Bratt *Discover Public Health* (2025) 22:354
https://doi.org/10.1186/s12982-025-00743-y

Discover Public Health

RESEARCH **Open Access**

Structural and cultural barriers to integrated care for co-existing mental health and substance use: a morphogenetic analysis

Simon Bratt[1*]

*Correspondence:
Simon Bratt
Simon.bratt@research.staffs.ac.uk
[1]Department of Social Work, Law & Criminology, School of Health, Education, Policing & Sciences, University of Staffordshire, Stoke-on-Trent, UK

Abstract
Co-existing mental health and substance use challenges (CEMS) remain a critical barrier to integrated care due to systemic fragmentation, rigid eligibility criteria, and risk-averse service cultures. Despite policy commitments to coordination, individuals with CEMS face exclusion, crisis-driven interventions, and stigma, reinforcing cycles of disengagement. This study applies Archer's (Being human: the problem of agency, 2004) morphogenetic framework to analyse structural and cultural barriers to integration. Using qualitative methods, it examines Freedom of Information (FOI) data from NHS mental health trusts and open interviews with professionals and individuals with lived experience. Findings reveal persistent service silos, abstinence-based eligibility policies, and professional constraints that sustain morphostasis, preventing reform. The Integrated Morphogenetic Care Model (IMCM) is proposed as a framework to promote structural flexibility, and co-produced service design. Urgent reforms are needed to ensure person-centred, trauma-informed care for individuals with CEMS.

Keywords Co-existing mental health and substance use (CEMS), Fragmentation, Morphogenetic framework, Integrated care, Policy reform, Social determinants of health

1 Introduction

Co-existing mental health and substance use challenges (CEMS)—also referred to as dual diagnosis—continue to represent one of the most persistent and poorly addressed issues in public health. CEMS refers to the co-occurrence of mental health conditions (such as depression, psychosis, or post-traumatic stress disorder) alongside substance use challenges (including alcohol, heroin, crack cocaine, or synthetic cannabinoids). These conditions do not exist in isolation; rather, they intersect and compound one another, requiring care that is coordinated, trauma-informed, and person-centred. Yet for many individuals with CEMS, service responses remain fragmented, crisis-driven, and systemically exclusionary.

This fragmentation has long been recognised. Over two decades ago, the Department of Health's *Dual Diagnosis Good Practice Guide* (2002) established that integrated care improves outcomes for people with co-occurring conditions. However, more recent evidence suggests that, despite repeated policy commitments, genuine integration remains elusive. Hughes et al. [1] reaffirmed this systemic disconnect, highlighting the persistence of service silos and disjointed care. For those with lived experience of CEMS—and for the professionals supporting them—this is neither surprising nor new. Despite rhetorical advances, the prevailing reality is one of being "ping-ponged" between mental health and substance use services, with each side denying responsibility for the other.

The scale of this treatment gap is stark. Approximately 70% of people in drug treatment and 86% of those in alcohol treatment report co-occurring mental health issues [2]. A history of alcohol or drug use is recorded in 54% of suicides among people with mental health problems. Yet only 36% of NHS mental health trusts in England report having dedicated CEMS pathways (Freedom of Information data,see Results). Hospital readmission rates among this population remain high, with 76% re-hospitalised within a year [3]. These data point not only to a mismatch between need and provision but also to longstanding institutional neglect.

Part of the challenge lies in the structure of UK service commissioning. Mental health and substance use services are typically commissioned through separate streams, governed by different performance frameworks, timelines, and accountability mechanisms [4]. These siloed arrangements are exacerbated by short-term funding, competitive tendering, and austerity-era disinvestment, which collectively discourage cross-sector collaboration [5]. The result is a system in which organisational fragmentation is not a failure of implementation but a feature of the underlying design.

Cultural barriers further compound this fragmentation. Stigma remains pervasive within professional cultures, with substance use still frequently understood as a moral failing or behavioural problem rather than a trauma response or strategy of survival [6]. These narratives shape treatment thresholds and eligibility criteria, resulting in arbitrary exclusions and retraumatisation. Harm reduction approaches—despite robust evidence of their effectiveness—remain marginalised within many risk-averse service environments.

Despite these entrenched barriers, efforts to envision and implement integrated approaches have emerged across disciplines. In public health, the "no wrong door" principle has been advanced to reduce exclusionary thresholds and promote continuity of care. In workforce policy and service design, Integrated Care Systems (ICSs) have been established to foster collaboration, resource sharing, and long-term transformation across organisational boundaries—even amidst economic turbulence and systemic strain [7]. In health services research, integrated care has been positioned not solely as a mechanism for cost reduction but as a means of improving continuity, relational care, and patient experience, even where the economic evidence remains inconclusive [8]. Meanwhile, sociological frameworks—particularly those rooted in critical realism and intersectionality—have challenged linear, diagnostic paradigms and called for structurally embedded, trauma-informed systems of care (Pilgrim 2015).

This article draws on Margaret Archer's morphogenetic framework [9, 10] to examine why integration efforts in mental health and substance use care often stall—even when policies promote them. Archer's theory helps explain how structural forces (like funding rules or service design), cultural beliefs (such as stigma or professional norms), and individual agency (how people act and make choices) interact over time to either produce change or reinforce the status quo.

Her model breaks this interaction down into a T1–T4 cycle, which is particularly suited to understanding complex systems like CEMS care:

- T1—Structural and Cultural Conditioning: this refers to the existing landscape people find themselves in. In the case of CEMS, this includes separately commissioned mental health and substance use services, siloed budgets, and abstinence-based eligibility criteria. These are not just background conditions—they actively shape what kinds of care are possible and who gets access.
- T2–T3—Social Interaction: here, individuals and organisations interact with those conditions. For example, professionals may try to work around eligibility rules by advising clients not to disclose substance use, or service users may disengage after repeated rejection. These moments of action—adaptation, resistance, or compliance—are shaped by personal histories, institutional constraints, and risk calculations.
- T4—Structural and Cultural Elaboration (or Reproduction): over time, these responses either reinforce the system (morphostasis) or contribute to its transformation (morphogenesis). For instance, when abstinence is routinely enforced as a gatekeeping tool, the system reproduces exclusionary practices. Conversely, when services begin to co-locate and pool budgets, even in pilot form, this can mark a move toward integration.

By applying this cycle to both the Freedom of Information (FOI) data and interview narratives, the study reveals why systemic change remains so difficult—even when frontline staff and service users both recognise the need for it. The framework offers a structured way of tracing how institutional inertia persists, and how transformation might begin.

To ensure that these structural insights do not eclipse personal voices, the study also uses transcendental phenomenology (Moustakas 1994) to foreground lived experience and emotional meaning—locating these stories within the broader institutional and policy context.

Together, these frameworks support a multi-layered inquiry into how CEMS is experienced, governed, and contested in practice. The study draws on two primary data sources: (1) responses to Freedom of Information (FOI) requests submitted to all 54 NHS mental health trusts in England, and (2) 24 qualitative interviews with professionals and individuals with lived experience. This paper addresses the following questions:

- Why do structural and cultural barriers to integrated care persist?
- How are these barriers experienced by those navigating the front lines of care and recovery?
- What practical and conceptual innovations might support a shift from morphostasis to morphogenesis in CEMS provision?

Ultimately, this article contributes to the wider discourse on integrated care by positioning structural reform as not merely a technical issue, but a moral and political imperative—one that must centre lived experience, dismantle systemic stigma, and reimagine service design through the lens of justice and dignity.

2 Methods

This study forms part of a larger doctoral research project undertaken at Staffordshire University, which explored the structural and cultural barriers to integrated care for individuals experiencing Co-existing mental health and substance use challenges (CEMS). The study employed a multi-method qualitative design that integrates transcendental phenomenology (Moustakas 1994) with Archer's morphogenetic framework [9, 10], enabling an exploration of both individual lived experiences and systemic institutional constraints.

2.1 Ethical approval and consent

The study received ethical approval from Staffordshire University and the NHS Health Research Authority (IRAS ID: 255063). Written informed consent was obtained from all participants. Ethical safeguards ensured voluntary participation, the right to withdraw at any time, and full confidentiality throughout.

2.2 Sampling and recruitment

A total of 24 participants were recruited using purposive sampling to ensure diverse perspectives:

- 12 individuals with lived experience of CEMS, all of whom had at least five years' engagement with both mental health and substance use services.
- 12 professionals, including clinicians, support workers, and managers from the NHS, local authorities, and third-sector organisations.

The third sector is defined here as community-based, non-profit organisations involved in delivering harm reduction, housing, outreach, and peer-led recovery support.

Participants were recruited through direct engagement with frontline services, community outreach networks, and digital and physical service posters. All interviews were conducted by the lead researcher—a qualified mental health social worker with over a decade of frontline experience in CEMS-related practice.

2.3 Data collection

1. Unstructured interviews

Unstructured, in-depth interviews were used to explore how participants experienced service disconnection, stigma, eligibility criteria, and strategies for navigating care. Interviews lasted between 60 and 90 min and were conducted either in person or via secure video conferencing software, depending on participant preference. Interviews were audio-recorded with consent and transcribed verbatim. This approach, grounded in transcendental phenomenology, allowed themes to emerge organically without imposing pre-determined categories.

2. Freedom of information (FOI) requests

To provide a macro-level view of institutional practices, Freedom of Information (FOI) requests were submitted to all 54 NHS mental health trusts in England under the Freedom of Information Act (2000). These sought:

- The existence of dedicated CEMS care pathways

- Staff training specific to dual diagnosis
- Eligibility and exclusion criteria
- Funding structures
- Referral processes
- Performance monitoring mechanisms

A total of 33 trusts responded (61%), offering valuable institutional insights that were used to triangulate and contextualise interview findings.

2.4 Interview guide development

The interview topic guide was developed using both phenomenological and morphogenetic principles. Drawing on pilot conversations with professionals and early-stage interviews, it evolved iteratively to explore key areas such as:

- Structural barriers to care
- Experiences of stigma and exclusion
- Navigating dual diagnosis thresholds
- Agency, coping, and resistance within fragmented systems

Open-ended questions were framed to support participant reflection while allowing links to Archer's [9] T1–T4 morphogenetic cycle to emerge during analysis.

2.5 Data analysis

Data analysis followed a hybrid framework, justified by the study's dual epistemological foundations:

- Phenomenological analysis used Moustakas' (1994) approach, including horizontalisation, clustering invariant constituents, imaginative variation, and synthesis of textural and structural meaning.
- Thematic analysis (Braun and Clarke 2022) was used to identify patterns across both interviews and FOI data, supporting a layered comparison between lived experience and institutional structures.
- FOI responses were analysed thematically and then integrated with interview data through comparative analysis, revealing contradictions and convergences between policy claims and service realities.

This hybrid analytical approach enabled a morphogenetic mapping of conditioning (T1), social interaction (T2–T3), and structural elaboration or reproduction (T4).

2.6 Rigour and reflexivity

As is common in doctoral research, all coding was conducted by the lead researcher. To ensure analytical rigour:

- A reflexive journal was maintained throughout to document emerging assumptions, decisions, and positionality.
- Peer debriefing and supervisory review informed theme development and interpretive decisions.
- Selected transcripts were revisited iteratively to ensure internal consistency and fidelity to participant meaning.

While intercoder reliability was not undertaken, methodological transparency and reflexive auditing enhanced credibility and trustworthiness.

2.7 Data security

All interview transcripts and FOI datasets were stored securely in encrypted folders on university-approved systems. Pseudonyms were used in all records and publications, and identifying details were removed during transcription to maintain confidentiality.

2.8 Participant compensation

No financial incentives were offered. Participants were thanked for their time, offered debriefing, and provided with signposting to support services if required.

3 Results

This section presents the key findings of the study, drawn from two primary data sources: (1) Freedom of Information (FOI) responses submitted to all NHS mental health trusts in England, and (2) qualitative interviews with individuals with lived experience of co-existing mental health and substance use challenges (CEMS), as well as professionals working within NHS, local authority, and third-sector settings. These data were analysed to explore the extent and impact of systemic fragmentation in service provision and to identify how structural barriers manifest in practice.

Of the 54 NHS mental health trusts approached—each representing a regionally governed statutory provider of specialist mental health services—33 responded to the FOI request, resulting in a 61% response rate. The content of these responses revealed a highly inconsistent approach to integrated care across England. Although national policy directives, including the *Dual Diagnosis Good Practice Guide* (DoH, 2002) and *Christie's Review* (2017), have long advocated for co-located, multidisciplinary approaches to CEMS support, only 12 of the 33 responding trusts (36%) reported having a dedicated care pathway for individuals with co-occurring conditions. In the remaining trusts, care remains fragmented across separate mental health and substance use services, with limited coordination or formal mechanisms for integrated treatment.

These national-level findings resonate with international trends: Alsuhaibani et al. [11] found that only 3 out of 21 international clinical guidelines explicitly reference co-occurring mental health and substance use disorders, reinforcing the global neglect of integrated care models. The data presented in this section reflect how that neglect plays out on the ground—in the lives of service users and the decisions of frontline professionals navigating complex, often contradictory systems.

3.1 Persistent service fragmentation and access barriers

Participants with lived experience consistently described how fragmented service systems contributed to feelings of exclusion, helplessness, and repeated rejection. Many reported being referred from one service to another without receiving appropriate support. For example:

> *"I've been to rehab three times, but as soon as I come out, I get sent between alcohol services and mental health services—none actually work together."*

(*P09 – Male, 43, lived experience*).

Others described how cyclical referrals between services—each with their own eligibility rules—prevented access to sustained care:

> *"I knew I had a drinking problem when I was arrested for drunk driving. The court told me to get help. My GP sent me to alcohol services, they sent me to mental health, then back to alcohol—it's an absolute joke."*

(*P04 – Female, 38, lived experience*).

Participants with long-term histories of substance use frequently reported being denied access to mental health care unless abstinence or stable housing had first been achieved. One participant noted:

> *"I've been using heroin for over five years… but trying to get any support is impossible. I've been referred to loads of different teams, but because I'm on gear or homeless, no one will pick me up."*

(*P03 – Male, 41, lived experience*).

Professionals working in NHS and community settings confirmed these patterns. Several interviewees described the impact of strict referral criteria and service boundaries:

> *"I assess people in crisis who use alcohol or drugs to cope with distress, but trying to get them into mental health services is near impossible. They're told to work with substance use teams first, but those teams don't deal with their mental health."*

(*P17 – Social Worker, NHS Crisis Team, 44*).

Others expressed concern about the emotional toll of working within systems they felt were not equipped to support individuals with CEMS:

> *"I've got three patients with a dual diagnosis on my caseload of 40. They take up most of my time… I often go home thinking tomorrow will be the day one of them is found dead."*

(*P15 – Community Psychiatric Nurse, 41*).

Several professionals admitted to working around official processes to help people access care:

> *"When I get someone who drinks or uses drugs and is mentally unwell, I tell them not to tell mental health services they use substances, because I know they won't get the support they need."*

(*P22 – Dual Diagnosis Link Worker, 28*).

Participants also reported experiencing dismissive or stigmatising attitudes from professionals. One service user explained:

> *"I'd been waiting so long for help. I ended up being sectioned. I thought, finally, I'll get support. But all I got was, 'You need to stop drinking; it's the alcohol.' I overheard the nurses calling me a raging alcoholic."*

(*P07 – Male, 38, lived experience*).

Another shared how their grief-related drinking led to being discharged from support:

> *"I lost my son, and I was drinking three bottles of wine a day. Mental health services referred me for bereavement counselling, but then told me I needed to stop drinking*

> *before they could help. I tried to explain—it's the only thing that helps—but they didn't care and discharged me."*

(*P12 – Female, 49, lived experience*).

Across these accounts, participants described services that prioritised abstinence or psychiatric stability as a precondition for care. This resulted in individuals being excluded at their most vulnerable moments and left to manage distress without sustained, integrated support.

3.2 Eligibility criteria and abstinence-based policies: a catch-22 for CEMS patients

Findings from both FOI data and qualitative interviews indicated that restrictive eligibility criteria and prolonged waiting times pose significant barriers for individuals with CEMS. Despite national endorsements of a 'No Wrong Door' approach [2], FOI responses revealed that many NHS trusts maintain access thresholds that require service users to demonstrate abstinence from substances prior to receiving mental health support.

Reported waiting times averaged between 2.4 and 3 weeks for an initial assessment, followed by an additional four-week delay before treatment could begin. This was echoed in multiple participant accounts, which detailed repeated rejections from services due to active substance use.

One service user described the recurring pattern of being excluded from care:

> *"I've been to mental health services so many times now, but I get the same message every time: 'You've got to stop drinking before we can treat you.' I gave up trying."*

(*P06 – Male, 45, lived experience*).

Another participant recalled:

> *"I've tried so many times to get help, but they just say, 'stop using drugs first.' If only it was that easy."*

(*P10 – Female, 36, lived experience*).

Professionals confirmed that these policies remain embedded in local service guidance. FOI data from several trusts included wording such as "support is contingent on engagement with substance use services" or "psychiatric care commences following abstinence." In practice, this creates a Catch-22 for individuals who use substances as a coping mechanism for mental distress, making access to support conditional on the resolution of the very problems they are seeking help for.

These eligibility rules were consistently described as barriers rather than gateways to care, particularly for those with long-standing trauma, complex needs, or unstable housing. While a small number of trusts reported efforts to relax these policies, the majority offered no alternative pathways for individuals who could not meet abstinence conditions.

3.3 Workforce challenges: burnout, stigma, and service disengagement

A further theme that emerged from the interview data concerned the emotional toll on professionals working within fragmented service systems. Several practitioners described the difficulty of supporting individuals with CEMS within existing caseload pressures and service limitations.

> *"I have three CEMS patients on my caseload of 40. They take all of my time. I often go home at night thinking tomorrow will be the day one of them is found dead. It's exhausting."*

(*P15 – Community Psychiatric Nurse, 42*).

Practitioners noted that the complexity of CEMS cases often exceeded the scope of available support structures, and some reported feeling powerless to address the underlying needs of service users. The limited availability of dual diagnosis training and the lack of integrated service frameworks contributed to professional frustration and distress.

Service users also described how they experienced professional stigma and felt that their needs were deprioritised or misunderstood. In several cases, participants recounted being told that their substance use was the primary issue, even in moments of acute psychological distress.

> *"I thought I'd finally get help. But all I got was, 'You need to stop drinking; it's the alcohol.' It was like my mental health didn't matter."*

(*P11 – Female, 39, lived experience*).

Across both service user and professional accounts, participants identified a pattern in which mental health needs were deprioritised in the presence of substance use, contributing to service disengagement, unresolved distress, and a reliance on emergency responses.

3.4 Structural inertia and morphostasis in CEMS care

The persistence of fragmented service provision for individuals with CEMS is emblematic of what sociologists identify as a structural contradiction: an area of social life where formal policy imperatives clash with the material realities of service delivery, reinforcing exclusion rather than integration. Despite a growing policy discourse advocating for joined-up care, what prevails in practice is a system in which institutional actors are structurally disincentivised from pursuing holistic, coordinated support.

From a critical realist and historical institutionalist perspective, this inertia is not accidental but reflects deeply entrenched path dependencies within state-led welfare provision [12]. The historical separation of mental health and substance use services—one guided predominantly by psychiatric medicalisation and the other by punitive or abstinence-based frameworks—has created parallel institutional logics, challenging efforts towards integration (Babor et al. 2018). Reform initiatives frequently struggle due to what Archer [9] describes as morphostasis: the enduring resistance of social structures to substantive change, despite considerable external pressures.

3.5 Structural contradictions and the political economy of CEMS care

At the heart of this inertia lies a fundamental structural contradiction within the UK's approach to public health governance. The Health and Social Care Act 2012, by shifting public health commissioning responsibilities to local authorities, introduced a quasi-market logic into service provision, effectively decentralising responsibility for integrated care without providing a unified funding mechanism [4]. The result is regional stratification, in which some localities invest in multi-agency service models, while others, constrained by austerity-era budget restrictions, have eliminated entire tiers of provision [13].

This policy shift aligns with broader neoliberal transformations in welfare governance, characterised by the retreat of state involvement from direct service provision in favour of competitive commissioning frameworks, effectively privatising risk and delegating accountability onto local bureaucracies and individual service users [14]. The withdrawal of centralised accountability exacerbates institutional fragmentation, producing what sociologists of health identify as austerity governance—a paradigm in which state welfare institutions function primarily as gatekeepers of scarce resources rather than providers of comprehensive care [15].

This has acute consequences for individuals with CEMS, particularly those experiencing homelessness and multiple disadvantage, who exist at the intersection of multiple bureaucratic regimes. For these populations, access to care is not simply a question of eligibility but of navigating overlapping systems of exclusion. Mental health services often impose abstinence-based criteria before engaging with individuals, while addiction services may refuse to work with those deemed to have 'severe and enduring' psychiatric conditions. These contradictions generate what Lipsky [16] described as 'street-level bureaucracy,' where frontline workers, faced with conflicting institutional mandates, make discretionary decisions that often reinforce systemic exclusion.

3.6 The failure of ICSs to resolve structural fragmentation

The Realising the Potential of Integrated Care Systems (ICSs) report [7] illustrates how these contradictions persist under contemporary health governance structures. While ICSs were intended to coordinate care across health and social services, their implementation has been largely NHS-centric, failing to integrate mental health and addiction services into a coherent system. Instead of dismantling silos, ICSs have replicated many of the funding and accountability constraints imposed by the Health and Social Care Act 2012.

The ICS workforce transformation agenda [7] acknowledges the complexity of CEMS care but fails to resolve fundamental integration barriers:

- Mental health and addiction services remain institutionally separated, despite growing recognition of their interdependence.
- Performance-based funding models reinforce sectoral competition, making cross-disciplinary care unsustainable.
- Bureaucratic constraints limit the flexibility of frontline professionals, reducing their ability to provide person-centred, adaptive interventions.

These findings align with broader critiques of neoliberal health governance, where service coordination is hindered by market-driven funding mechanisms rather than patient needs. As Bachrach [17] demonstrated in her analysis of deinstitutionalization, shifting psychiatric care from state-run institutions to general hospitals created a new category of chronically excluded patients—a pattern now replicated in the failure to integrate CEMS services within ICSs.

In summary, the synthesis of FOI data and interview findings underscores the urgent need for structural and cultural reform in CEMS service provision. Persistent fragmentation, restrictive eligibility criteria, stigma, and workforce burnout all signal a systemic morphostasis that has long impeded effective CEMS care. Real progress will require a decisive shift toward morphogenetic models that embrace harm reduction, trauma-informed principles, and interdisciplinary collaboration—ultimately ensuring that individuals with CEMS can access uninterrupted, high-quality support.

4 Discussion: structural morphostasis and the challenge of integrated CEMS care

This study has shown that, despite sustained policy commitments to integration, care for individuals with co-existing mental health and substance use challenges (CEMS) remains deeply fragmented. The findings highlight five persistent barriers to effective service delivery: (1) a lack of dedicated CEMS pathways in the majority of NHS mental health trusts; (2) exclusionary eligibility criteria that prioritise abstinence and stability before access to care; (3) systemic stigma and dismissive professional attitudes; (4) workforce burnout and training gaps; and (5) limited inter-service collaboration due to siloed funding models. These interlocking barriers reflect a broader phenomenon of structural morphostasis [9], whereby entrenched institutional systems resist substantive change, even in the face of external pressures and internal failures.

4.1 Structural inertia and policy contradictions

The enduring bifurcation of mental health and substance use services exemplifies what Pierson [12] calls path dependency—a process by which early policy choices become embedded in institutional logics, constraining future reform. Mental health services remain predominantly shaped by psychiatric medicalisation, whereas substance use services continue to oscillate between abstinence-oriented frameworks and harm reduction models, often excluding those with complex mental health needs. This divide is sustained not only by tradition but also by divergent clinical training, risk frameworks, and performance targets.

The Health and Social Care Act 2012, which devolved public health commissioning to local authorities, further institutionalised this fragmentation. By introducing quasi-market principles into service provision without a unifying funding mechanism [4], the Act created conditions for regional disparity. In wealthier areas, investment in multi-agency teams has progressed; in under-resourced localities, entire pathways have been dismantled [13]. This decentralisation of responsibility without meaningful redistribution of resources has exacerbated institutional inertia and deepened systemic inequalities.

These dynamics were vividly illustrated in both FOI responses and participant narratives. Individuals described being “ping-ponged” between services, denied access unless abstinent, or discharged due to “complex needs” that fell outside any one team’s remit. Professionals echoed this, describing ethical distress, service constraints, and workarounds—including advising service users to withhold substance use information just to access mental health care.

4.2 Integrated care systems and the illusion of reform

The recent development of Integrated Care Systems (ICSs) was intended to resolve such fragmentation by promoting collaboration between health and social care providers. However, this study’s findings suggest that ICSs have so far failed to deliver meaningful integration for CEMS. Echoing critiques by Naylor et al. [7], the research found that ICS implementation remains highly NHS-centric, with little structural linkage between mental health and addiction services. Instead of dismantling silos, ICSs have replicated legacy constraints—including rigid funding allocations, short-term commissioning cycles, and an overemphasis on performance metrics.

The ICS workforce transformation agenda, while acknowledging the complexity of CEMS care, has not translated into front-line integration. Interviewees described caseload overload, inadequate dual diagnosis training, and persistent professional silos. These barriers mirror findings by Mechanic [18] and Livingston [19], who argue that reforms grounded in market logic often exacerbate fragmentation by rewarding competition over cooperation.

In line with Cairney's [20] "policy-implementation gap", the study revealed a disconnect between national integration rhetoric and local service realities. Despite principles like the 'No Wrong Door' approach [2], service users frequently encountered multiple closed doors. FOI responses showed that fewer than 40% of trusts had a dedicated dual diagnosis pathway, and even where such pathways existed, access remained conditional on service readiness or abstinence—criteria that individuals could not meet precisely because of the lack of coordinated care.

4.3 Cultural barriers and epistemic hierarchies

Beyond structural and financial constraints, the research identified entrenched cultural barriers to integration. Professional hierarchies and disciplinary identities continue to shape how CEMS is conceptualised and responded to. Mental health services, guided by biomedical stabilisation logics, often regard active substance use as a behavioural problem to be resolved before care can be accessed. In contrast, addiction services may reject those with complex psychiatric presentations as "too risky" or "too ill." These epistemic divisions actively discourage collaboration and prevent holistic responses.

This dual exclusionary logic reinforces what Lipsky [16] calls "street-level bureaucracy," in which frontline staff must make case-by-case decisions under conflicting mandates. The findings of this study confirm that such discretion often results in gatekeeping, risk avoidance, and the quiet reproduction of systemic inequality.

4.4 Toward a morphogenetic model: operationalising the IMCM

The findings of this study directly informed the development of the Integrated Morphogenetic Care Model (IMCM)—a novel, theoretically grounded framework proposed by the author to disrupt structural morphostasis and facilitate integrated care for individuals with CEMS. The IMCM is not simply an overlay for existing systems; it is a reconceptualisation of how care is structured, delivered, and governed. It responds to the identified failures of current policy implementation—particularly the 'No Wrong Door' principle and ICS reforms—by embedding integration into the fabric of service provision rather than relying on alignment across separate systems.

A defining feature of the IMCM is its modular organisational design, which enables flexibility and responsiveness across diverse local contexts. Unlike previous integration initiatives that attempt to coordinate siloed services through referral networks or liaison roles, the IMCM begins from the premise that care must be co-located, co-delivered, and co-owned by multiple disciplines working collaboratively. This is operationalised through Integrated Care Networks (ICNs), which function as embedded teams across mental health, substance use, housing, and social support domains. ICNs are governed by shared outcomes, cross-sector protocols, and pooled budgets, rather than the narrow service-specific metrics that dominate NHS commissioning.

Another central principle of the IMCM is decentralised decision-making. Clinical discretion is enhanced through real-time team collaboration and service-user involvement, enabling care plans to be modified dynamically based on lived experience and frontline feedback. This contrasts sharply with the current system, where risk-averse, bureaucratically imposed care plans often delay or deny access based on rigid eligibility criteria.

Crucially, the IMCM introduces feedback loops—mechanisms that connect service-user experience, practitioner insight, and system-level evaluation. These loops are informed by Archer's morphogenetic cycle (T1–T4), enabling services to respond to structural constraints while actively contributing to cultural and institutional transformation. The model therefore provides not just an alternative structure for service delivery, but a praxis-oriented framework for systemic change.

4.5 Embedding the IMCM: structural challenges and strategic imperatives

Despite its potential, the implementation of the IMCM faces significant structural and cultural challenges. As this study's FOI data reveal, fragmented funding models remain the greatest barrier to integrated care. NHS mental health and substance use services are still governed by competitive commissioning, which disincentivises collaboration and prioritises short-term cost containment over long-term, person-centred outcomes. In practice, many CEMS services remain dependent on temporary pilots, with no guarantee of sustainability or scalability.

The IMCM confronts this by proposing the restructuring of funding mechanisms through pooled budgets across health, housing, and social care. However, this requires legislative and policy reform to override existing budgetary silos and incentivise integrated delivery. Without this realignment, even the most well-designed models risk becoming isolated examples of good practice rather than national standards.

Equally significant is the issue of professional resistance. The findings of this study confirm that disciplinary boundaries—rooted in divergent epistemologies, risk frameworks, and accountability structures—remain deeply entrenched. The IMCM directly challenges these by mandating shared training, co-location of services, and joint accountability. However, such shifts can be perceived as threats to professional identity and autonomy, particularly when integration is imposed without adequate consultation or resourcing.

To mitigate this, the IMCM incorporates a layered implementation strategy:

- Phase 1: Relationship-building and cross-sector training
- Phase 2: Piloting with built-in flexibility for adaptation
- Phase 3: Evaluation using cost-consequence analysis and service-user-led review panels
- Phase 4: Strategic scaling tied to national commissioning standards

This staged approach reflects the recognition that integration must be both structurally mandated and culturally co-produced. Top-down directives alone are insufficient; successful implementation must emerge from the dynamic interaction of structure, culture, and agency—the very heart of morphogenetic theory.

A final but critical challenge lies in balancing local adaptability with national coherence. While the modular nature of the IMCM allows for tailored implementation, this also introduces risks of inconsistency and inequity if not accompanied by robust governance. The findings of this study support previous critiques (e.g., [21]), which argue that the absence of clear national integration mandates perpetuates geographic disparities and reinforces reliance on discretionary leadership. To prevent this, the IMCM must be anchored within a national policy framework that combines local autonomy with central accountability.

The IMCM is a response to the failures surfaced in this study—failures of integration, compassion, coordination, and political imagination. It offers not just a model of care, but a theory-informed intervention grounded in empirical data, designed to break the cycle of morphostasis that has defined CEMS services for decades. Its success will depend not only on technical adjustments to commissioning frameworks, but on a collective willingness to reimagine care as a relational, participatory, and socially embedded process.

To this end, the IMCM represents a paradigmatic shift: from systems that manage risk to systems that cultivate trust; from services that gatekeep to services that collaborate; and from crisis-driven responses to structures that sustain dignity, agency, and hope. For policymakers, practitioners, and researchers alike, the imperative is clear: integration must move beyond aspiration. It must be built into the very architecture of care—and models like the IMCM provide the blueprint for doing so.

5 Conclusion

This article has examined the enduring fragmentation of services for individuals with co-existing mental health and substance use challenges (CEMS), revealing how institutional morphostasis continues to obstruct the delivery of integrated, person-centred care. Drawing on Archer's morphogenetic framework, and grounded in empirical findings from both FOI data and qualitative interviews, the study demonstrates that systemic disconnection is not a matter of isolated failure but a function of structural, cultural, and policy-level inertia.

The findings underscore that integration has been hindered by a combination of siloed commissioning, restrictive eligibility criteria, risk-averse professional cultures, and the persistence of epistemic hierarchies. These dynamics maintain a system in which services function reactively, prioritising crisis response over prevention, and often exclude the very individuals they are designed to support. While policy rhetoric continues to promote holistic, trauma-informed approaches, the implementation gap remains wide—and for many, insurmountable.

In response to these challenges, this article introduces the Integrated Morphogenetic Care Model (IMCM) as a novel, theoretically grounded proposal for structural transformation. Developed from the study's empirical insights and informed by critical realist principles, the IMCM offers a new foundation for care—one that embeds interdisciplinary collaboration, trauma-informed practice, and social determinants of health into the design of service delivery itself. Unlike models that seek to retrofit integration into fragmented systems, the IMCM begins from the premise that complexity is the norm—not the exception—and that systems must be built accordingly.

While the IMCM presents a viable pathway for reform, its implementation requires more than policy endorsement. It demands structural and cultural shifts across multiple domains: the pooling of budgets across sectors; the redesign of workforce training and incentives to support interdisciplinary collaboration; and the creation of governance frameworks that ensure consistency without sacrificing local adaptability. These changes must be supported by a move away from abstinence-based performance metrics toward broader indicators of social inclusion, stability, and relational trust.

Crucially, service-user leadership must be central to this transformation. The IMCM is grounded in the belief that those most affected by fragmented care must be co-creators of its redesign. Embedding lived experience at every level of service planning, delivery, and evaluation is essential not only for legitimacy, but for effectiveness.

Ultimately, bridging the gap between aspirational policy and operational reality will require a fundamental reimagining of care: one that prioritises dignity over diagnosis, agency over compliance, and continuity over crisis. The IMCM provides a blueprint for this reimagining. Whether it is realised will depend on the collective willingness of policymakers, practitioners, and communities to move beyond incrementalism—and to commit to a future in which integration is not simply an aspiration, but the organising principle of care.

Author contributions

S.B. conceived and designed the study, conducted the literature review, collected and analyzed the data, and wrote the manuscript. S.B. also prepared the figures and tables, revised the manuscript for critical content, and approved the final version for submission.

Funding

This study received no external funding, and there are no competing interests that could influence the findings or conclusions presented in the manuscript.

Data availability

The datasets generated and/or analysed during the current study are not publicly available due to ethical considerations regarding participant confidentiality, but are available from the corresponding author on reasonable request. FOI data used in the study are publicly accessible through NHS Trust transparency portals.

Declarations

Ethics approval and consent to participate

Ethical approval for this study was obtained from the Staffordshire University Research Ethics Committee and the National Health Services (NHS) Health Research Authority (HRA). All methods were carried out in accordance with relevant guidelines and regulations as stipulated by these ethics bodies.

Consent for publication

Written informed consent was obtained from all participants prior to their involvement in the study. Where applicable, consent was also obtained from legal guardians. Participants were fully informed about the purpose of the study, and their right to confidentiality, anonymity, and voluntary withdrawal was upheld throughout the research process.

Competing interests

The authors declare no competing interests.

Received: 6 March 2025 / Accepted: 11 June 2025

References

1. Hughes E, Harris J, Ainscough T, Bate A, Copello A, Dalkin S, Gilchrist G, Griffith E, Jones L, Maden M, Mitcheson L, Sumnall H, Walker C. Care models for coexisting serious mental health and alcohol/drug conditions: the RECO realist evidence synthesis and case study evaluation. Health Technol Assess. 2024. https://doi.org/10.3310/JTNT0476.
2. Christie E. Better care for people with co-occurring mental health and alcohol: drug use conditions.pdf. Public Health England. 2017.
3. Di Lorenzo R, Galliani A, Ferri P, Landi G, Guicciardi A. A retrospective analysis focusing on a group of patients with dual diagnosis treated by both mental health and substance use services. Neuropsychiatr Dis Treat. 2014. https://doi.org/10.2147/NDT.S65896.

4. Gadsby EW. Commissioning for health improvement following the 2012 health and social care reforms in England: what has changed?. 2017.
5. Thomson LJM, Chatterjee HJ. Barriers and enablers of integrated care in the UK: a rapid evidence review of review articles and grey literature 2018–2022. Front Public Health. 2024;11:1286479. https://doi.org/10.3389/fpubh.2023.1286479.
6. Pinderup P. Challenges in working with patients with dual diagnosis. Adv Dual Diagn. 2018;11(2):60–75. https://doi.org/10.1108/ADD-11-2017-0021.
7. Naylor C, Cream J, Chikwira L, Gowar C. Realising the potential of integrated care systems: developing system-wide solutions to workforce challenges. London: The King's Fund; 2024.
8. Hazarika R, Purdy S. Integrated care: demonstrating value and valuing patients. Future Hosp J. 2015;2(2):132–6. https://doi.org/10.7861/futurehosp.2-2-132.
9. Archer MS. Realist social theory the morphogenetic approach. Cambridge: Cambridge University Press; 1995.
10. Archer MS. Being human: the problem of agency. 2004.
11. Alsuhaibani R, Smith DC, Lowrie R, Aljhani S, Paudyal V. Scope, quality and inclusivity of international clinical guidelines on mental health and substance abuse in relation to dual diagnosis, social and community outcomes: a systematic review. BMC Psychiatry. 2021;21(1):209. https://doi.org/10.1186/s12888-021-03188-0.
12. Pierson P. Politics in time: history, institutions, and social analysis. Princeton: Princeton University Press; 2004.
13. Fuller JS. The impact of the Health and Social Care Act, 2012 on the health and wellbeing of rough sleepers. 2012.
14. Peck J, Tickell A. Neoliberalizing space. Antipode. 2002;34(3):380–404. https://doi.org/10.1111/1467-8330.00247.
15. Wacquant L. Punishing the poor: the neoliberal government of social insecurity. Durham: Duke University Press; 2009.
16. Lipsky M. Street-level bureaucracy: dilemmas of the individual in public services. 30th ed. New York: Russel Sage Foundation; 2010.
17. Bachrach LL. General hospital psychiatry and deinstitutionalization: a systems view. Gen Hosp Psychiatry. 1985;7(3):239–48. https://doi.org/10.1016/0163-8343(85)90076-3.
18. Mechanic D, McAlpine DD, Rochefort DA. Mental health and social policy: beyond managed care. 6th ed. Boston: Pearson Education; 2014.
19. Livingston JD. Structural stigma in health-care contexts for people with mental health and substance use issues: a literature review. 2020. https://doi.org/10.13140/RG.2.2.21168.17929.
20. Cairney P. The 'British Policy Style' and mental health: beyond the headlines. J Soc Policy. 2009;38(4):671–88. https://doi.org/10.1017/S0047279409003249.
21. Peckham S, Hudson B, Hunter D, Redgate S. Policy success: what is the role of implementation support programmes? Soc Policy Adm. 2022;56(3):378–93. https://doi.org/10.1111/spol.12771.
22. Adams EA, Parker J, Jablonski T, Kennedy J, Tasker F, Hunter D, Denham K, Smiles C, Muir C, O'donnell A, Widnall E, Dotsikas K, Kaner E, Ramsay SE. A qualitative study exploring access to mental health and substance use support among individuals experiencing homelessness during COVID-19. Int J Environ Res Public Health. 2022. https://doi.org/10.3390/ijerph19063459.
23. Anandan R, Cross W, Olasoji M. Mental health nurses' attitudes towards consumers with co-existing mental health and drug and alcohol problems: a scoping review. Issues Ment Health Nurs. 2021;42(4):346–57. https://doi.org/10.1080/01612840.2020.1806964.
24. Anastas T, Waddell EN, Howk S, Remiker M, Horton-Dunbar G, Fagnan LJ. Building behavioral health homes: clinician and staff perspectives on creating integrated care teams. J Behav Health Serv Res. 2019;46(3):475–86. https://doi.org/10.1007/s11414-018-9622-y.
25. Archer MS. The mess we are in: how the morphogenetic approach helps to explain it: IACR 2020 Warsaw. J Crit Realism. 2021;20(4):330–48. https://doi.org/10.1080/14767430.2022.1984698.
26. Avery J, Zerbo E, Ross S. Improving psychiatrists' attitudes towards individuals with psychotic disorders and co-occurring substance use disorders. Acad Psychiatry. 2016;40(3):520–2. https://doi.org/10.1007/s40596-015-0361-6.
27. Cosgrove L, Karter JM. The poison in the cure: Neoliberalism and contemporary movements in mental health. Theory Psychol. 2018;28(5):669–83. https://doi.org/10.1177/0959354318796307.
28. Harris J, Dalkin S, Jones L, Ainscough T, Maden M, Bate A, Copello A, Gilchrist G, Griffith E, Mitcheson L, Sumnall H, Hughes E. Achieving integrated treatment: a realist synthesis of service models and systems for co-existing serious mental health and substance use conditions. Lancet Psychiatry. 2023;10(8):632–43. https://doi.org/10.1016/S2215-0366(23)00104-9.
29. Hawn SE, Cusack SE, Amstadter AB. A systematic review of the self-medication hypothesis in the context of posttraumatic stress disorder and comorbid problematic alcohol use. J Trauma Stress. 2020;33(5):699–708. https://doi.org/10.1002/jts.22521.
30. Ikkos G. Not doomed: sociology and psychiatry, and ignorance and expertise. BJPsych Bull. 2023;47(2):90–4. https://doi.org/10.1192/bjb.2022.60.
31. Marcus E, Brown M, Stockton S, Pilling S. Review 2: Service user, family and carer, provider and commissioner views and experiences of health and social care services for people with a severe mental illness who also misuse substances. 2016.
32. Oute J, Bjerge B, Davidson L. What are dually diagnosed patients' problems represented to be in mental health? A WPR analysis of the multistability purpose of digital health records. Sociol Health Illn. 2022;44(8):1361–80. https://doi.org/10.1111/1467-9566.13518.
33. Phillips P. The mad, the bad, and the dangerous—harm reduction in dual diagnosis. Int J Drug Policy. 1998;9(5):345–9. https://doi.org/10.1016/S0955-3959(98)00047-4.
34. Ross N, Brown C, Johnstone M. Dismantling addiction services: neoliberal, biomedical and degendered constraints on social work practice. Int J Ment Health Addict. 2022. https://doi.org/10.1007/s11469-022-00779-0.
35. Yule A, Kelly J. Integrating treatment for co-occurring mental health conditions. Alcohol Res Curr Rev. 2019;40(1): arcr.v40.1.07. https://doi.org/10.35946/arcr.v40.1.07.

Publisher's Note