessed May 2022.
[383] Living Well UK. Our Team. Accessed May 2024.
[384] Sandwell African Caribbean Mental Health Foundation. Our History. Accessed Sep 2022.

and their withdrawal from these substances.[385] The codes F10 to F19 include tobacco among other substances, in line with the definition of dual diagnosis used in this report for co-occurring substance misuse and mental health conditions. As noted in section 1.4.1, we recognise that other organisations may not include tobacco in their definition of dual diagnosis.

For the purposes of this research, we have identified dual diagnosis inpatient data during the seven-year period from April 2014 until end of March 2021. The number of patients entering hospital during 2020-21 was affected by the COVID-19 pandemic, causing the number of dual diagnosis patients admitted to hospital to decrease by a third, compared to the previous year.

We have categorised hospital inpatient dual diagnosis admissions for each patient, based upon the number of dual diagnosis conditions that they were recorded with on each hospital visit.

- **Dual diagnosis patients**: This group includes patients who were admitted with one or more dual diagnosis code(s) (i.e. F10 to F19 codes).
- **Dual Diagnosis patients with a separate underlying mental health condition:** This group includes individuals who were admitted with one or more underlying mental health condition(s) (e.g., dementia, schizophrenia) in addition to the presence of one or more dual diagnosis code(s).

It should be noted that patients from either of the two groups above may be admitted to hospital for an underlying cause, which is not a dual diagnosis or mental health code.

4.3.5.1 Admission Trends

There were 229,517 hospital admissions that were recorded with an F10-F19 dual diagnosis code in Birmingham between 2014-21. 79.7% of these hospital admissions (n=182,923) involved 74,908 patients who were recorded as having a dual diagnosis code(s). A further 46,594 hospital admissions (20.3%) involved 20,677 patients, who were recorded as having a mental health condition and one or more dual diagnosis code(s) (Table 21). Of the 229,517 hospital admissions with a F10-F19 dual diagnosis code, 62.8% of these hospital admissions (n=144,105) involved 62,601 patients who were recorded as having a mental health condition due to tobacco misuse (F17 code). The remaining 37.2% of these admissions (n=85,412) involved 32,984 patients who were not recorded as having a mental health condition due to tobacco misuse.

Table 21: Dual Diagnosis Admissions (2014-21).

Dual Diagnosis Group	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	Total
Dual diagnosis	26,223	27,869	26,896	26,244	29,178	27,313	19,200	182,923
Dual diagnosis plus MHC	5,606	6,636	7,620	6,422	8,166	6,837	5,307	46,594
Total admissions	**31,829**	**34,505**	**34,516**	**32,666**	**37,344**	**34,150**	**24,507**	**229,517**

Source: Internally calculated from NHS HES Inpatients data (2022).

[385] ICD-10. Mental and behavioural disorders due to psychoactive substance use. Accessed Apr 2022.

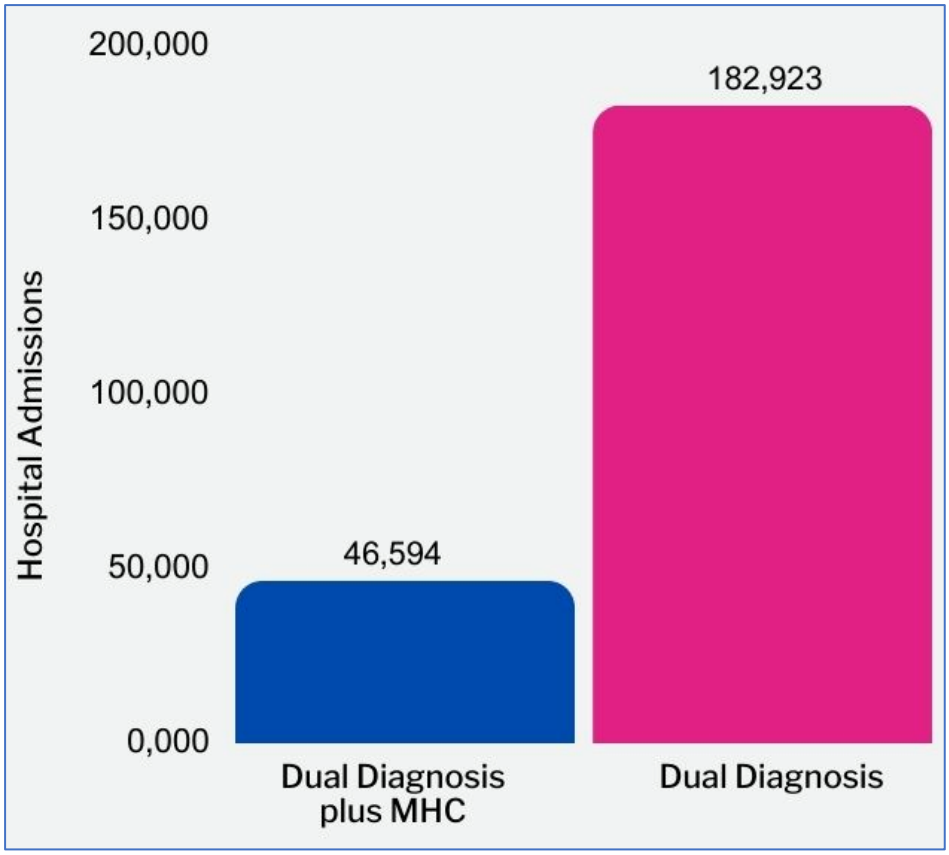


Figure 15: Hospital Admissions for Patients with Dual Diagnosis Codes (2014-21).

Source: Internally calculated from NHS HES Inpatients data (2022).

The average length of stay for all dual diagnosis patients (2014-21) was 3.2 days. However, there is a significant difference in length of hospital stay between the different groups. The average length of stay for patients with an underlying mental health condition alongside a dual diagnosis code(s) was 9.6 days, which is 4 times longer than those with only a dual diagnosis code(s) in their admission codes (1.6 days).

4.3.5.2 Patient Numbers

Among people who were admitted to hospital in Birmingham with dual diagnosis codes in their causes of admission, the majority 74,908 (78.4%) had dual diagnosis code(s) listed in their admission causes. A further 20,677 (21.6%) had dual diagnosis code(s) alongside other mental health conditions (e.g., dementia).

50,447 dual diagnosis patients (52.8%) were admitted to hospital once during the seven-year review period. A further 35,293 patients (36.9%) were admitted between 2 and 4 times, with 7,772 patients (8.1%) admitted between 5 and 10 times and 1,541 patients (1.6%) admitted between 11 and 20 times. However, 533 (0.6%) of patients were admitted 21 times or more, and the data also showed that some patients were admitted over 100 times.

4.3.5.3 Hospital Admission Causes

The following data focuses on hospital admissions in Birmingham for patients that have dual diagnosis code(s) included in their admission causes. The main dual diagnosis admission causes for each dual diagnosis group were analysed, and these are distinguished from the underlying admission causes (e.g., liver disease).

Table 22 contains a summary of the main dual diagnosis causes for Birmingham patients with a dual diagnosis code(s) in their causes of entry into hospital, and with a dual diagnosis code(s) plus an additional mental health condition (e.g. dementia, schizophrenia). This shows that tobacco misuse was the main dual diagnosis cause of hospital admission for both females (88.1%) and males (70.8%) with dual diagnosis code(s), and females (77.6%) and males (52.2%) with dual diagnosis code(s) and an additional mental health condition. In total, smoking accounted for 75.3% of all dual diagnosis admission codes during 2014-21.

The second most common cause of entry was due to alcohol for both females (9.0%) and males (23.8%) with dual diagnosis code(s), as well as females (16.4%) and males (32.2%) with dual diagnosis code(s) plus an underlying mental health condition.

Table 22: Top Three Hospital Admission Causes for Patients Living with Dual Diagnosis, by Gender (2014-21).

Dual Diagnosis Only Code	Female	Male	Dual Diagnosis with Additional MHC Codes	Female	Male
Mental health disorder due to tobacco	88.1%	70.8%	Mental health disorder due to tobacco	77.6%	52.2%
Mental health disorder due to alcohol	9.0%	23.8%	Mental health disorder due to alcohol	16.3%	32.2%
Mental health disorder due to opioids	1.5%	2.4%	Mental health disorder due to cannabinoids	2.3%	6.1%

Source: Internally calculated from NHS HES Inpatients data (2022).

Table 23 contains the top three underlying causes of admission to hospital for Birmingham patients within the two dual diagnosis categories. In the dual diagnosis admissions only category, the main causes of entry into hospital were pain in throat and chest (4.7%), COPD (3.9%) and abdominal and pelvic pain (3.3%). This differs from patients with admission code(s) for dual diagnosis and an underlying mental health problem, where the main causes of entry into hospital were mental health due to alcohol misuse (6.5%), schizophrenia (5.6%) and COPD (4.4%).

Table 23: Top Three Underlying Causes of Hospital Admission for Patients Living with Dual Diagnosis (2014-21).

Dual Diagnosis Only	Percentage of Admissions	Dual Diagnosis with Additional MHC Codes	Percentage of Admissions
Pain in throat and chest	4.7%	MH due to alcohol misuse	6.5%
COPD	3.5%	Schizophrenia	5.6%
Abdominal and pelvic pain	3.3%	COPD	4.4%

Source: Internally calculated from NHS HES Inpatients (2022).

4.3.5.4 Characteristics of Inpatients

Between 2014 and 2021, the majority of hospital admissions for patients with dual diagnosis code(s) were for male patients (58.1%), whilst 41.9% were for female patients. For hospital admissions that included an underlying mental health cause(s) (e.g. dementia), 50.8% of admissions were for male patients and 49.2% were for female patients (Figure 16).

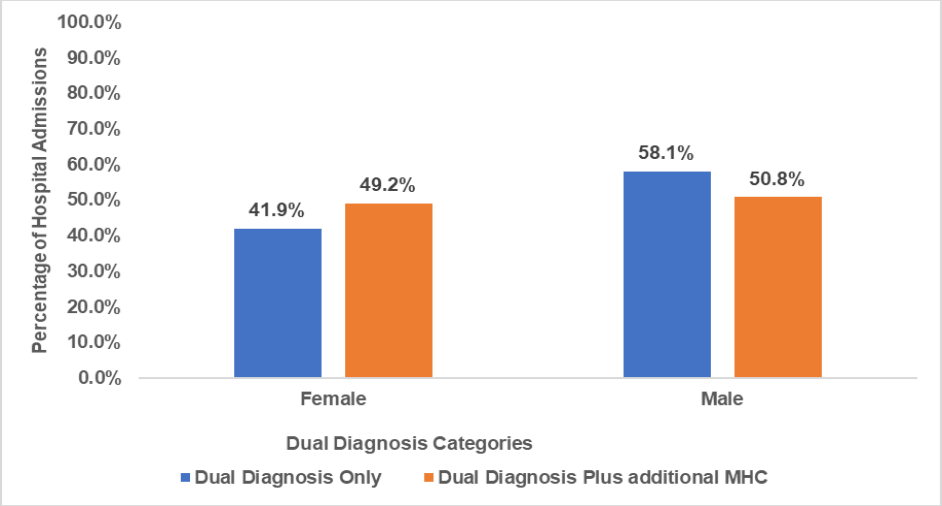


Figure 16: Dual Diagnosis Hospital Admissions, by Gender (2014-21).

Source: Internally calculated from NHS HES Inpatients data (2022).

Table 24 provides a summary of hospital admissions for dual diagnosis, categorised by whether the admissions were recorded as planned, unplanned or by maternity transfer. This shows that the majority of hospital admissions for patients with dual diagnosis code(s) were unplanned (62%), whilst 31% were planned and 6.9% were through a maternity transfer. For patients who had an additional mental health condition as well as dual diagnosis, a larger percentage were unplanned (77.4%), whilst 16.5% were planned and 6.2% were via maternity transfer.

Table 24: Types of Admissions by Group Categories for Dual Diagnosis Patients (2014-21).

Admission Type	Dual Diagnosis	Dual Diagnosis Plus Additional MHC
Unplanned	62.0%	77.4%
Planned	31.0%	16.5%
Maternity transfer	6.9%	6.2%

Source: Internally calculated from NHS HES Inpatients data (2022).

Figure 17 and Figure 18 provide a summary of hospital admissions for patients living with dual diagnosis (2014-21), by gender and type of entry into hospital (e.g., planned, unplanned or maternity transfer).

Figure 17 contains data for female patients, by type of entry into hospital. The majority of hospital admissions for female patients living with dual diagnosis were unplanned (51.4%), with 32.0% being planned and 16.6% related to maternity. For female patients admitted to hospital with dual diagnosis plus an underlying mental health condition, a larger majority of admissions were unplanned (68.9%), with 18.6% planned and 12.6% related to maternity.

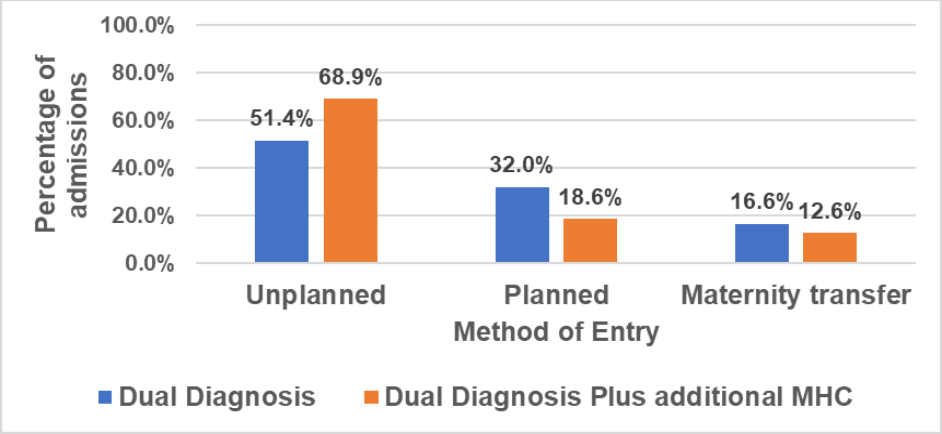


Figure 17: Types of Entry into Hospital for Female Patients Living with Dual Diagnosis in Birmingham (2014-21).

Source: Internally calculated from NHS HES Inpatients data (2022).

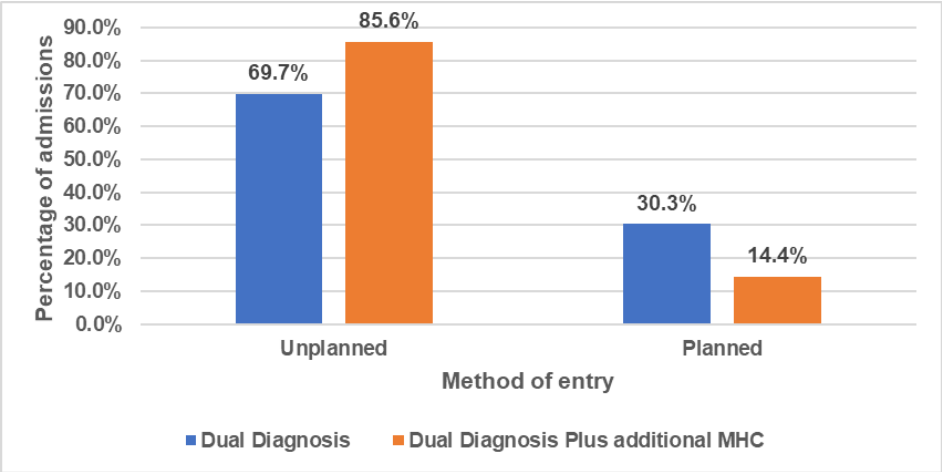


Figure 18: Types of Entry into Hospital for Male Patients Living with Dual Diagnosis in Birmingham (2014-21).

Source: Internally calculated from NHS HES Inpatients data (2022).

Figure 18 (above) contains hospital admission data for male patients, by type of entry into hospital. This shows that the majority of admissions for male patients with dual diagnosis code(s) were unplanned (69.7%) and 30.3% were planned. For male patients admitted to hospital with dual diagnosis plus an underlying mental health condition, a larger majority of admissions were unplanned (85.6%), with 14.4% being planned.

Within the group of patients with one or more dual diagnosis code(s) and an underlying mental health condition(s), both genders have higher admission rates for mood affective disorders (females 59%, males 47%) than other MHCs. However, in the remaining MHCs, neurotic, stress related and somatoform disorders are more prevalent in females (24%) (vs males, 16%), whereas schizophrenia, schizotypal and delusional disorders were more prevalent in males (25%) (vs females, 7%).

Table 25 provides a summary of hospital admissions for patients living with dual diagnosis, by ethnic group. This shows that the majority of patients with dual diagnosis only (66.2%) and those with underlying mental health issues (70.5%) were from a white ethnic background. However, the 2021 census revealed that 51.4% of the Birmingham population are from Black,

Asian and other ethnic groups. Therefore, the hospital admission data for patients living with dual diagnosis (by ethnicity) is not reflective of this.

Table 25: Hospital Admissions for Patients Living with Dual Diagnosis, by Ethnic Group (2014-21).

Ethnicity	Dual Diagnosis	%	Dual Diagnosis Plus Additional MHC	%	2021 Census
White	121,178	66.2%	32,861	70.5%	48.6%
Asian	23,455	12.8%	4,409	9.5%	31.0%
Black	10,469	5.7%	3,124	6.7%	11.0%
Mixed	4,153	2.3%	1,630	3.5%	4.8%
Any other ethnicity	4,686	2.6%	744	1.6%	4.5%
Unknown	18,982	10.4%	3,826	8.2%	0.0%

Source: Internally calculated from NHS HES Inpatients data (2022).

Table 26 contains length of hospital stay and ethnicity data. This shows that there are differences in length of hospital stay between white and ethnic minority groups. For example, patients with a dual diagnosis code(s) from a white ethnic background spend on average 0.5 days more in hospital than those from an Asian background.

Table 26: Average Length of Hospital Stay (in Days) for Patients Living with Dual Diagnosis, by Ethnic Group (2014-21).

Ethnicity	Dual Diagnosis Only	Dual Diagnosis Plus Additional MHC	All Admissions
White	1.7	6.3	2.7
Asian	1.3	17.7	3.9
Black	1.5	32.2	8.6
Mixed	1.5	24.9	8.1
Any other ethnicity	1.4	14.5	3.2
Unknown	1.3	2.0	1.5

Source: Internally calculated from NHS HES Inpatients data (2022).

These differences intensify when we consider patients living with dual diagnosis and an underlying mental health condition(s). The average length of stay for white patients within this group is 6.3 days, which is just under a week. However, the average length of stay for patients from ethnic minorities is significantly longer, especially for black patients who spend an average of 32.2 days in hospital, which is just over a month. The reasons behind these differences are not clear but are suggestive of a significant inequality which needs to be addressed.

4.3.5.5 Maternity Admissions with Dual Diagnosis Codes

Table 27 provides a summary of the five most frequently recorded dual diagnosis hospital admission codes for pregnant women during the seven-year review period (2014-21). This shows that the most frequently used code was ‘mental health disorder due to tobacco misuse’ (F17), which was entered in 94% of the dual diagnosis maternity admissions. Table 27 also reflects the percentage of each dual diagnosis code(s) where F17.1 (related to harmful use of tobacco) was included. Of those admitted with mental health disorders due to tobacco misuse, F17.1 was included in 97.5% of the admissions. Further analysis identifies that dependent on the drug, the percentage directly related to harmful use (F17.1) ranges from 97.5% (mental

health disorder due to tobacco misuse) to 37.9% (mental health disorder due to cocaine misuse).

Table 27: Top Five Dual Diagnosis Causes of Entry with % Harmful Smoking Included (2014-21).

Top Five Dual Diagnosis Causes	Admissions	%	% Harmful Smoking (F17.1) Included in Coding
Mental health disorder due to tobacco	14,651	94.0%	97.5%
Mental health disorder due to cannabinoids	419	2.7%	56.1%
Mental health disorder due to opioids	268	1.7%	50.7%
Mental health disorder due to multiple drugs	124	0.8%	61.3%
Mental health disorder due to cocaine	58	0.4%	37.9%

Source: HES Inpatient Data provided by NHS Digital (2022).

Table 28 contains hospital admission data for maternity patients living with dual diagnosis, by ethnicity. Overall, patients from a white ethnic background formed the largest percentage of hospital admissions (76%). However, this was not consistent with Birmingham's ethnicity data in the 2011 Census and is suggestive of an over-representation of dual diagnosis in maternity patients from a white ethnic background. Approximately two thirds of all maternity admissions for each ethnicity included an F17.1 harmful smoking use code among their causes.

Table 28: Hospital Admissions for Maternity Patients with Dual Diagnosis, by Ethnicity (2014-21).

Ethnicity	2014 -15	2015 -16	2016 -17	2017 -18	2018 -19	2019 -20	2020 -21	Total Admission	% F17.1 Harmful Smoking Use
White	76%	77%	74%	74%	72%	70%	68%	73%	58%
Asian	6%	8%	9%	8%	8%	8%	9%	8%	56%
Black	4%	3%	3%	4%	4%	5%	4%	4%	60%
Mixed	5%	6%	5%	5%	5%	5%	6%	5%	61%
Any other ethnicity	4%	2%	4%	5%	5%	5%	3%	4%	56%
Unknown	6%	4%	5%	4%	6%	8%	10%	6%	59%

Source: HES Inpatient Data provided by NHS Digital (2022).

With regards to age of patients who were admitted to hospital with a dual diagnosis code(s) and a maternity code, the 25 to 29 years age group recorded the most hospital admissions (32%).

4.3.5.5.1 Effect of Drugs and Mental Health on Maternity Outcomes

Birmingham maternity data from February 2019 to April 2022 was analysed to determine the relationship between mothers with dual diagnosis and the likelihood of negative pregnancy outcomes. Mothers who received an inpatient code for dual diagnosis within one month of giving birth (before or after) were included in the data.

The analysis showed that mothers with substance misuse-related mental health problems were 1.9 times more likely to have a premature birth than the general population. Furthermore, maternity patients who have had dual diagnosis plus an additional chronic mental health condition were 1.26 times more likely to have a premature birth. Mothers with a diagnosis of substance misuse-related mental health problems were 1.8 times more at risk of suffering a

stillbirth. However, we found no increase in risk associated with having a chronic mental health condition.[386]

4.3.6 Homeless Health Exchange

The Homeless Health Exchange is a primary care service for the homeless community in Birmingham, provided by Birmingham and Solihull Mental Health Foundation Trust.[387] It provides primary care assessments, nursing care and treatments for homeless people in Birmingham. The Exchange are able to refer individuals to other health and social care services and carry out city-wide outreach visits. They also provide alcohol assessments and provide information and support and referrals for detox and rehab placements.[388]

During August 2023, 1,227 citizens were in contact with the Birmingham Homeless Health Exchange. Among these citizens, 531 were recorded as having a drug or alcohol problem (43.3%). Of these 531 citizens, 84% were recorded as male and 16% were recorded as female. The age category accounting for the largest proportion of citizens was 40-49 years (37%), followed by 30-39 years (28%), 50-59 years (21%), 20-29 years (7%), and 60+ years (6%). The white ethnicity category accounted for the largest proportion of citizens (41%), followed by 'other' (25%), not recorded (22%), Asian (4%), black (4%), and mixed (3%).

Among the 1,227 citizens, 105 were recorded as having a mental health problem. The mental health problem may be self-reported, or could be information provided by another mental health team or professional, including diagnosed by GPs where this is low-level.

[386] Maternity Services Dataset. Internal Analysis. Accessed May 2024.
[387] Birmingham City Council. Street Intervention Team. Accessed May 2022.
[388] Homeless Link. Homeless Health Exchange. Accessed May 2022.

5 Lived Experience

Birmingham City Council commissioned lived experience research for this deep dive because it is important to involve the local population, whose needs are being assessed. The aim of this exercise was to harness the lived experience of seldom heard voices who experience dual diagnosis inequalities. Lived experience data from eight targeted research groups were gathered by two local organisations: Change Grow Live (CGL) and the Family Drug and Alcohol Court (FDAC). The targeted research groups were:

- **LGBTQ+ citizens living with dual diagnosis.** This targeted research group was organised by staff at Change Grow Live (CGL). Fourteen LGBTQ+ citizens participated in structured interviews about their experiences undergoing treatment for dual diagnosis. Nine of the respondents were male, four were female and one was non-binary.
- **Migrants living with dual diagnosis.** This targeted research group was organised by staff at Change Grow Live (CGL). Fifteen male migrants with dual diagnosis agreed to be interviewed. All of the participants had been residing in the UK for 10 years or more. Some of the migrants had gained British citizenship (n=5), some were awaiting visa or passport applications (n=5), and some had indefinite visas (n=3).
- **Citizens undergoing substance misuse treatment, without a mental health diagnosis.** This targeted research group was organised by staff at Change Grow Live (CGL). Thirteen citizens who were not known to have received a mental health diagnosis participated in structured interviews about their experiences undergoing substance treatment. Eleven of the respondents were male and two were female.
- **Parents living with dual diagnosis.** This targeted research group into parents living with dual diagnosis was organised by staff at Change Grow Live (CGL). Seven CGL clients participated in structured interviews about their experiences with substance misuse and mental health. All of the respondents were female.
- **Change Grow Live staff.** This targeted research group was organised by staff at Change Grow Live (CGL). Nine CGL staff members participated in structured interviews about their experiences working with clients who are undergoing substance treatment. All of the respondents were female.
- **FDAC parents living with dual diagnosis.** These interviews were organised by staff at the Family Drug and Alcohol Court (FDAC). Nine clients with substance misuse and mental health conditions were interviewed. All participants were female and aged between 28 and 50, with a mean age of 34. All were receiving support from FDAC.
- **FDAC staff.** This targeted focus group was organised by staff at the Family Drug and Alcohol Court (FDAC). Five members of staff participated in structured interviews about their experiences working at FDAC. Four participants were female, and one was male.
- **Citizens living with dual diagnosis, who have experience of homelessness.** This targeted research group was organised by staff at Change Grow Live (CGL). Nine clients experiencing homelessness participated in structured interviews about their experiences undergoing treatment for dual diagnosis. One participant didn't clearly state their ethnicity, while the remaining eight participants were white. All were male.

The lived experience data which was captured during this research is summarised below. Participant quotes are italicised.

5.1 Personal Experience of Dual Diagnosis

Many of the participants described having more than one mental health condition. However, there were mixed reports about receiving diagnoses for these. One citizen noted the mixed impact of having diagnoses, as a help when it opens access to support, but a hindrance when seeking employment due to prejudice. Some participants had experience of hospitalisation due to their mental health, and some had been in contact with criminal justice services.

The majority of participants felt that their mental health problems arose prior to their substance misuse. Alcohol and drugs were misused for varying reasons and the relationship between substance misuse and mental health was described differently by different people. Responses ranged from *"reward after a hard day's work"*, escape from everyday life and environment, to *"not being* permitted to work". For others, substance misuse was a coping mechanism for mental ill health, which itself originated from trauma or abuse. Several respondents spoke about the link between their mental health and substance misuse. One respondent shared: *"I started taking drugs because of my mental health [and] swapped one demon for another."*

For a few respondents, society's responses to their sexual orientation had impacted their mental health significantly and has been a driver of their alcohol dependency. *"At 14-15, I was hit with the realisation that I was attracted to the same sex. I had nowhere to go or nobody to speak to about it. I started drinking at home when I was around that age."*

Some recognised that substance misuse only provided temporary relief while leading to worse outcomes in the long-term. One client shared, *"You just want to go into isolation. You just sit with yourself and your feelings. The drugs help for a bit but then they stop working. All you know is using, to feel better physically and mentally. But it's temporary."* Some respondents described the relationship between their mental health and substance misuse as a vicious cycle, whereas others saw their mental health as negatively impacted by their substance misuse and that abstinence improved their mental health symptoms.

Many sought treatment and support for their substance misuse and mental health when things became too difficult, when a turning point or a breaking point was reached. For some, the impact of their dual diagnosis on relationships was the catalyst for help-seeking, and some reported that their children were motivation for change, or that family and friends had prompted them to seek help. The main driving force for seeking help among many clients was loss (e.g., loss of their jobs, families and mostly their children). One client shared: *"In the end, it was my children who motivated me to change. I had that motivation. Other people don't, and only really have themselves to think about and change for. I think that's harder."*

5.2 Citizens Living with Dual Diagnosis

5.2.1 Impact on Personal Relationships

Many of the participants experienced feelings of shame or anger towards themselves due to their dual diagnosis, or their past behaviour. "*When I look back at my drug use and how I feel about it, it makes me feel ashamed of what I have become and some of the things I've needed to do in order to get them."*

Participants also reported isolation as a result of their dual diagnosis, which could occur from relationship breakdowns with loved ones. One respondent who has lost three partners and most of his family, declared: *"I have never met an addict that hasn't got relationship issues, from being in AA, NA etc."*. Another client reported that it *"Messed up my family life and*

personal relationships, due to having to hide my addiction and function in society with my mental health."

Dual diagnosis was recognised to strain relationships with partners and family, with some noting that during active addiction, their focus on relationships reduced significantly and could be further complicated with financial issues. One client stated, *"[it] took away quality time, took away finances"***,** and the other sharing: *"Mum stopped talking to me, stopped financial help."*

Several participants had experience of domestic abuse, and some acknowledged they had been vulnerable to this in the past. *"I went through a lot of domestic abuse. This has all led to depression and anxiety. I was drinking to cover it all up."*

Some parents from FDAC reported a strong support network with people and places to rely on when they needed support. The individuals listed included their siblings, their parents and *"family from FDAC"*. One client felt that they now had *"more supportive friends."*

5.2.2 Experiences of Services

Many participants reported that the support they had received was very helpful, including from CGL and FDAC. *"Change Grow Live and the two workers I've had from there have been amazing. From the first time I met them they have been brilliant. They want to know how I am doing, and they will respond to my calls and texts. They care and they have really helped me."* Receiving the right support and the feeling of being heard could boost self-worth. Outreach workers were noted to be particularly helpful.

Support from family and friends was felt to be beneficial when received, but this was not always the case. Peer support was also described as helpful. *"Other addicts in recovery have helped too. Learning from them and feeling understood."*

Support from wider healthcare professionals and services was more variable and was not always viewed positively. Some respondents felt judged by their doctors or by mental health services because of their substance misuse issues. *"Made me feel judged and like crap, felt like I was scum."*

Some felt that services were only responsive when the person was at high risk and that seeking support before crisis point was more difficult. One client was sectioned twice for acute psychosis but felt they did not receive much support. *"If you are not an immediate risk to self, they do not seem to be interested"*. Others felt that waiting times were too long and that there were complicated processes to follow which were experienced alongside being passed around. "*Long waiting times for doctor's appointments.*"

Suggestions for improvement were wide ranging. These included having more holistic support with integrated services for all support needs and greater promotion of services including how these can be accessed. Further suggestions included having group activities, support groups, employment and finance support, further support after detoxes and follow-ups after contact with services. One client suggested *"a one stop shop, where you can go in and get everything sorted really quickly under one roof",* with a fast-track option for parents. Another client noted that *"[The] key is advertisement and letting people know where services are and what they offer."*

5.2.3 Health, Healthcare, and Stigma

While some respondents reported positive interactions with healthcare professionals, others felt that their access to healthcare was unaffected by their dual diagnosis. *"I just need help*

with everything. If it wasn't for my support workers, I wouldn't be able to look after myself. I've just spent six weeks in hospital for septic arthritis. I'm disabled." Conversely, some respondents reported experiences of stigma, being misunderstood, and prejudice from healthcare workers. *"People assume you're automatically being dishonest and that you can't be trusted. You get used to people like GPs and other health professionals looking down on you."* Some respondents also reported being excluded from mental health services due to their substance misuse.

Those with unstable housing or with experience of homelessness noted that this was a barrier to accessing healthcare, with particular barriers including being difficult to contact or having difficulty getting transport to appointments. One client expressed difficulty engaging with healthcare services due to being homeless and not easily contactable, resulting in deterioration of their mental health and substance misuse. *"Yes, since I couldn't be contacted easily…both my mental health and substance use were worse, and it seemed harder to engage with services. It really affected my self-worth and motivation to engage."*

Dual diagnosis was seen as an obstacle to looking after oneself and a barrier to help-seeking when needed. *"There have been 3 or 4 times where I could have engaged but couldn't leave the flat because of [my] mental health. This has been a barrier to getting that important support."*

When experiencing challenges with mental health or when actively misusing, motivation to reach out could be evasive, and for others, shame around relapses was also a barrier. *"You just don't take care of [your health]. You don't even wash. You just stay as you are. Even when there are places you can go and get a shower, sometimes it's easier for you to just not go there."* The knock-on effect of missing appointments meant that participants had long wait times for further appointments. "*My mental health and substance use makes it hard to engage. I miss appointments. And when you miss appointments, you have to wait a long time for another one."*

5.2.4 Housing

Some respondents reported no effect of their dual diagnosis on their housing situations. However, many reported knock-on or direct negative impacts. Housing could be affected through difficulty keeping on top of bills or due to relationship breakdowns, but also through being evicted, and difficulty finding a landlord who would agree a lease. *"When a landlord finds out you're an alcoholic, they won't accept you."*

Experiences of shared housing were generally negative, due to drug misuse of others being problematic and the poor conditions of the home. One respondent who used to live in an HMO found it "*dangerous*" and said that his life turned around completely once he found his own home. Another respondent stated *"Living in HMO was difficult because of other residents, drug use, alcohol use and chaos, very behavioural. Constantly on edge never feeling at ease."*

Some respondents experienced homelessness as a result of their dual diagnosis. *"Substance misuse and mental health has made me homeless in the past and led to evictions from hostels. Not being able to pay rent or keep on top of responsibilities."* Those who had not had their housing affected reported having a supportive network around them.

Participants with experience of homelessness noted that this had negatively affected their mental health and substance misuse, which had led to increased substance misuse to cope with this. Having the right housing support improved mental health, whilst unstable housing

created a barrier to receiving treatment, due to difficulty travelling and keeping appointments. *"By being homeless, substance use increased, I would 'graft' more. If I am out on the road, there is more chance of money and temptation. Now that I'm housed, I have lowered my time in the city centre, which decreased my using. I have more control over my money management on drugs."*

5.2.5 Employment

Many participants reported that their employment opportunities were negatively affected by their dual diagnosis, and some had lost their job due to this. *"My old employers weren't great. They were a small team and from a different culture and their attitude towards mental health was 'pull yourself together'." They didn't have the tools or experience to support their staff around mental health, and it was horrible towards the end."*

Some respondents had lost hope of finding a job, due to their mental health and substance misuse, either because these hindered their ability to maintain work, or because of a perception that employers would not perceive them as valuable employees. *"I have lost my job and everything because of this, and now can't apply for jobs because as soon as they hear 'mental health', they think you're crazy. No point applying."*

There were some perceptions that not all employers had the right skills to support employees with dual diagnosis. Others felt it was difficult to work while taking care of themselves. *"Monthly pay doesn't work for me, so I work jobs where I can get paid weekly. I find it hard managing a monthly budget, so weekly works best for me."* Some reported hiding their mental health or substance misuse from colleagues in order to avoid judgement, whereas others found support from colleagues which helped them stay in work.

5.2.6 Parents with Dual Diagnosis

Participants engaging with interviews were asked whether they were parents. Among those who were, some reported having little or no contact with their children as a result of substance misuse. Some respondents experienced difficulties during pregnancy. One respondent was struggling during her pregnancy and was given Subutex (an opioid painkiller) by her partner. She sought help for this once it started leading to other issues and reported that the hospital staff/midwives made her feel judged. *"I stopped before my baby was born, but they made me feel judged and like a druggie. They made me feel like scum."*

Some respondents described how their children were a motivation to change and seek treatment. One client stated that the loss of their child was what forced them to get better: "*I don't think I would have got better if I hadn't had my child taken off me. I needed the space, so I had room to get myself sorted but I also needed the kick up the bum." However, a*nother client said *"When I had my kids, I feel like my drug use and my mental health was much better than it is now. But since they've been taken away, I feel like it's made things worse. Having to deal with the emotions of not having my children is very difficult."*

Balancing childcare with attending appointments was reported to be difficult. Having appointment times which work around this were seen as useful. A client noted that "*It's just important you have appointments in the daytime whilst she's at school. If you have appointments when they're with you, it's pretty impossible to attend."*

Some respondents feared engaging with services, due to worry of having custody removed. One client shared how they were afraid to get help for their mental health, *"I was petrified if I told professionals about my mental health that they would try and take my baby away."*

5.3 Staff Experiences

CGL staff noted that difficulty accessing mental health help was a barrier to treatment for citizens with dual diagnosis, and some clients were not able to access this while having ongoing substance misuse. *"A lot of our clients have trauma past and present. But when we have tried to work alongside the mental health team, [they] are saying they have to address their alcohol/drugs problem first instead of working alongside. It's almost impossible to get through to the mental health teams and there is not a team delegated to work with people with substance misuse."* One respondent has noticed that if clients are already registered with a community mental health team, it is easier to engage with conversations about joint care-recovery planning.

Partnerships working between substance misuse and mental health services were emphasised to be important. Multi-agency collaboration was identified as good practice and could support wider wellbeing (e.g., housing), although this was also perceived to have challenges. Collaboration between internal teams, building links with community services, and having high empathy and competence, were examples of good practice that were shared by participants.

Staff members highlighted the need for more coordinated and collaborative working relationships with mental health services. Some specific ideas were to have recovery coordinators placed on community mental health teams and to hold regular meetings with mental health services to let them know what CGL's role is and what services they actually offer clients.

Some professionals felt additional mental health training would be useful, as well as training around sexual health, smoking, trauma, substances and physical health impacts. Specific suggestions included training on dual diagnosis, overview of what local mental health services exist, what they offer, and training on different types of psychological disorders so that staff treat clients in an appropriate and fair way.

Staff viewed stigma and discrimination as challenges to accessing support for clients. Misconceptions such as poor mental health always resulting from the substance misuse, difficulty attending appointments, stigma, and lack of collaboration between services, were thought to hinder help-seeking. Suggestions to overcome these centred on better partnership working between substance misuse and mental health services. *"If you could provide both mental health support and drug support, the barriers in place would diminish and we would be able to provide a more stable recovery journey for them."*

Prejudice and discrimination by employers were thought to obstruct employment opportunities for clients, leading to the suggestion that more education on this was needed. A respondent who has worked for CGL for 20 years observed that clients are "*faced with double stigmatism of mental health and substance misuse*". Opening hours of services clash with work hours of clients and when travel time is factored in, it makes it very challenging for people to attend an appointment without this affecting their employment. Additionally, individual placement support was thought to be able to overcome other barriers to employment faced by clients, including lack of work experience and gaps in employment history.

Clients were perceived to experience challenges with housing, including the substance misuse of other tenants, digital exclusion creating a barrier to online applications and bids, previous debt, prejudice from landlords, and lacking a deposit.

More holistic working between services was noted as being needed, *"everything seems to be separate rather than holistic"* and *"a more holistic approach would provide better support"*. Another respondent said, *"I have seen how effective a multi-disciplinary team can be for parents with a complex level of need, so they have access to different professionals and expertise."*

Furthermore, greater empathy was noted to be important in supporting clients. The importance of empathy, of *"people needing to be treated like people"* was highlighted by several staff members. *"These individuals are not horrendous people on the earth, but they are often seen as untreatable, criminal. They've often experienced situations which have affected their mental health which underpins most, if not all substance misuse cycles. Continuation of poor knowledge and understanding amongst professionals (the people paid to support individuals), further contributes to the horrendous experiences these individuals face."*

FDAC staff noted that timescales given to them by courts posed a challenge due to parents' complex needs, including past experiences of trauma. *"The challenges of FDAC include balancing the timescales of court and the children with the realistic timescales of parents' recovery from addiction. We often work with parents with high levels of trauma and complicated background history*". Another staff member said *"as a team, we have very limited clinic experience / job roles to support trauma which our parents often require. It can also be difficult to manage parents who are struggling to engage with the service, due to their high level of chaos and drug use."*

Building good relationships with parents was seen as best practice by professionals. Staff mostly worked with families with young children (below 5 years) who were acknowledged to face challenges throughout the FDAC process. Staff felt children could benefit from more explanations about the process, the reasons behind this, and the roles of different professionals involved. The importance of a *"child friendly narrative"* about their parents' drug misuse was also shared by two participants, with one participant stating, *"It is difficult to tell children about drugs and alcohol in an appropriate way due to the sensitivity of the subject. Professionals often get nervous about this and so do not do the work with the child when it would actually be helpful as the child has lived through it."*

FDAC staff felt that parents find the process difficult. *"The intensity of the process and the demands placed upon them from the very start can be a lot for parents to take on"*. Another staff member described how *"the assessment process can be challenging, as they are sharing areas of their lives that they may have never shared with anyone."*

The FDAC process requires parents to maintain motivation while remaining abstinent. Further difficulties for parents included barriers to treatment (e.g., exclusion from services due to substance misuse, challenges accessing employment, and resulting isolation after ceasing relationships held previously). *"Parents are often declined forms of psychological therapy as they need to be clean before services will accept them, but this is part of the problem. Parents cannot achieve that without support."*

Difficulty obtaining appropriate housing were multi-fold and had negative impacts on parents' wellbeing, leading staff to suggest greater housing support as one way to better support parents. Some participants felt that *"lack of suitable housing, rent arrears, trapping them in unsuitable housing"*, its limited availability, *"not enough houses available"*, or being forced to be in shared housing amongst other misusers in HMOs, acted as barriers to employment and housing itself.

When asked what additional services or adjustment to current services they thought would benefit parents, responses included "*quicker access to counselling support*", "*more specialised housing and employment support*" and "*better communication between different services offering support*."

6 Opportunities for Action

This section identifies 'areas of need' to address through commissioning or other actions by local organisations.

6.1 What Would We Like to Achieve?

The aim of this deep dive report is to establish an evidence base to support dual diagnosis commissioning in Birmingham, including identifying the level of need in the population, and the gaps and barriers in service provision. A broad range of evidence has been used to explore the needs of citizens living with dual diagnosis in Birmingham. This evidence shows the work being carried out to support the needs of these populations, and the valuable work provided by services that are available across the city. However, there are gaps in data, gaps in service provision and ultimately there continues to be unmet need and inequalities for these citizens.

This chapter outlines the key findings of this deep dive report and also provides recommendations for each of the findings, in the hope of addressing the areas of unmet need for these groups. Focused work on the wider determinants of health among citizens living with dual diagnosis will support the reduction of health inequalities and enable these citizens to live well within the community.

6.2 Key Findings and Recommendations

Here we set out the key findings from this JSNA deep dive and make recommendations for how local partners can help us achieve our local ambitions.

Key Finding 1: There is demand for system leadership, partnership working and co-ordination of key services for citizens living with dual diagnosis.

Key Finding 2: There is currently insufficient data to allow a full understanding of dual diagnosis prevalence in Birmingham and the associated health and wellbeing needs.

Key Finding 3: There are opportunities to further understand training needs and embed specific dual diagnosis training opportunities.

Key Finding 4: There are opportunities to improve holistic and person-centred support for citizens living with dual diagnosis.

Key Finding 5: There is a need for more research to take place to build the evidence base around health inequalities for citizens living with dual diagnosis.

6.3 Key Finding 1: There is Demand for System Leadership, Partnership Working and Co-ordination of Key Services for Citizens Living with Dual Diagnosis.

6.3.1 What is the Gap?

Lived experience data that has been gathered in this deep dive research shows that some citizens continue to fall between gaps in services and are not receiving treatment for their mental health and substance misuse conditions. In addition, some service users report exclusion from services, due to having the other condition. There is a need to work with services to ensure that no exclusions occur on the basis of coexistence of these conditions.

It is recognised that joint working can be a complex issue due to differences between mainstream and specialist services, which cause people to be considered too severe for mainstream services, but not complex enough for specialist services. A separation can also

reinforce an exclusion from mainstream services. Alternatively, specialist provision (e.g., homeless outreach workers) may be more flexible, with increased ability to provide more person-centered support.[389,390]

While a refreshment of the Birmingham Dual Diagnosis Joint Working Protocol between CGL, BSMHFT, and FTB has been carried out during 2024, further development of this could support the formalisation of working relationships and to integrate findings and recommendations from this deep dive. The ongoing development of Birmingham's Dual Diagnosis Joint Working Protocol sets out the context for joint working and allows for continual enhancement of the work already being undertaken in local services.

This deep dive highlighted particular inequalities faced by vulnerable groups (see section 3.2). While individualised support is recognised in Birmingham's Dual Diagnosis Joint Working Protocol, insights from the research in this deep dive should be embedded into the continuous development of person-centred support for groups who may face additional risk of experiencing dual diagnosis. This is one element of development for Birmingham's Dual Diagnosis Joint Working Protocol which has been identified.

Another area of development identified in Birmingham's Dual Diagnosis Joint Working Protocol is the explicit integration of experts by experience into the process of service development, training of staff, service evaluation, and staff recruitment.

Another avenue for embedding evidence identified from this deep dive is within the Birmingham Voluntary Sector Council's ongoing work to design Quality Standards for providers of exempt accommodation (see section 3.2.18). This is an opportunity to build on good work taking place, and ensure it is informed by the research from this deep dive.

6.3.2 What does the Evidence Say?

The Substance Use Mental Health Resource Pack (2021) and Multiple Disadvantage and Co-occurring Substance Use and Mental Health Conditions (2022) recognise that services should work jointly to support the needs of citizens with dual diagnosis, rather than creating separate dual diagnosis-specific services.[391,392]

The Community Mental Health Framework recognises the discontinuity in care that citizens with dual diagnosis may experience, and advocates for the principle of inclusivity to overcome this.[393] NICE Guidelines also note the importance of reducing multiple assessments and passing citizens between services,[394] and research supports the idea that continuity of care can benefit both patients and staff.[395]

This deep dive has highlighted the role that unpaid carers have in supporting citizens living with dual diagnosis. NICE guidance acknowledges that carers' roles may change over time and the value of carers (with their experiences) as expert partners.[396] NICE quality standards need to be upheld in routine practice to support the identification of carers, their involvement in care planning, and to ensure carers receive the support they are entitled to.[397]

[389] MEAM. (2022). Multiple disadvantage and co-occurring substance use and mental health conditions. Accessed Nov 2023.
[390] Turning Point. (2021). The SUMH Resource Pack. Accessed Dec 2023.
[391] MEAM. (2022). Multiple disadvantage and co-occurring substance use and mental health conditions. Accessed Nov 2023.
[392] Turning Point. (2021). The SUMH Resource Pack. Accessed Dec 2023.
[393] NHS. (2019). The Community Mental Health Framework for Adults and Older Adults. Accessed Mar 2023.
[394] NICE. (2011). Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services. Accessed May 2023.
[395] King's Fund. (2010). Continuity of care and the patient experience. Accessed May 2023.
[396] NICE Guideline (NG150). (2020). Supporting Adult Carers. Accessed Apr 2023.
[397] NICE Quality Standard (QS200). (2021). Supporting Adult Carers. Accessed Apr 2023.

Birmingham's Dual Diagnosis Joint Working Protocol highlights principles including working jointly and 'no wrong door'. The process of further developing this protocol, to be carried out by Birmingham Public Health Addictions Team in conjunction with the Birmingham Dual Diagnosis Steering Group, will ensure that the key guidance highlighted in this deep dive is embedded within practice in Birmingham. This will support an ongoing system of evaluation and improvement, building on current systems in place.

Reinforcing the importance of a holistic approach, the Government's Alcohol Strategy (2012) suggested that recovery should tackle wider factors that reinforce dependence, which include housing and employment needs.[398]

There is good evidence of the value of embedding experts by experience into service development and evaluation (see section 3.4.2).

Data and research explored in this deep dive has suggested that some demographics may be particularly at risk of dual diagnosis or of experiencing further health inequalities associated with dual diagnosis. This includes those from ethnic minority backgrounds, citizens experiencing homelessness (who may experience particular barriers in accessing primary healthcare), veterans, citizens identifying as LGBTQ+, sex workers, and citizens living with neurodivergence. Gender inequalities also need to be considered, particularly pregnant women and those with experience of intimate partner violence. Additionally, focus on gender inequalities also needs to consider males due to representing the majority of CGL clients and the majority of the hospital admissions among citizens experiencing homelessness with a dual diagnosis code on their inpatient hospital record. The Dual Diagnosis Steering Group will be tasked with developing Birmingham's Dual Diagnosis Joint Working Protocol to enhance patient-centred support for these groups.

6.3.3 Recommendations

Recommendations have been developed in collaboration with stakeholders, which build on the gaps identified and on evidence of good practice. The recommendations for Key Finding 1 involve system leadership, partnership working and collaboration and a person centred approach.

System Leadership: As an operational subgroup of the Birmingham Drug and Alcohol Partnership, the Birmingham Dual Diagnosis Steering Group will be developed. This group will involve key stakeholders across Birmingham who, in conjunction with the Birmingham Public Health Addictions Team, will develop the Birmingham Dual Diagnosis Joint Working Protocol.

Number	Recommendation
K1.1	Develop a Dual Diagnosis Steering Group of key stakeholders across Birmingham, who are tasked with ensuring that this deep dive's recommendations for the Dual Diagnosis Working Protocol are carried out.
K1.2	Commit to an evidence-based, signed off, Birmingham Dual Diagnosis Joint Working Protocol for people with co-existing mental health and substance misuse disorders.

Partnership Working and Collaboration: The Dual Diagnosis Steering Group, an operational sub-group of the the Birmingham Drug and Alcohol Partnership will be developed. In conjunction with the Birmingham Public Health Addictions Team, they will ensure that Birmingham's Dual Diagnosis Joint Working Protocol for people with co-existing mental health

[398] HM Government. (2012). The Government's Alcohol Strategy. Accessed Jul 2022.

and substance misuse disorders is further developed to encompass the recommendations from this deep dive report. The Dual Diagnosis Steering Group will provide an opportunity for key stakeholders to clearly define roles and responsibilities, in addition to navigating difficulties associated with joint working as they arise.

Number	Recommendation
K1.3	In accordance with the Community Mental Health Framework, develop formal links between substance misuse and mental health services, where they do not currently exist. The outcome of the links is to overcome discontinuity in care through the principle of inclusivity.
K1.4	Substance Use Mental Health Resource Pack Integration of the core principles of the Substance Use Mental Health Resource Pack (2021) into Birmingham's Dual Diagnosis Joint Working Protocol, where these principles are not already integrated into the Dual Diagnosis Joint Working Protocol. • Focus upon improving integration between existing substance and mental health services, rather than the creation of separate 'dual diagnosis' services. • Provide an effective mental health referral process (including a 'No Wrong Door' approach), and an early and joint assessment, which is of high quality. This should involve having either a community mental health team assessor joining the local substance misuse services for joined assessments or having a dual diagnosis nurse consultant work with both substance misuse and mental health teams.
K1.5	Uphold NICE guidance and quality standards for children and young people a) Substance misuse services to uphold NICE guidance and quality standards for children and young people around supporting children and young people with mental health conditions and those assessed as vulnerable to drug misuse [NG134, QS48, CG155, QS102, NG64, QS165]. b) Mental health services to uphold NICE guidance and quality standards for children and young people around supporting children and young people with mental health conditions and those assessed as vulnerable to drug misuse [NG134, QS48, CG155, QS102, NG64, QS165].
K1.6	Uphold NICE guidance and quality standards for adults • Coexisting Severe Mental Illness and Substance Misuse [QS188]. • Professionals taking a person-centred approach, taking time to build a trusting relationship, recognising that stigma and discrimination are associated with psychosis and substance [CG120]. [399] • Supporting continuity of care during transitions between mental health and substance misuse services, to avoid the need for citizens to repeat their story [NG58]. [400] • Supporting adult carers who provide unpaid care [QS200].
K1.7	To include the findings of the Dual Diagnosis Deep Dive within the development and implementation of the Birmingham Quality Standards for exempt accommodation.

A Person Centred Approach: This is needed to address the coexistent nature of dual diagnosis, recognise that the relationship between the two conditions may vary between individuals, and that this can change over time. This can be strengthened with formal embedding of experts by experience within service development. There is potential for these person-centred approach recommendations to be achieved through integration into the service specifications of substance misuse services (i.e. Aquarius and Change Grow Live) that are commissioned by the Birmingham Public Health Addictions Team.

[399] NICE. (2011). Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings. Accessed May 2023.
[400] NICE. Overview | Coexisting severe mental illness and substance misuse: community health and social care services. Clinical Guideline [NG58]. Accessed Jul 2022.

Number	Recommendation
K1.8	The value of experts by experience should be recognised and utilised through being embedded in the process of service development, training of staff, service evaluation, and staff recruitment. Experts by experience should be appropriately recompensed for their time.
K1.9	Provide a person-centred, accessible approach to support vulnerable groups who have been identified from evidence in this deep dive and may be at an increased risk of experiencing dual diagnosis. These include individuals from ethnic minority backgrounds, citizens experiencing homelessness (who may experience particular barriers in accessing primary healthcare), veterans, those identifying as LGBTQ+, sex workers, and individuals living with neurodivergence (particularly ADHD). Gender inequalities also need to be considered, particularly pregnant women and those with experience of intimate partner violence. This should also extend to males, due to representing 72% of CGL clients and 84% of the hospital admissions among citizens experiencing homelessness with a dual diagnosis code on their inpatient hospital record.

6.3.4 What Next?

The authors of this Dual Diagnosis Deep Dive have worked with stakeholders from across Birmingham's healthcare system, services and voluntary sector and listened to the voices of lived experience to produce the report's recommendations. The following table outlines the stakeholders, who have agreed to take forward each of the report's recommendations concerning Key Finding 1.

Number	Ownership of Recommendation
K1.1	To be taken forward by the Birmingham Public Health Addictions Team.
K1.2	To be taken forward by the Birmingham Public Health Addictions Team and the Birmingham Dual Diagnosis Steering Group.
K1.3	To be taken forward by the Birmingham Public Health Addictions Team (and partners collectively) to be integrated into the Dual Diagnosis Working Protocol.
K1.4	To be taken forward by the Birmingham Public Health Addictions Team (and partners collectively) to be integrated into the Dual Diagnosis Working Protocol.
K1.5	a) To be taken forward by the Birmingham Public Health Addictions Team and integrated into their service specifications for substance misuse services in Birmingham. b) To be taken forward by the Birmingham Public Health Addictions Team and the Birmingham Dual Diagnosis Steering Group.
K1.6	To be taken forward by the Birmingham Public Health Addictions Team (and partners collectively) to be integrated into the Dual Diagnosis Working Protocol.
K1.7	To be taken forward by the Birmingham Voluntary Sector Council (BVSC).
K1.8	To be taken forward by the Birmingham Public Health Addictions Team and integrated into their service specifications for substance misuse services in Birmingham.
K1.9	To be taken forward by the Birmingham Public Health Addictions Team (and partners collectively) to be integrated into the Dual Diagnosis Working Protocol.

6.4 Key Finding 2: There is Currently Insufficient Data to Allow a Full Understanding of Dual Diagnosis Prevalence in Birmingham and the Associated Health and Wellbeing Needs.

6.4.1 What is the Gap?

System Leadership

Dual diagnosis is a condition with large health implications, including significantly lower life expectancy. Currently, there is no national prevalence data that covers all ages that can be applied locally with accuracy. Similarly, there is a gap in the evidence base around an accurate

estimate of the impact of dual diagnosis on life expectancy, as while estimates exist, they are based on a small cohort. Furthermore, the data on homelessness is also insufficient to understand the scale of the needs of citizens experiencing these issues and to identify this vulnerable community. Enhanced data collection and sharing will support the continued development of an evidence-based approach to supporting these citizens. Other limitations to the data presented in this deep dive include a lack of data available about parents with dual diagnosis and their children, where families were not in contact with services. This gap means a complete picture of need is not able to be shown.

Partnership Working and Collaboration

The authors of this deep dive have highlighted the gaps in the data and the limitations of the evidence base (see section 2.8). Data from services has provided valuable insights to support the work of this deep dive, but further improvements may be possible. Furthermore, this deep dive has highlighted the vulnerability of citizens with dual diagnosis. It has therefore been identified that JSNAs should always recognise this group of the population.

Data Insights

A lack of a standardised definition of 'dual diagnosis' was a challenge for the research team of this report. This contributes to the difficulty ascertaining a prevalence of dual diagnosis. While the research team sought to include a wide range of data sources, some data was not available at the time of writing (e.g., GP data and data relating to children and young people). Currently, some sources of data lack detail on the gender, age and ethnicity of those with dual diagnosis. This lack of detail prevents a rich evidence base from being formed, which makes it difficult to make specific recommendations for targeted services. Furthermore, differences in the way in which information is stored and recorded, for example in case notes rather than a database, can limit the use of this data for public health research. There is also insufficient data on those in the criminal justice system, precluding an understanding of the scale of the needs of these citizens.

6.4.2 What does the Evidence Say?

System Leadership

Establishing a dual diagnosis GP read code, which may be triggered when both a mental health condition and substance misuse are present on a patient's record, could support the development of local and national prevalences. Furthermore, the creation of a local prevalence of dual diagnosis which could be upscaled for national usage would allow for a more accurate understanding of the needs of citizens with these conditions. Further work to build on current practices and identify best practice in recording dual diagnosis on patient records in mental health services will support local services to continue to develop practices enabling streamlined access to an accurate and up to date evidence base.

Partnership Working and Collaboration

As each dual diagnosis condition may interact and worsen the other,[401] the identification of both conditions is essential to ensuring citizens with dual diagnosis have access to the right care. NICE Quality Standards (QS188) state that anyone aged 14+ with suspected or confirmed severe mental illness should be asked about their drug or alcohol use.[402]

[401] NICE Guideline Scope: Severe mental illness and substance misuse (dual diagnosis): community health and social care services. Accessed Mar 2023.
[402] NICE Quality Standard. (2019). Coexisting severe mental illness and substance misuse. Accessed Mar 2023.

Furthermore, NICE guidance (CG120)[403] suggests that those with suspected psychosis and substance misuse should be referred to mental health services and NICE guidance (CG115)[404] recommends that those with alcohol misuse and comorbid mental health problems should be referred for psychiatric assessment.

Any changes to practices around recording data and improving what is available at a national and local level should be available to support public health analysis. In accordance with the aims of the deep dive programme, future JSNAs will include data on citizens living with dual diagnosis. A whole system approach to consistent and rich data collection could support public health research leading to an enhanced evidence base. This includes consistent recording of parental status, carer status, comorbidities, homelessness, and domestic abuse on citizens with dual diagnosis, to create insights from which evidence-based targeted services can be developed.

Data Insights

NICE guidelines highlight that a prevalence for dual diagnosis is in part made difficult to ascertain, due to varying definitions of dual diagnosis in the literature, which means that a clear understanding of prevalence is missing.[405] Therefore, consensus around which mental health and substance misuse conditions are within the scope of the term 'dual diagnosis' could support increased consistency in health and social care settings, and in organising and collecting relevant data, such as creating a national prevalence.

The data limitations outlined in this deep dive represent opportunities to develop current data collection and recording practices. This will strengthen data insights and allow future evidence to be more in-depth.

6.4.3 Recommendations

System Leadership

Recommendations have been developed in collaboration with stakeholders, which build on the gaps identified and on evidence of good practice. The recommendations for Key Finding 2 involving national action require system leadership.

Number	Recommendation
K2.1	The Cabinet Member for Health and Social Care to write a letter to the Health Secretary lobbying to establish a dual diagnosis GP read code, which could be triggered when a mental health condition and substance misuse are both recorded on a patient's record. Aligned to this, the Director of Public Health to take similar action with OHID.
K2.2	The Cabinet Member for Health and Social Care to write a letter to the Health Secretary lobbying for creating a local prevalence of dual diagnosis (including an estimate of unmet need and a projection of future need for those with this condition), which could be upscaled for national usage. This would need to be accurate, up to date and available for all ages (including citizens aged 65+). Aligned to this, the Director of Public Health to take similar action with OHID.

[403] NICE Guideline [CG120]. (2011). Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings. Accessed Jan 2024.
[404] NICE. Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence. Clinical Guideline [CG115]. 2011. Accessed May 2022.
[405] NICE. (2011). Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings. Accessed Mar 2023.

K2.3	The Cabinet Member for Health and Social Care to write a letter to the Health Secretary lobbying for NHS England to request that local areas carry out an audit of mental health services to investigate how dual diagnosis is being captured on patient records. This may support the identification of best practice which can be implemented across Birmingham. Aligned to this, the Director of Public Health to take similar action with OHID.
K2.4	The Cabinet Member for Health and Social Care to write a letter to the Health Secretary lobbying for consistent recording of carers, parental status and family members of citizens with dual diagnosis in GP routine data. Similarly, consistent recording of citizens living with dual diagnosis who have endured other inequalities (e.g., domestic abuse, homelessness, sex working) within GP routine data. This will enable identification of unmet need and make relevant referrals for support. Aligned to this, the Director of Public Health to take similar action with OHID.

Partnership Working and Collaboration

Recommendations have been developed in collaboration with stakeholders, which build on the gaps identified and on evidence of good practice. There are three recommendations for Key Finding 2 which require partnership working and collaboration between local services in Birmingham.

Number	Recommendation
K2.5	a) Substance misuse services to actively support citizens with dual diagnosis (e.g., by referring citizens with suspected mental health concerns to mental health services for assessment and by screening for substance misuse among citizens with mental health needs). Services to record presence of dual diagnosis (where known) and for this data to be shared across our system, including being made available for public health analysis, to further inform our future commissioning priorities. Data to be made available for public health analysis should be expanded (e.g., the number of joint assessments undertaken, the number of clients with self-reported and confirmed mental health conditions, those with a recorded risk of suicidality or suicide attempt, those who are homeless and those with a parent or caring responsibility). b) Mental health services to actively support citizens with dual diagnosis (e.g., by screening citizens with suspected mental health concerns and referring citizens with suspected substance misuse to substance misuse services). Services to record presence of dual diagnosis (where known) and for this data to be shared across our system, including being made available for public health analysis, to further inform our future commissioning priorities. Data to be made available for public health analysis should be expanded (e.g., the number of joint assessments undertaken, the number of clients with self-reported and confirmed mental health conditions, those with a recorded risk of suicidality or suicide attempt, those who are homeless and those with a parent or caring responsibility).
K2.6	In accordance with the aims of the deep dive programme, include data on citizens with dual diagnosis in future JSNA dashboards and other relevant products.

Data Insights

Recommendations have been developed in collaboration with stakeholders, which build on the gaps identified and on evidence of good practice. The recommendation below for Key Finding 2 involve building data insights.

Number	Recommendation

K2.7	The Justice Health Needs Assessment to explore current data collection processes to identify the prevalence of dual diagnosis and collect data on associated inequalities and unmet needs of these citizens within HMP Birmingham.

6.4.4 What Next?

The authors of this Dual Diagnosis Deep Dive have worked with stakeholders from across Birmingham's healthcare system, services and voluntary sector and listened to the voices of lived experience to produce the report's recommendations. The following table outlines the stakeholders, who have agreed to take forward each of the report's recommendations concerning Key Finding 2.

Number	Ownership of Recommendation
K2.1	To be taken forward by the Cabinet Member for Health and Social Care and the Director of Public Health.
K2.2	To be taken forward by the Cabinet Member for Health and Social Care and the Director of Public Health.
K2.3	To be taken forward by the Cabinet Member for Health and Social Care and the Director of Public Health.
K2.4	To be taken forward by the Cabinet Member for Health and Social Care and the Director of Public Health.
K2.5	a) To be taken forward by the Birmingham Public Health Addictions Team and integrated into their service specifications for substance misuse services in Birmingham. b) To be taken forward by the Birmingham Public Health Addictions Team (and partners collectively) to be integrated into the Dual Diagnosis Working Protocol.
K2.6	To be taken forward by the Birmingham Public Health Knowledge Team.
K2.7	To be explored in the Birmingham Justice Health Needs Assessment.

6.5 Key Finding 3: There are Opportunities to Further Understand Training Needs and Embed Specific Dual Diagnosis Training Opportunities.

6.5.1 What is the Gap?

Partnership Working and Collaboration

There are opportunities to further understand the training needs of professionals in Birmingham working in mental health and substance misuse services. In the lived experience chapter (section 5.3) it was highlighted that some professionals felt additional mental health training would be useful, as well as training around sexual health, smoking, trauma, substances and physical health impacts. Specific suggestions included training on dual diagnosis, overview of what local mental health services exist, what they offer, and training on different types of psychological disorders to support their continuous professional development and build on current knowledge and skills.

6.5.2 What does the Evidence Say?

Partnership Working and Collaboration

Better Care for People with Co-occurring Mental Health, Alcohol and Drug Conditions (2017)[406] suggests that a local training needs assessment be carried out locally, which would enable an understanding of cross-cutting training needs.

[406] Public Health England. (2017). Better care for people with co-occurring mental health, and alcohol and drug use conditions. Accessed Jul 2022.

NICE Guidelines state that professionals in mental health services should have the competence to recognise and treat individuals with coexisting substance misuse.[407] Reciprocal training can support the cross development of skills for staff within mental health and substance misuse services. Reciprocal training can also raise awareness of dual diagnosis, to enable staff to identify those living with both mental health need and substance misuse more effectively. This opportunity can be expanded with wider relevant services (e.g., domestic abuse and homelessness services) through using reciprocal training. These ways of joint working may support increased awareness and identification of dual diagnosis in addition to strengthening relationships between services for professionals in these areas.

The evaluation of recent training tools such as Turning Point's e-learning on Dual Diagnosis for use in mental health and substance misuse services in Birmingham should be considered, to support staff understanding of these conditions.[408]

Recognising the wellbeing needs of the Birmingham workforce across mental health and substance misuse services, including the impact of secondary traumatic stress (see section 3.2.21), local services should consider the mental health needs of their staff. Services should enhance the wellbeing support available to professionals, including training which staff can use to support their own mental wellbeing.

6.5.3 Recommendations

Recommendations have been developed in collaboration with stakeholders, which build on the gaps identified and on evidence of good practice. The recommendations for Key Finding 3 involve partnership working and collaboration.

Number	Recommendation
K3.1	a) Consideration of substance misuse organisations within Birmingham's Dual Diagnosis Joint Working Protocol to use Turning Point's e-learning on Dual Diagnosis, in accordance with staff training needs. This should be informed by the training needs analysis. b) Consideration of mental health organisations within Birmingham's Dual Diagnosis Joint Working Protocol to use Turning Point's e-learning on Dual Diagnosis, in accordance with staff training needs. This should be informed by the training needs analysis.
K3.2	a) Substance misuse organisations in Birmingham to consider the mental health needs of their workforce and provide training tools that staff can use to support their own mental health. b) Mental health organisations in Birmingham to consider the mental health needs of their workforce and provide training tools that staff can use to support their own mental health.
K3.3	To support the COMPASS programme in their roll out of the model of supervision, consultation and training which develops the skills of the mental health workforce in Birmingham. This includes the development of tiered training which can be delivered flexibly to meet the needs of mental health staff. This also includes consideration to increasing the capacity of the COMPASS service to extend their training to relevant partner organisations including substance misuse services and domestic abuse services through a reciprocal training model.

[407] NICE. (2011). Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings. Accessed Mar 2023.
[408] Turning Point (2023). Turning Point launches Dual Diagnosis Training. Accessed Jan 2024.

K3.4	a) Substance misuse services to pursue cross-cutting training and ongoing, consistent reciprocal training between organisations in Birmingham's Dual Diagnosis Joint Working Protocol and its partner organisations (e.g., domestic abuse services, homelessness services, mental health services). Furthermore, substance misuse services to share training and advice with other Dual Diagnosis Joint Working Protocol organisations. This should allow for consolidation of skills and further develop working relationships with partner organisations of Birmingham's Dual Diagnosis Working Protocol. This will support the holistic needs of citizens with dual diagnosis and promote effective dual diagnosis treatment and recovery. b) Mental health services to pursue cross-cutting training and ongoing, consistent reciprocal training between organisations in Birmingham's Dual Diagnosis Joint Working Protocol and its partner organisations (e.g., domestic abuse services, homelessness services, substance misuse services). Furthermore, mental health services to share training and advice with other Dual Diagnosis Joint Working Protocol organisations. This should allow for consolidation of skills and further develop working relationships with partner organisations of Birmingham's Dual Diagnosis Working Protocol. This will support the holistic needs of citizens with dual diagnosis and promote effective dual diagnosis treatment and recovery.

6.5.4 What Next?

The authors of this Dual Diagnosis Deep Dive have worked with stakeholders from across Birmingham's healthcare system, services and voluntary sector and listened to the voices of lived experience to produce the report's recommendations. The following table outlines the stakeholders, who have agreed to take forward each of the report's recommendations concerning Key Finding 3.

Number	Ownership of Recommendation
K3.1	a) To be taken forward by the Birmingham Public Health Addictions Team and integrated into their service specifications for substance misuse services in Birmingham. b) To be taken forward by the Birmingham Public Health Addictions Team (and partners collectively) to be integrated into the Dual Diagnosis Working Protocol.
K3.2	a) To be taken forward by the Birmingham Public Health Addictions Team and integrated into their service specifications for substance misuse services in Birmingham. b) To be taken forward by the Birmingham Public Health Addictions Team (and partners collectively) to be integrated into the Dual Diagnosis Working Protocol.
K3.3	To be taken forward by the Birmingham Public Health Addictions Team (and partners collectively) to be integrated into the Dual Diagnosis Working Protocol.
K3.4	a) To be taken forward by the Birmingham Public Health Addictions Team and integrated into their service specifications for substance misuse services in Birmingham. b) To be taken forward by the Birmingham Public Health Addictions Team (and partners collectively) to be integrated into the Dual Diagnosis Working Protocol.

6.6 Key Finding 4: There are Opportunities to Improve Holistic and Person-Centred Support for Citizens Living with Dual Diagnosis.

6.6.1 What is the Gap?

System Leadership

Life Course Approach: While NICE guidance on co-existing substance misuse and mental health is available (e.g., NG158, QS188, CG120), this applies only to those aged 14 years and above. However, no similar NICE guidance for children under this age was identified by the research team. Nevertheless, there may be a need for such guidance due to the mental health problems faced by children and young people, and the engagement with substance misuse (see section 3.2.3).

Research suggests the need for action to tackle vaping, particularly among young people, for whom vaping is not recommended (section 3.1.1). There is an opportunity to further raise awareness to support preventative action and discourage young people from taking up vaping.

Supporting Mental Health Capacity: The research team recognise that perceptions of mental health need, and self-reported mental health concerns, may differ from diagnosed mental health conditions. There was a discrepancy in the data between clients in substance misuse services who self-reported, and those who had a diagnosed mental health concern (see section 4.3.3.1.2). There were also some clients with mental health risks recorded, but no self-reported nor diagnosed mental health condition. This discrepancy suggests an opportunity to enhance person-centred support through increased attention to this group.

Supporting the Implementation of Best Practice: Evidence reported in this deep dive suggests that the smoking prevalence is higher among those with substance misuse and mental health problems (see section 3.1.1.).

There are opportunities to further develop person-centred support for citizens with dual diagnosis who have previous or present contact with the criminal justice system. While some guidance relating to the criminal justice system was reviewed in this deep dive, there is a need to fully evaluate this best practice.

Partnership Working and Collaboration

Citizens living with dual diagnosis may require support for their mental health and substance misuse conditions. However, this deep dive has highlighted additional wider support needs relating to education, employment, housing and resultant health inequalities. There are opportunities to improve holistic and person-centred support through a focus on the wider determinants of health, including employment and housing. Furthermore, citizens living with dual diagnosis may experience health inequalities including poorer general health and may face additional barriers to being physically active.

During the course of this deep dive research, the authors identified the Dual Diagnosis Anonymous organisation as a unique support service for citizens (see section 4.3.2.2). While there are online support groups available, there are currently no in-person support groups in Birmingham. Additionally, opportunities to further develop person-centred support for citizens with dual diagnosis who have previous or present contact with the criminal justice system have been identified in this deep dive.

6.6.2 What does the Evidence Say?

System Leadership

Life Course Approach: A life course approach has been taken in this deep dive report, recognising that citizens may experience dual diagnosis directly or indirectly at any age. The association between childhood adversity and difficulties later in life with mental health and substance misuse has been recognised (see section 3.2.4). Birmingham Children's Trust's practice model raises awareness of the experiences of childhood adversity and the importance of working with families to support positive relationships, resilience and life skills.[409]

To address the gap in national guidance for children and young people experiencing dual diagnosis aged 14 and below, there is an opportunity for lobbying by the Cabinet Member for Health and Social Care.

To address the need to support children and young people around the use of vaping, local actions have been identified which build on guidance from Action on Smoking and Health,[410] assessing the effectiveness of national guidance regarding youth vaping within Birmingham schools.

Derby's Family Drug and Alcohol Service was identified as an example of good practice, from which there may be the opportunity to consider the value of piloting a similar service in Birmingham. This may support families through the provision of support for the parent with substance misuse, but also the children affected by parental substance misuse, in addition to the consideration of the wider support needs of the family.[411]

Supporting Mental Health Capacity: Where the data highlighted a discrepancy in data between clients self-reporting and those with diagnosed mental health problems, there is an opportunity to enhance support. A pathway to assessment for those with self-reported mental health concerns may reduce these discrepancies and support clients and services to understand how these discrepancies may arise. In-house capacity of substance misuse services to support clients with mental health problems, particularly those which are lower in severity, may help provide integrated care for people. Substance misuse services may benefit from having mental health professionals within their services who are able to carry out mental health assessments, support citizens with prescriptions related to mental health and in delivering therapeutic interventions.

Supporting the Implementation of Best Practice: There is a need to enhance smoking support to citizens with dual diagnosis through establishing smoke free policies in substance misuse and mental health services which are grounded in best practice from NICE guidance.[412] This should include offering timely smoking cessation support and the involvement of service users and staff in creating these smoke free policies.

A future Justice Health Needs Assessment will explore several areas which are opportunities to further develop holistic and person-centred support for citizens living with dual diagnosis who are in contact with the criminal justice system. The Justice Health Needs Assessment will

[409] Birmingham Children's Trust. (2023). Practice Model Handouts v05.05.23. Accessed Internally Oct 2023.
[410] ASH. (2022). New national vaping guidance for schools released by Action on Smoking and Health. Accessed Mar 2024.
[411] Aquarius, Family Drug and Alcohol Service. Information received internally. Accessed Mar 2024.
[412] NICE guideline [NG209]. (2021). Tobacco: preventing uptake, promoting quitting and treatment dependence. Accessed Mar 2024.

review best practice of guidance to support citizens living with dual diagnosis, building on the work of this deep dive in addition to reviewing the pilot 'From Prison to Work'.

Partnership Working and Collaboration

This deep dive has highlighted that housing is a key component for supporting wellbeing, with an interactional relationship being acknowledged between mental health and housing.[413] Recommendations to improve services relating to this involves raising awareness of the supported exempt housing quality standards in Birmingham to encourage further providers to comply with these standards.

Physical exercise has been found to support treatment and recovery outcomes (see section 3.3.2) and is thus an important aspect of wellbeing that citizens should have the opportunity to engage with.

There is an opportunity to consider the value of having an in-person Dual Diagnosis Anonymous support group in Birmingham, for those who wish to connect in person with others locally.

A future Justice Health Needs Assessment will cover the topic of the criminal justice system in more depth than was possible within the scope of this deep dive. Recommendations are made for areas of exploration for the Justice Health Needs Assessment, including a review and evaluation of the findings of the 'From Prison to Work' pilot and its potential value in Birmingham. Finally, the value of an integrated pathway from prison to the community will be explored. This will enable a review of the recommendations from Public Health guidance.[414]

6.6.3 Recommendations

System Leadership

Recommendations have been developed in collaboration with stakeholders, which build on the gaps identified and on evidence of good practice. These include recommendations for Key Finding 4 which focus upon a life course approach, supporting mental health capacity and the implementation of best practice involve system leadership.

Life Course Approach

Number	Recommendation
K4.1	Mirror the commitment of Birmingham Children's Trust to raise awareness of the impact of significant childhood adversity across the lifespan and work with families to support positive relationships, resilience, and life skills. This is in recognition of the potential negative impact of these experiences and increased risk in relation to mental health difficulties, substance misuse, physical health and psycho-social functioning at a population level.
K4.2	The Cabinet Member for Health and Social Care to write a letter to the Health Secretary lobbying to create NICE guidance on dual diagnosis for those aged under 14 years. This should include clear national guidance on multi-agency working to support clear referral pathways and joint working protocols when supporting children and young people living with dual diagnosis. Aligned to this, the Director of Public Health to take similar action with OHID.

[413] Mind. Housing and Mental Health. Accessed Mar 2023.
[414] Public Health England. (2018). Guidance for improving continuity of care between prison and the community. Accessed Nov 2023.

K4.3	Assess the effectiveness of the Action on Smoking and Health (ASH) National Vaping Guidance for use in Birmingham schools regarding youth vaping.
K4.4	To consider the added value of piloting a service in Birmingham similar to that of Derby's Family Drug and Alcohol Service.

Supporting Mental Health Capacity

Number	Recommendation
K4.5	A pathway to be created for citizens undergoing substance misuse treatment who have self-reported mental health concerns to access a mental health assessment. This should include those with self-reported mental health concerns (with absence of a diagnosed mental health condition) and citizens who have neither a self-reported nor diagnosed mental health condition (but have recorded mental health risks).

Supporting the Implementation of Best Practice

Number	Recommendation
K4.6	The prevalence of smoking is far higher amongst those with a severe mental illness and those in substance misuse treatment services compared with the national average. Therefore: a) Establish a comprehensive smoke free policy, implemented within substance misuse treatment settings that include timely, best practice (NICE guideline - NG209) in-house smoking cessation intervention and support. All service users of substance misuse treatment services are to have their smoking status recorded and offered timely smoking cessation intervention in accordance with tobacco dependence treatment pathway as set out in smoke free policy. Involve service users and staff for developing and implementing smoke free policy for successful implementation and compliance. b) Establish a comprehensive smoke free policy, implemented within mental health treatment settings that include timely, best practice (NICE guideline - NG209) in-house smoking cessation intervention and support. All service users of mental health treatment services are to have their smoking status recorded and offered timely smoking cessation intervention in accordance with tobacco dependence treatment pathway as set out in smoke free policy. Involve service users and staff for developing and implementing smoke free policy for successful implementation and compliance.
K4.7	The Justice Health Needs Assessment to review best practice around guidance to support citizens with dual diagnosis in the criminal justice system.

Partnership Working and Collaboration

Recommendations have been developed in collaboration with stakeholders, which build on the gaps identified and on evidence of good practice. The recommendations for Key Finding 4 around wider determinants of health involve partnership working and collaboration.

Number	Recommendation
K4.8	Raise awareness of the findings from the supported exempt housing pilot in Birmingham, carried out by Birmingham City Council, Spring Housing Association and BVSC in improving standards across exempt accommodation supporting citizens living with dual diagnosis, through the Charter of Rights, Quality Standards Awards and employment of multi-disciplinary inspection teams.
K4.9	Increased opportunities for citizens living with dual diagnosis to be physically active and participate in sport in the community.

K4.10	Consideration to creation of an in-person Dual Diagnosis Anonymous service in Birmingham, to support citizens with dual diagnosis.
K4.11	The Justice Health Needs Assessment to explore the value of an employment support scheme in Birmingham, similar to that outlined in the 'From Prison to Work' pilot.
K4.12	The Justice Health Needs Assessment to explore how the Public Health England Guidance (2018) and commitment to the continuous improvement of continuity of care between prison and community settings is upheld. For example, to consider how healthcare and probation services use a standard referral form and protocol for use between prison and community settings including contact from community health care providers with clients before their release from prison, and coordination with other services to continue to improve continuity of care in relation to dual diagnosis.[415]

6.6.4 What Next?

The authors of this Dual Diagnosis Deep Dive have worked with stakeholders from across Birmingham's healthcare system, services and voluntary sector and listened to the voices of lived experience to produce the report's recommendations. The following table outlines the stakeholders, who have agreed to take forward each of the report's recommendations concerning Key Finding 4.

Number	Ownership of Recommendation
K4.1	To be taken forward by the Birmingham Public Health Addictions Team and integrated into their service specifications for substance misuse services in Birmingham.
K4.2	To be taken forward by the Cabinet Member for Health and Social Care and the Director of Public Health.
K4.3	To be taken forward by the Birmingham Public Health Adults Team.
K4.4	To be taken forward by the Birmingham Public Health Addictions Team and integrated into their service specifications for substance misuse services in Birmingham.
K4.5	To be taken forward by the Birmingham Public Health Addictions Team and integrated into their service specifications for substance misuse services in Birmingham.
K4.6	a) To be taken forward by the Birmingham Public Health Addictions Team and integrated into their service specifications for substance misuse services in Birmingham. b) To be taken forward by the Birmingham Public Health Addictions Team (and partners collectively) to be integrated into the Dual Diagnosis Working Protocol.
K4.7	To be explored in the Birmingham Justice Health Needs Assessment.
K4.8	To be taken forward by the Birmingham Voluntary Sector Council (BVSC).
K4.9	To be taken forward by the Birmingham Public Health Physical Activity Team and Birmingham Public Health Addictions Team.
K4.10	To be taken forward by the Birmingham Public Health Addictions Team.
K4.11	To be explored in the Birmingham Justice Health Needs Assessment.
K4.12	To be explored in the Birmingham Justice Health Needs Assessment.

6.7 Key Finding 5: There is a Need for More Local Research to be Commissioned to Support the Evidence Base around Health Inequalities for Citizens Living with Dual Diagnosis.

There is a need for more local research to take place to build the evidence base around health inequalities for citizens living with dual diagnosis. Local lived experience research is needed

[415] Public Health England. (2018). Guidance for improving continuity of care between prison and the community. Accessed Nov 2023.

for groups which were unable to be explored by the research team for this deep dive to support greater insight into the needs of particular groups. These include sex workers, unemployed citizens, young people (aged 18-24), citizens from ethnic minority communities, citizens residing in supported housing, and citizens without a mental health diagnosis who have attempted suicide.

Local research should feed into a dynamic system where research and evidence evaluation is a continuous process supporting the whole system approach to person centred care (see K1.8). This includes identification and implementation of evolving and new research on best practice to effectively support groups at risk of dual diagnosis including those with experience of homelessness, veterans, sex workers, neurodivergence, and inequalities associated with sexual orientation and gender. Further research is needed to explore the experience of neurodivergent conditions among citizens living with dual diagnosis. Individuals with ADHD and learning disabilities may be at an increased risk of mental health problems, and those with ADHD may be similarly at an increased risk of substance misuse problems. Living with a mental health problem has been suggested to be a risk factor for substance related problems among people with learning disabilities (see section 3.2.8).

Further research is required to support a greater understanding of the needs of pregnant citizens living with dual diagnosis. Hospital Episode Statistics showed that among the admissions for patients with a dual diagnosis code between 2014-21, 6.8% were women with pregnancy listed as the underlying cause of admission (see section 4.3.5). Further research may provide additional evidence to ensure these women are sufficiently supported with their mental health problems and substance misuse.

This deep dive report presented research suggesting citizens identifying as LGBTQ+ may be at an increased risk of mental health and substance misuse problems. Additionally, these citizens may face unique barriers to support, stigma and negative experiences with accessing healthcare (see section 3.2.15). Inequalities between citizens with different ethnicity backgrounds need exploring. Data presented in this deep dive suggests that patients with dual diagnosis from a black, or mixed ethnicity background were more likely to endure longer hospital stays than those from a white background (see section 4.3.5.4). There is also a need to consider inequalities and needs of citizens across the life course. Research presented in this deep dive shows inequalities in mental health and substance misuse between different age groups (see section 3.2.1), as well as the impact of dual diagnosis on carers and families (see section 3.2.21.2). In particular, the needs of unpaid carers should be recognised, acknowledging the impact of caring for someone living with dual diagnosis. Local research should evaluate the training and support needs of unpaid carers of citizens with dual diagnosis as research has highlighted the burden of responsibility for these carers. Local research may support an understanding of the experience of carers, including the emotional impact, financial strain and diminished quality of life.[416]

Homelessness is associated with higher rates of mental health and substance misuse disorders (see section 3.2.19). Furthermore, national data shows that 5% of adults starting substance misuse treatment in 2021-22 reported an urgent housing problem (see section 3.2.18). Best practice for wrap-around support for those experiencing homelessness and housing needs is needed.

[416] Brown et al. (2011). Likelihood of Asking for Help in Caregivers of Women with Substance Use or Co-Occurring Substance Use and Mental Disorders. Accessed Aug 2022.

Evidence of the main causes of premature death are presented for adults with severe mental illness in England, which include cancer, cardiovascular disease, respiratory disease and liver disease (see section 1.6.3). Evidence has also suggested that cancers, digestive diseases, external causes, and respiratory disease are significant factors in deaths of people with a history of opioid misuse (see section 1.6.4). Furthermore, there are significant health conditions including dementia, which commonly affect the general population and mental health problems and substance misuse increase the risk of this (see section 3.2). Further research investigating these significant health inequalities among citizens living with dual diagnosis is needed.

There is also a lack of evidence on the cost effectiveness of treatment and recovery models locally. This is a gap in the evidence base that would benefit from local insight to improve the delivery of services.

Number	Recommendation
K5.1	Local research to gather lived experience for citizens living with dual diagnosis that were not able to be commissioned for this deep dive. These include sex workers, unemployed citizens, young people (aged 18-24), citizens from ethnic minority communities, citizens residing in supported housing, and citizens without a mental health diagnosis who have attempted suicide. Similarly, research to understand the experience of particular groups including: • the experience of neurodivergent conditions among citizens with dual diagnosis. • the needs of pregnant citizens and the experience of maternity care for those with dual diagnosis. • inequalities among citizens identifying as LGBTQ+. • the needs of unpaid carers of citizens with dual diagnosis.
K5.2	Existing and future research to feed into a dynamic continuous system of research and evidence evaluation which supports the whole system approach to person centred care (see K1.9). This includes identification and implementation of research on best practice to effectively support groups at risk of dual diagnosis including those with experience of homelessness, veterans, sex workers, neurodivergence, and inequalities associated with sexual orientation and gender.
K5.3	Further research to explore the main causes of death linked to mental health and substance misuse including cancer, cardiovascular disease, respiratory disease, liver disease. Additionally, other significant health inequalities require further research (e.g., dementia).
K5.4	Local research to identify best practice in relation to a pathway of wrap-around support for individuals with dual diagnosis who are experiencing housing needs and homelessness.
K5.5	Local research to identify best practice in relation to raising awareness and promoting engagement with services among ethnic minority communities, in recognition of cultural stigma associated with mental health and substance misuse.
K5.6	Local research across the life course, examining inequalities between age groups for citizens, carers and families with experience of dual diagnosis.
K5.7	Local research to explore the impact of the new government restrictions around vaping on the use of vapes among children and young people in Birmingham.

K5.8	Local research to evaluate the cost effectiveness of current engagement, treatment and recovery models for citizens living with dual diagnosis in Birmingham.

6.7.1 What Next?

The research recommendations in Key Finding 5 highlight the gaps in research relating to citizens living with dual diagnosis. Therefore, this research team have listed these research gaps with the aim of encouraging other researchers to carry out their own investigations. In addition, Birmingham City Council's Public Health Division have committed to utilising the learning from this deep dive to inform future JSNAs.

Birmingham City Council

"When you first start drinking it's a release, to deal with normal stress. But when it's taken hold of you, it makes your mental health worse and will start to affect other important areas of your life."

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