From Fragmentation to Integration: An Inquiry into Co-Existing Mental Health and Substance Use Challenges

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March 2025

Abstract

The intersection of mental health and substance use ,referred to as Co-Existing Mental Health and Substance Use Difficulties (CEMS), remains one of the most pressing yet neglected challenges in contemporary care systems. Despite growing recognition of the need for integrated support, services remain fragmented, constrained by structural, cultural, and systemic barriers that leave individuals navigating an often inaccessible and inadequate system.

This thesis, grounded in Archer's morphogenetic framework, critically examines these systemic failures, exposing how biomedical dominance marginalises the sociocultural and contextual factors essential to meaningful intervention. Drawing on Freedom of Information (FOI) data analysis and qualitative interviews, this research explores disparities in service provision, the realities of policy in practice, and the lived experiences of both individuals and professionals entangled in a system that often works against them.

At the heart of this study is the Integrated Morphogenetic Care Model (IMCM), a framework that reimagines CEMS care by aligning structural reform with individual agency. Through a synthesis of empirical evidence and theoretical insight, this thesis moves beyond critique, offering a blueprint for policy reform that prioritises dignity, justice, and empowerment.

Rather than merely identifying gaps in care, this research serves as a call to action, advocating for a fundamental shift in how we approach CEMS treatment. By bridging

structural analysis with lived experience, it challenges prevailing assumptions and provides a roadmap for meaningful, lasting change.

Acknowledgments

This thesis is the culmination of six years of work, perseverance, and the unwavering support of several remarkable individuals and institutions, without whom this journey would not have been possible.

First and foremost, I would like to extend my deepest gratitude to my supervisor, Jo Turner, for her unwavering support, guidance, and encouragement throughout this journey. Your insightful feedback, patience, and belief in my work have been instrumental in shaping this thesis. Over the last six years, you have been a source of inspiration, and I am profoundly grateful for your mentorship. I would also like to sincerely thank Naomi Ellis and Sarah Page, whose guidance, support, and invaluable insights have played a crucial role in this research. Your contributions have been deeply appreciated.

I must also express my heartfelt thanks to the late Margaret Archer. Her profound contributions to social theory have greatly influenced my research. I am incredibly fortunate to have had the opportunity to correspond with her and am deeply appreciative of the time and patience she showed in explaining her morphogenetic framework to me. Her insights have left an indelible mark on this thesis.

To my incredible wife, no words can adequately express my gratitude for your love, support, and sacrifices over the past six years. You have selflessly put your life on hold, providing me with the time and space to immerse myself in this work. Your unwavering belief in me has been my greatest strength, and this achievement is as much yours as it is mine.

Finally, to everyone who has supported me in various ways during this journey, thank you.

Your encouragement, assistance, and understanding have made this achievement possible. A special thank you goes to the participants of this research; without your willingness to share your experiences, this thesis simply would not have been achievable. This work is, in essence, for you, and I hope it contributes meaningfully to the ongoing efforts to improve care and support for those facing co-existing mental health and substance use challenges.

Declaration

I declare that this thesis is a presentation of original work, and I am the sole author. This work has not previously been presented for an award at this, or any other, University. All sources are acknowledged as references.

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1. Illuminating Lived Experiences: A Morphogenetic Analysis of Co-Existing Mental Health and Substance Use Challenges

The intersection of mental health disorders and substance use difficulties (CEMS) represents a significant challenge in contemporary healthcare. These co-existing conditions not only intensify individual suffering but also create systemic obstacles for service delivery, research, and policy (Christie, 2014). Historically, treatment approaches have operated in silos, separating mental health and substance use services, which has led to fragmented care and poor outcomes (Hamilton, 2014). Although progress has been made towards integrated care models, enduring barriers, including stigma, systemic fragmentation, and disparities in resources, continue to hinder effective intervention (Hughes et al., 2024).

This thesis examines these challenges by situating CEMS within a broader socioeconomic and systemic context. Stoke-on-Trent serves as a case study, providing a microcosm through which national and international issues can be explored. The research employs a dual-theoretical framework, integrating Archer's (1995) morphogenetic approach, which examines the dynamic interplay of structure, culture, and agency, with transcendental phenomenology, which prioritises lived experiences within these systemic constraints (Moustakas, 1994). This interdisciplinary approach ensures that the research not only interrogates the structural and cultural determinants of CEMS but also center's the voices of those directly affected.

This introductory chapter establishes the foundation for the thesis, outlining its structure and key themes. Chapter 2 provides a historical overview of the evolution of mental health and substance use treatment, highlighting the systemic factors that have shaped current care models. Chapter 3 examines contemporary challenges in CEMS treatment, including policy shortcomings, service fragmentation, and socio-economic determinants. Chapter 4 details the theoretical framework, explaining how the morphogenetic approach and transcendental phenomenology are employed to analyse CEMS complexities. Chapter 5 presents the research methodology, outlining the qualitative approach and the integration of Freedom of Information (FOI) data to examine systemic service gaps.

The core findings and analysis are explored in Chapters 6, Chapter 7, Chapter 8, and Chapter 9, leading to the development of the Integrated Morphogenetic Care Model (IMCM) in Chapter 10. The IMCM proposes a novel framework for addressing systemic service fragmentation, advocating for structural flexibility, service integration, and policies that enhance both individual agency and social support structures. The final chapter synthesises these insights, highlighting the thesis's theoretical contributions and practical implications for policy and service reform.

By critically engaging with the systemic, cultural, and individual dimensions of CEMS care, this research aims to challenge existing paradigms and advocate for integrated, holistic approaches to treatment. The thesis contributes to academic discourse while providing tangible, evidence-based solutions that can improve care at both local and national levels. In doing so, it seeks to inform the development of policies and interventions that prioritise person-centered, trauma-informed care, ultimately enhancing the dignity and well-being of individuals affected by CEMS.

1.1 Challenges and Evolution of Co-Existing Mental Health and Substance Use Treatment

Addressing co-existing mental health and substance use difficulties (CEMS) remains one of the most complex challenges in healthcare. These intertwined conditions intensify distress and complicate treatment, creating significant obstacles for clinicians, policymakers, and researchers striving to develop evidence-based interventions that consider both medical and psychosocial dimensions (DoH, 2002; Harris et al., 2023; Anandan, Cross, and Olasoji, 2024; Hughes et al., 2024). Historically, mental health and substance use services have operated as distinct entities, reinforcing siloed models of care that fail to address the interdependencies between the two (Harris et al., 2023; Hughes et al., 2024). Throughout much of the twentieth century, mental health treatment was primarily institutional, while substance use was treated as a behavioural or criminal issue, often managed through the criminal system rather than healthcare services (Pepper, Kirshner, and Ryglewicz, 1981; Bachrach, 1982; Harding, 1985). This division was based on outdated assumptions that positioned mental illness and addiction as separate conditions requiring different interventions, an approach that ignored the significant overlap in service users and their needs (Parssinen and Kernet, 1980).

The deinstitutionalisation movement of the late twentieth century marked a shift towards community-based mental health care, yet this transition exposed new challenges. Many individuals with severe mental illness, once housed in long-term institutional settings, struggled to access coordinated substance use support upon returning to the community (Pepper et al., 1980). As it became evident that a significant proportion of people with mental health difficulties also experienced substance use problems, calls for integrated treatment models emerged (Drake and Mueser, 2000). Despite this recognition, systemic separation persisted, sustained by differing funding structures, regulatory frameworks, and professional cultures (Bachrach, 1982). As a result, individuals with CEMS continued to fall through the gaps, often excluded from both mental health and addiction services due to rigid eligibility criteria and a lack of cross-sector collaboration.

Although integrated treatment models have gained prominence, service fragmentation remains widespread. Contemporary healthcare approaches increasingly emphasise holistic models that combine medical, psychological, and social interventions to address the complexity of CEMS (Drake et al., 2001; Guest and Holland, 2011). However, significant barriers endure, particularly in the form of stigma and discrimination, which continue to shape both policy responses and clinical practices (Hartwell, 2004; Evans-Lacko and Thornicroft, 2010; Thornicroft et al., 2016). Many service users encounter healthcare systems that prioritise a biomedical understanding of their difficulties while neglecting the structural and social determinants that contribute to their distress. This reinforces cycles of marginalisation, leaving many individuals unable to access the comprehensive, long-term support they require.

The increasing prevalence of CEMS has further exacerbated existing challenges. Socio-economic inequality, housing instability, and employment precarity have contributed to rising rates of mental health difficulties and substance use disorders (Harris et al., 2023). The opioid epidemic has placed additional strain on health and social care systems, revealing the inadequacy of existing treatment infrastructures in addressing complex, co-existing conditions (Rogers et al., 2018). Similarly, the rise in anxiety and depression, particularly in the wake of the COVID-19 pandemic, has heightened demand for services that integrate mental health and substance use care (Baker, 2020). Despite these growing needs, healthcare systems remain under-resourced, with many lacking the infrastructure or workforce capacity to implement comprehensive, integrated models of care (Laker, 2006). The continued reliance on fragmented services has resulted in significant gaps in provision, with individuals frequently forced to navigate disjointed pathways in search of support.

To explore these challenges, this research employs Archer's (1995) morphogenetic approach, which provides a structured framework for examining the dynamic interactions between social structures, cultural norms, and individual agency over time. This perspective is particularly relevant for understanding CEMS, as it enables an analysis of how healthcare policies, economic conditions, and societal attitudes shape service provision and individual experiences. While structural factors influence access to care and the availability of integrated services, cultural attitudes, including stigma and public perceptions of substance use and mental illness, play a crucial role in shaping both policy decisions and clinical interactions. Individual agency, though often constrained by systemic barriers, remains central to the ways in which people navigate these challenges, seek support, and engage with treatment.

Alongside this structural analysis, the study integrates transcendental phenomenology, ensuring that lived experiences remain central to the research. By prioritising subjective perspectives, phenomenology provides a means of understanding how individuals with CEMS make sense of their experiences within the constraints imposed by healthcare systems and societal structures (Moustakas, 1994). This combination of theoretical approaches offers a comprehensive method for examining the realities of CEMS, moving beyond clinical definitions to incorporate the perspectives of those most affected.

While previous research has primarily focused on clinical outcomes, such as treatment efficacy and co-occurrence rates (Leshner, 1997; Jablensky, 2007; Watmuff et al., 2016), there has been relatively little attention given to the broader social, cultural, and economic factors shaping the experiences of individuals with CEMS. Studies have often failed to consider how systemic inequalities, such as healthcare policy, stigma, and economic deprivation, influence access to treatment and long-term recovery (Hamilton, 2014; Heather et al., 2022). The dominance of biomedical perspectives has further reinforced a reductionist approach, frequently framing CEMS as an individual pathology rather than recognising its embeddedness within wider social structures. This thesis addresses these critical gaps by adopting an interdisciplinary approach that draws from sociology, psychology, and public health, thereby providing a more holistic and actionable understanding of CEMS and informing the development of more effective care models.

Stoke-on-Trent serves as a focal point for this research, offering a context in which to examine the broader issues associated with CEMS. The city has disproportionately high rates of mental health difficulties and substance use disorders, compounded by economic deprivation, unemployment, and housing instability (Trinder, 2022). These socioeconomic challenges make it an ideal setting for exploring the intersection of individual struggles and structural factors, particularly in relation to service accessibility, treatment pathways, and policy responses. By using Stoke-on-Trent as a microcosm, this research not only provides insights into local policy and practice but also contributes to national and international discussions on CEMS care. The findings have the potential to inform both regional service provision and broader efforts to develop integrated, person-centred models of care.

This thesis critically examines the enduring challenges of CEMS care and the systemic barriers that prevent meaningful integration of services. By applying a morphogenetic lens and foregrounding lived experiences, it advances both theoretical and practical understandings of how CEMS is navigated by individuals and managed within healthcare systems. In doing so, it seeks to contribute to the development of evidence-based policies and interventions that prioritise accessibility, person-centered care, and long-term support. Ultimately, the research aims to enhance the dignity and well-being of those affected by CEMS while informing sustainable approaches to healthcare that extend beyond the immediate study context.

1.2 A Dual Theoretical Framework: The Morphogenetic Approach and Transcendental Phenomenology

Archer’s (1995) morphogenetic approach provides a dynamic framework for analysing social reality through three core components: structure, culture, and agency. Structure refers to the objective social and material conditions that shape human behaviour, such as economic systems, legal frameworks, and institutional arrangements. Culture encompasses the subjective dimensions of social life, including norms, values, beliefs, and ideologies that guide and constrain individual actions. Agency represents the capacity of individuals to make choices, take actions, and influence both their own lives and the broader social context.

A central tenet of the morphogenetic approach is analytical dualism, the distinction between the analysis of structure and culture on the one hand and the analysis of agency on the other (Archer, 2013). This separation allows for a more precise examination of how social structures and cultural systems shape human actions and, conversely, how human actions can lead to the transformation or reproduction of these structures and systems. By maintaining this analytical dualism, the research avoids the pitfalls of structural determinism (which overemphasises the influence of social structures) and voluntarism (which overemphasises individual agency) (Brock et al., 2017).

Archer's framework is inherently temporal and dynamic, recognising that interactions between structure, culture, and agency unfold over time through processes of morphogenesis (change) and morphostasis (stability). Morphogenesis refers to the processes through which human actions reshape social structures and cultural systems, leading to societal change (ibid). Conversely, morphostasis refers to the forces that maintain and reproduce existing structures and systems, preserving continuity and stability. This temporal dimension is crucial for understanding the evolving nature of CEMS, as it allows for an exploration of how historical and contemporary factors contribute to the persistence of these challenges.

However, while the morphogenetic approach provides a robust framework for analysing structural and cultural conditions, it does not fully capture the lived experiences of individuals navigating these conditions. To address this limitation, this thesis integrates transcendental phenomenology, which prioritises subjective consciousness and firstperson perspectives (Moustakas, 1994). Phenomenology seeks to uncover the essence of experience as perceived by individuals, making it particularly valuable for understanding how those with CEMS engage with and interpret their realities (Larsen and Adu, 2022).

By combining morphogenesis with transcendental phenomenology, this research offers a holistic approach, one that situates individual experiences within broader sociostructural contexts while also ensuring that the voices of those directly affected remain central. This integration is essential for capturing the full complexity of CEMS, as it acknowledges the dynamic interplay between objective conditions and subjective experiences. In doing so, it provides a nuanced understanding of CEMS that not only deepens theoretical insights but also informs the development of more responsive and human-centered interventions.

1.3 Application and Theoretical Contribution to CEMS

This thesis applies Archer's morphogenetic approach and transcendental phenomenology as complementary frameworks to analyse the complexities of CEMS. While the morphogenetic approach provides a macro-level analysis of how structures, cultural norms, and agency shape service provision and individual experiences, transcendental phenomenology brings an essential micro-level perspective, ensuring that the voices of individuals navigating CEMS remain central to the analysis. This integration bridges the gap between structural conditions and subjective experiences, moving beyond reductionist explanations that attribute these difficulties solely to personal choices or biomedical pathology.

The morphogenetic approach enables a systematic examination of how healthcare policies, socio-economic conditions, and institutional practices interact with cultural influences, such as stigma and public attitudes towards mental health and substance use. This framework reveals the historical and contemporary forces that shape CEMS care, showing how systemic fragmentation persists despite growing recognition of the need for integrated models of treatment. By considering how morphogenesis (social change) and morphostasis (continuity) operate within healthcare structures, this thesis uncovers why reform efforts have often been incremental or ineffective.

Transcendental phenomenology further enriches this structural-cultural analysis by prioritising first-person perspectives, ensuring that the lived experiences of individuals are not subsumed under macro-level explanations. While morphogenesis highlights policy and institutional shifts, phenomenology reveals how these systemic forces are felt, internalised, and resisted. This perspective is essential for understanding the barriers individuals face when engaging with mental health and substance use services, including experiences of exclusion, discrimination, and service inadequacy. It also captures the adaptive strategies people develop to navigate complex and often punitive service landscapes, providing insights that cannot be fully accounted for through structural analysis alone.

By applying this dual-theoretical lens, this thesis offers a significant contribution to both academic discourse and practical solutions for CEMS. It moves beyond existing models by explicitly linking structural and cultural determinants to lived experience, offering a more dynamic understanding of how service users, practitioners, and policymakers engage with CEMS care. This theoretical innovation informs the development of integrated, holistic care models that account for both medical and psychosocial dimensions.

Ultimately, the combination of Archer’s morphogenetic approach and transcendental phenomenology allows for a more comprehensive exploration of how systemic constraints, cultural narratives, and personal agency interact to shape both the persistence and potential transformation of CEMS care. By embedding this analysis within policy and practice recommendations, the thesis ensures that its theoretical insights contribute directly to service reform and improved outcomes for individuals living with these dual challenges.

1.4 Methodological Approach

This study adopts a critical realist perspective, aligning with Archer's (1995) morphogenetic approach, to examine how structural factors, cultural influences, and individual agency interact over time to shape the experiences of individuals with CEMS (refer to Chapter 5). By combining this with transcendental phenomenology, the research places a strong emphasis on the lived experiences of individuals, seeking to understand their personal narratives within broader structural contexts.

The central research question asks: *what are the challenges faced by people with a dual diagnosis of co-existing mental health and substance use, and how do these challenges impact treatment and recovery?* From this, the study aims to deepen understanding of these challenges, to explore how stigma and discrimination shape treatment and recovery trajectories, to identify the difficulties faced by people with lived experience when seeking support, and to examine current systemic issues and possible solutions in order to improve services. These aims are pursued through specific objectives: conducting interviews with service users to gather their perspectives on stigma, discrimination, and access to care; collecting evidence of issues within service provision and exploring possibilities for improved delivery; and examining the broader questions of whether substance dependence co-exists with mental illness, whether people use substances as a form of self-medication, and whether appropriate treatment is available for individuals with a dual diagnosis.

In addition to qualitative interviews, the research incorporates data obtained through Freedom of Information (FOI) requests. These requests provided a macro-level perspective on systemic challenges within CEMS services across England, revealing gaps in service provision, access, funding, and workforce capacity. By triangulating FOI data with qualitative insights, the study bridges the systemic and individual dimensions of CEMS care. This integration enriches the analysis by highlighting the structural and cultural barriers encountered at both the service and policy levels (see Chapter 6).

The qualitative component of the study involves in-depth interviews with individuals experiencing CEMS, as well as professionals in the field, including healthcare providers, social workers, and nurses. These interviews were designed to elicit rich, detailed accounts of participants' experiences, challenges, and perspectives. The use of unstructured interview guides allows for flexibility in exploring emergent themes while ensuring that key topics relevant to the research objectives are covered.

Participants are selected using purposive sampling to ensure a diverse range of experiences and perspectives. This includes individuals from various socio-economic backgrounds, age groups, and stages of recovery, as well as professionals with different roles and expertise in the field of CEMS. The qualitative data are analysed using thematic analysis (Braun and Clarke, 2022), guided by the principles of transcendental phenomenology. This involves coding the data to identify significant themes and patterns, which are then interpreted in light of the morphogenetic framework to understand how individual experiences are influenced by broader structural and cultural factors.

Ethical considerations are paramount in this study, given the sensitive nature of the topic and the potential vulnerability of participants. Ethical approval was obtained from the relevant institutional review boards, and all participants provided informed consent. Measures were taken to ensure confidentiality and anonymity, and participants were given the option to withdraw from the study at any time without consequence. Additionally, the research design included provisions for offering support and referrals to participants who may have experienced distress as a result of discussing their experiences.

This methodological approach not only allowed for a thorough exploration of the research question but also ensured that the findings are robust and comprehensive. By triangulating qualitative data, FOI insights, and Archer's morphogenetic approach, the study provided a more holistic understanding of CEMS, highlighting the interplay between individual experiences and systemic factors.

1.5 Significance, Contributions, and Implications for CEMS

This thesis offers a significant and original contribution to the fields of mental health and substance use by providing a comprehensive, interdisciplinary understanding of the challenges faced by individuals with CEMS. By situating lived experiences within broader structural and cultural contexts, the research highlights the profound systemic barriers affecting those with CEMS and proposes practical solutions to address them.

A key aspect of this work is its focus on critical gaps in existing research. Previous studies have predominantly centered on clinical aspects, such as treatment effectiveness and prevalence rates, often overlooking the broader socio-cultural and structural dimensions that significantly influence the experiences and outcomes of individuals with CEMS. By integrating insights from sociology, psychology, and public health, this research offers a nuanced perspective that considers how systemic factors, such as healthcare policies, stigma, and economic conditions, intersect to shape the realities of those affected. This holistic approach is crucial for understanding why current care models often fail to meet the needs of this population.

Central to this thesis is the emphasis on lived experiences. Prioritising the subjective perspectives of individuals with CEMS enhances understanding of the personal and emotional dimensions of these difficulties and underscores the importance of involving those with lived experience in developing treatment and support services. This approach aligns with contemporary movements in mental health and addiction care, advocating for patient-centered, trauma-informed methodologies. Through in-depth qualitative analysis, the research reveals how fragmented services, social stigma, and systemic discrimination exacerbate the struggles of individuals with CEMS, reinforcing cycles of marginalisation and poor health outcomes. By bringing these challenges to the forefront, the study advocates for a more compassionate and responsive healthcare system that acknowledges and prioritises the lived realities of affected individuals.

One of the most significant practical contributions of this thesis is the development of the Integrated Morphogenetic Care Model (IMCM), a novel framework designed to bridge gaps in service provision for individuals with CEMS. The IMCM emphasises the need for structural flexibility, integration of social determinants of health, and the enhancement of individual agency within structural constraints. Unlike existing models, which often separate mental health and substance use treatment, the IMCM proposes a holistic, context-sensitive approach that aligns services with the complex realities of individuals experiencing CEMS. Importantly, the IMCM is not merely theoretical; it provides concrete strategies for implementing integrated care, including policy recommendations, service design improvements, and collaborative care pathways. These strategies aim to improve continuity and coherence in service delivery, ensuring that research findings translate into tangible improvements in healthcare policy and practice.

The policy and practice implications of this research are extensive. By identifying the structural and cultural barriers that individuals with CEMS face when accessing support, the study offers actionable insights for enhancing service provision. The thesis advocates for policy reforms that promote integrated care models, reduce stigma, and expand access to person-centered services. Furthermore, its focus on Stoke-on-Trent as a case study provides insights that are not only locally relevant but also broadly applicable to other regions facing similar socio-economic challenges. By presenting a detailed analysis of service gaps and proposing practical solutions, this research aims to inform both local policy and national discussions on CEMS.

Beyond its practical applications, this thesis advances theoretical understanding by integrating Archer's morphogenetic framework with transcendental phenomenology. This dual-theoretical approach offers a new lens for analysing the complexities of CEMS, particularly how structural factors, cultural influences, and individual agency interact to shape experiences and outcomes. By bridging sociological theory with phenomenological inquiry, the thesis enriches academic discourse and provides a robust foundation for developing integrated care models that prioritise both structural realities and individual experiences.

Ultimately, the significance of this thesis lies in its commitment to enhancing the well-being and dignity of individuals with CEMS. By advocating for holistic, integrated, and humane approaches to care, it challenges existing service fragmentation and promotes systemic reforms that empower those affected. The proposed solutions aim not only to improve service delivery but also to foster a more inclusive and just society, where the needs of the most vulnerable are recognised, addressed, and prioritised.

In summary, this research makes a multifaceted contribution to the study of CEMS by addressing critical gaps in understanding through an interdisciplinary, socio-structural approach; highlighting lived experiences to ensure that personal narratives shape service development; proposing practical and theoretical innovations, such as the IMCM, to enhance care integration; and influencing policy and practice by advocating for systemic change in healthcare services. Through its deep exploration of systemic barriers, lived experiences, and actionable solutions, this thesis seeks to inform both academic discourse and real-world interventions, ultimately aiming to improve the quality of life for individuals living with CEMS.

1.6 Chapter Breakdown

Chapter 1: Introduction

This chapter establishes co-existing mental health and substance use difficulties (CEMS) as a critical issue in contemporary healthcare, highlighting the fragmented nature of service provision. It situates the research within Stoke-on-Trent, a city that exemplifies broader socio-economic and systemic challenges in CEMS care. The chapter introduces the dual theoretical framework, integrating Archer's morphogenetic approach and transcendental phenomenology, which together explore how structural, cultural, and individual factors shape CEMS experiences. It concludes with an overview of the thesis structure, demonstrating how each chapter contributes to understanding and addressing systemic barriers to effective care.

Chapter 2: Historical Development of CEMS Treatment

This chapter examines the historical divergence of mental health and substance use treatment pathways, tracing their development from medieval supernatural beliefs to contemporary medical models. It explores how moral, medical, and custodial approaches reinforced systemic fragmentation, focusing on key historical shifts such as the rise of asylums, the Temperance Movement, and legislative changes across the 19th and 20th centuries. While deinstitutionalisation and community care initiatives aimed to close gaps in service provision, this chapter argues that these efforts ultimately failed to resolve structural fragmentation. It critiques the Health and Social Care Act 2012, demonstrating how policy reforms have often deepened systemic divides rather than fostering genuine integration.

Chapter 3: The Evolution of Perspectives on CEMS

This chapter explores how conceptualisations of CEMS have evolved from the 1980s to the present day, shifting from simplistic dual diagnosis models to more nuanced understandings. It critically examines the dominance of the biomedical model, highlighting its limitations in addressing the psychosocial and structural dimensions of CEMS. The development of psychiatric classification systems is analysed, from psychoanalytic frameworks to modern diagnostic categories, revealing how evolving clinical perspectives have shaped treatment pathways. Systemic stigma, professional resistance, and structural barriers to integrated care are also explored, demonstrating how these factors continue to marginalise individuals with CEMS and limit access to holistic, person-centred support.

Chapter 4: Theoretical Framework – Morphogenesis and Phenomenology

This chapter provides a comprehensive exploration of Archer’s morphogenetic approach, explaining how structure, culture, and agency interact over time through morphogenesis (change) and morphostasis (continuity). It applies these concepts to CEMS service fragmentation, demonstrating how entrenched systems resist reform despite increasing recognition of the need for integration. The chapter then introduces transcendental phenomenology, ensuring that the lived experiences of individuals with CEMS remain central to the analysis. By integrating these perspectives, the framework bridges macro-level systemic analysis with micro-level experiential insights, allowing for a richer understanding of the challenges faced by individuals navigating CEMS care.

Chapter 5: Methodological Framework

This chapter outlines the qualitative methodology employed in the study, which is rooted in critical realism and transcendental phenomenology. It explains the participant selection process, which used purposive sampling to ensure diverse perspectives, incorporating both service users and professionals. The research design included in-depth interviews and Freedom of Information (FOI) requests, which provided a macro-level view of systemic gaps alongside rich personal narratives. The chapter also discusses thematic analysis (Braun & Clarke, 2022) as the primary method of data interpretation, ensuring that the findings capture both structural challenges and lived experiences. Ethical considerations, including informed consent, participant well-being, and the impact of COVID-19 on data collection, are also addressed.

Chapter 6: Mapping Gaps – Insights from FOI Data

This chapter presents findings from Freedom of Information (FOI) requests, mapping systemic gaps in CEMS service provision across England. It highlights disparities in service availability, inconsistent commissioning practices, and workforce shortages, demonstrating how these structural failings contribute to inequitable access to care. The analysis reveals barriers in funding distribution, leadership accountability, and service integration, showing that many services lack the infrastructure to implement policy driven reforms such as the 2017 Policy Implementation Guide (PIG). The morphogenetic framework is applied to contextualise these barriers, explaining how policy inertia and institutional fragmentation perpetuate service disconnection despite growing recognition of the need for change.

Chapter 7: Lived Experiences of Individuals with CEMS

This chapter shifts from systemic analysis to individual narratives, capturing the realities of navigating fragmented CEMS services. Through qualitative interviews, it explores the barriers faced by service users, including long waiting times, stigma, and rigid eligibility criteria, such as the requirement to be substance-free before receiving mental health support. It examines how service users experience institutional gatekeeping, exclusion, and professional distrust, leading many to disengage from care altogether. By foregrounding lived experience, this chapter highlights the human cost of policy failures, reinforcing the need for trauma-informed, integrated care approaches.

Chapter 8: Structural and Cultural Challenges in CEMS Care

Applying Archer's morphogenetic framework, this chapter critically examines why CEMS service fragmentation persists. It explores how morphostasis operates in professional cultures, funding models, and policy frameworks, creating resistance to integration despite growing recognition of its benefits. The disempowerment of individuals with CEMS is also analysed, revealing how systemic structures limit agency and restrict opportunities for advocacy. The chapter argues that entrenched cultural norms and institutional inertia reinforce service silos, identifying specific policy and practice obstacles that must be overcome to achieve meaningful reform.

Chapter 9: Challenges of a Fragmented System

This chapter synthesises the challenges identified throughout the thesis, illustrating how structural, cultural, and systemic fragmentation collectively undermine efforts to provide integrated care. It examines how service misalignment, competing funding priorities, and bureaucratic inefficiencies reinforce poor outcomes for individuals with CEMS. The chapter also explores how professionals within the system navigate these challenges, highlighting tensions between policy rhetoric and practical constraints. By critically dissecting why past integration efforts have failed, this chapter establishes the necessary conditions for sustainable reform.

Chapter 10: The Integrated Morphogenetic Care Model (IMCM)

This chapter introduces the Integrated Morphogenetic Care Model (IMCM) as a practical framework for addressing systemic failures in CEMS care. The IMCM is structured around three core principles:

Structural flexibility – ensuring care models accommodate individual needs rather than enforcing rigid criteria.

Integration of social determinants of health – recognising that housing, employment, and social support are essential to long-term recovery.

Enhancing individual agency – promoting service user involvement in treatment planning and decision-making.

The chapter provides policy recommendations, outlining strategies for service integration, workforce training, and funding reform. A theoretical case study illustrates how the IMCM could be implemented in practice, demonstrating its potential to create holistic, sustainable CEMS care models.

Chapter 11: Conclusion and Future Directions

The final chapter synthesises the key findings and theoretical contributions of the thesis, reflecting on how the research addresses systemic gaps in CEMS care. It revisits the policy and service implications of the IMCM and discusses potential barriers to implementation. The chapter also outlines limitations of the study, including the challenges of conducting research during the COVID-19 pandemic and the need for further empirical validation of the IMCM in practice. Future research directions are proposed, including longitudinal studies on IMCM implementation and its adaptability to different healthcare systems. The thesis concludes with a call to action, advocating for systemic reforms that prioritise accessibility, dignity, and long-term recovery for individuals with CEMS.

1.7 Summary

This chapter has established co-existing mental health and substance use difficulties (CEMS) as one of the most pressing and complex challenges facing contemporary health and social care. It has demonstrated that fragmented systems of provision, rooted in historical divisions between mental health and substance use treatment, continue to shape poor outcomes for individuals. By situating CEMS within Stoke-on-Trent, a context marked by high deprivation and health inequality, the chapter has grounded the research in a setting where these challenges are most visible.

In doing so, the chapter has introduced the dual theoretical framework, Archer's morphogenetic approach and transcendental phenomenology, which together provide the conceptual lens for examining the interplay of structure, culture, and agency alongside lived experience. This framework ensures the research can meet its central aim: to deepen understanding of the challenges faced by people with CEMS and the ways stigma, discrimination, and systemic barriers shape treatment and recovery.

The chapter has also outlined the methodological design, showing how qualitative interviews and FOI data provide complementary perspectives on both systemic structures and individual experience. This contributes directly to the research objectives of capturing lived experiences, identifying service-level barriers, and examining whether treatment pathways for dual diagnosis exist in practice.

By bringing together theoretical, contextual, and methodological foundations, this chapter prepares the ground for the historical and conceptual analysis in Chapter 2, which explores how today's fragmented CEMS landscape is the product of long-standing moral, medical, and policy divides.

2. Historical Separations, Policy Failures, and Structural Barriers

This chapter establishes the historical conditioning that produced today's fractured landscape of co-existing mental health and substance use care. Using Archer's morphogenetic frame, it sits squarely at T1, the long arc of structures and cultures that prefigure what later becomes practice. The argument is simple and unfashionable: the split between "mental health" and "addiction" is not a contemporary policy blunder; it is sedimented through centuries of moral governance, medicalisation, and criminalisation. By tracing the move from supernatural attributions to moral regulation, to psychiatric classification and prohibition, the chapter shows how morphostasis has repeatedly won out over reform. This historical lens clarifies why integration schemes keep sticking, even when the evidence base looks unanimous. It also explains the professional silos, eligibility games, and gatekeeping that people with CEMS still face. The materials covered range from early religious and legal codes to nineteenth- and twentieth-century statute, classification systems, and temperance politics, setting the stage for later analysis of policy and lived experience. Read this as the ground beneath the feet of every clinician, commissioner, and service user who finds themselves trapped between doors that never quite meet.

2.1 Supernatural Explanations and Mysticism in Medieval Europe

The earliest recorded understandings of mental health and substance use were deeply rooted in supernatural and religious frameworks, which shaped early social responses and institutional practices. Within Archer’s (1995) Morphogenetic Framework (T1), these dominant cultural beliefs acted as conditioning structures, influencing how mental distress and substance use were conceptualised and regulated for centuries. The persistence of morphostasis, where supernatural explanations reinforced punitive and exclusionary responses, laid the foundation for the structural fragmentation that continues to define mental health and addiction services today.

During the medieval period, mental health conditions were commonly attributed to demonic possession, divine punishment, or spiritual imbalance (Brightman, 1935). These beliefs were deeply embedded in religious doctrine, with abnormal behaviour often interpreted as a sign of a cosmic struggle between good and evil (Mackay, 2009). Treatments reflected this theological framing, focusing not on care but on exorcism, purification, and punishment. Individuals exhibiting symptoms that would now be recognised as mental illness were subjected to physical restraints, isolation, and even execution, reinforcing a dominant cultural logic that prioritised social order over individual well-being (Garson, 2022).

In contrast, substance use was largely accepted within controlled contexts, particularly in religious, medicinal, and social settings. Crocq (2007) notes that alcohol, opium, and cannabis were widely used in ceremonial and therapeutic practices, often integrated into spiritual and healing traditions. Unlike mental illness, which was demonised, substance use was tolerated unless it threatened societal stability. This distinction is critical, as it set a precedent for later regulatory frameworks, where mental health gradually became medicalised, while substance use was increasingly framed as a moral or legal transgression.

Through the lens of morphogenetic conditioning (T1), these early cultural and religious ideologies shaped the institutional separation of mental health and addiction services. The supernatural explanations of mental illness entrenched exclusionary and punitive responses, reinforcing a morphostatic cycle where those experiencing distress were confined rather than treated. Meanwhile, the socially accepted yet regulated use of substances established early mechanisms of moral governance, which would later influence prohibitionist policies and the criminalisation of addiction.

While later scientific advancements and Enlightenment-era philosophies would challenge some of these supernatural beliefs, elements of these early frameworks persisted. The notion that mental distress required external control rather than support remained embedded in institutional structures, contributing to the development of asylums and moral treatment models. Simultaneously, the cultural acceptance of substance use within certain contexts laid the foundation for later distinctions between "acceptable" and "deviant" drug use. These deeply ingrained perspectives reinforced a historical trajectory of service separation, shaping the structural barriers that continue to fragment mental health and addiction services today.

As supernatural explanations began to give way to moral reform movements, the perception of mental illness and substance use evolved, but not necessarily toward more compassionate models. The next section explores how these emerging moral frameworks reinforced punitive responses, further embedding the division between treatment and discipline in mental health and addiction policies.

2.2 The Shift to Moral Explanations

The Renaissance and Enlightenment periods marked a gradual shift away from supernatural explanations of mental illness and addiction, replacing them with moral and naturalistic interpretations that reshaped early institutional responses. Within (T1), these evolving cultural narratives became conditioning structures, reinforcing new mechanisms of social control that framed mental distress and substance use through moral regulation rather than medical understanding.

During this period, mental illness was increasingly viewed through the lens of morality and discipline rather than supernatural forces. Influential reformers such as Philippe Pinel and Jean-Martin Charcot advanced the idea that mental disorders were not demonic afflictions but human conditions requiring structured care (Shorter, 2013). This perspective led to asylum reforms, which sought to replace physical punishment with moral treatment, a model based on the belief that structured environments and behavioural regulation could restore individuals to rationality (Fernandez, 1981). However, while this shift represented a departure from supernatural explanations, it did not fundamentally challenge the institutional control of mental illness. The asylum remained a site of surveillance and discipline, reinforcing morphostasis by maintaining rigid institutional oversight (Foucault, 1965).

While mental illness was increasingly integrated into medical and welfare models, substance use remained deeply embedded in moralistic and social order discourses. Throughout the 18th and 19th centuries, alcohol and opium were widely consumed, particularly among working-class populations, but were increasingly portrayed as threats to social stability rather than medical concerns (Lawrie, 1879; Crocq, 2007). The temperance movement became a dominant force in shaping societal and legal responses to addiction, advocating abstinence-based moral reform over medical intervention (Brown, 1973). Unlike mental illness, which had been incorporated into state-supported health services, addiction was positioned as a moral failing requiring social and legal control.

This distinction solidified with legislative interventions, such as the Licensing Act of 1872 and the Dangerous Drugs Act of 1920, which restricted access to alcohol and narcotics under the justification of public morality and social order (Harding, 1998). These policies reinforced addiction as a criminal issue rather than a medical one, further embedding institutional separation between mental health and substance use services. The medical profession, despite its growing influence in psychiatric care, remained largely absent from addiction treatment, allowing punitive policies to dominate substance use regulation.

Through the lens of morphogenetic conditioning (T1), this period entrenched distinct institutional responses to mental illness and substance use. The asylum movement reinforced the idea that mental distress required medical management, while addiction became increasingly regulated through social discipline and criminalisation. These conditioning structures created long-term institutional divides, ensuring that when later policy changes attempted integration, they faced systemic resistance and deeply ingrained professional silos.

This chapter now moves to the 19th century, where the medicalisation of mental illness gained momentum, while substance use policies remained locked in moral governance and state regulation, further entrenching the separation between these two domains.

2.3 Early Medicalisation of Mental Health

By the 19th century, scientific and medical advancements led to a shift in the conceptualisation of mental illness, marking a transition away from supernatural and moral explanations towards more systematic medical classification, this period with T1 reflects a crucial phase of structural and cultural conditioning, in which new medical frameworks became embedded within institutional practices and state policies. However, rather than dismantling earlier forms of social control, the medicalisation of mental illness reinforced institutional management, consolidating the dominance of asylum-based care while maintaining the exclusion and criminalisation of addiction.

The development of modern psychiatric classification systems played a crucial role in reshaping medical responses to mental illness. Emil Kraepelin and Jean-Martin Charcot were influential figures in systematising mental disorder classifications, moving towards diagnostic categories based on symptomatology and clinical progression (Shorter, 2013). Kraepelin's work laid the foundation for structured psychiatric diagnosis, ultimately influencing the development of the Diagnostic and Statistical Manual of Mental Disorders (DSM) in the 20th century (Paris & Phillips, 2013). This shift represented a key moment in conditioning the dominance of the medical model, legitimising biological and diagnostic approaches over earlier supernatural or moral explanations.

Despite these advances, the expansion of asylums as the dominant institutions for mental health care reflected both the progress and limitations of early medicalisation. The asylum system was intended to provide structured care and rehabilitation, but it also served as a mechanism for containment and social control, reinforcing state intervention in regulating mental illness (Kibria & Metcalfe, 2016). While moral treatment philosophies promoted compassion and structured therapy, many asylums functioned as custodial institutions, reinforcing morphostasis by ensuring that those deemed mentally ill were institutionalised rather than integrated into the community (Foucault, 1965).

In contrast, addiction remained outside of medical classification, reinforcing its continued regulation through moral and legal frameworks. While some early medical professionals, such as Thomas Trotter and Benjamin Rush, advocated for addiction to be recognised as a medical disorder rather than a moral failing, these perspectives remained marginal throughout the 19th century (Berridge, 1999). Instead, substance use continued to be framed as a moral vice, shaping punitive policy responses rather than medical intervention. Unlike mental health, which was gradually incorporated into state welfare systems, addiction was increasingly subjected to criminalisation, reinforcing the structural separation between these two domains of care (South, 1985).

Through the lens of morphogenetic conditioning (T1), this period entrenched two distinct institutional trajectories. The medicalisation of mental illness legitimised asylum-based treatment, ensuring that psychiatric care became embedded within state supported health systems. Meanwhile, addiction remained locked in moral governance, paving the way for prohibitionist policies and punitive legal frameworks. These deeply embedded structural conditions shaped the long-term fragmentation of mental health and addiction services, ensuring that when later policy changes attempted integration, they encountered significant systemic resistance.

The next section explores the 19th-century legislative and institutional reforms that further entrenched the separation between mental health and substance use services, reinforcing institutional and professional silos that persist to this day.

2.4 The 19th Century: The Rise of the Medical Model and Moral Reform

The 19th century saw a significant transformation in the regulation of mental illness and substance use, as state intervention, medical classification, and moral reform movements reinforced distinct institutional responses to these issues. This period reflects a phase of structural and cultural conditioning, where long-standing moral and institutional frameworks became further embedded within state policy, legal structures, and medical practice. The expansion of the asylum system, moral treatment models, and the temperance movement ensured that mental health was increasingly medicalised, while addiction remained governed by moral discipline and legal intervention.

The emergence of asylums as the dominant institutions for mental health care reflected both scientific progress and entrenched social control mechanisms. Prior to this period, individuals with mental illnesses were often confined to prisons, workhouses, or private care settings, with little formal medical intervention (Scull, 1985). The development of asylums was framed as a humanitarian response, but it also served as a mechanism of containment, reinforcing state control over those deemed socially disruptive.

The moral treatment movement, which gained prominence in the early 19th century, positioned mental illness as a condition that could be managed through discipline, structured care, and behavioural interventions (Shorter, 2013). Figures such as Philippe Pinel in France and William Tuke in England advocated for more humane treatment, promoting regimented routines and therapeutic environments (Scull, 2015). However, rather than dismantling institutional control, moral treatment reinforced the authority of asylums, ensuring that mental health remained a state-regulated issue. While appearing progressive, these institutions still functioned as sites of surveillance and exclusion, reinforcing morphostasis through long-term institutionalisation rather than true integration into society (Foucault, 1965).

In contrast, addiction remained outside medical classification, reinforcing its continued governance through moral and legal frameworks. The temperance movement, which gained momentum throughout the 19th century, framed alcohol use as a moral failing that required social intervention (Brown, 1973). Rather than integrating addiction into emerging psychiatric care models, legislation such as the Licensing Act of 1872 and the Dangerous Drugs Act of 1920 positioned substance use as a criminal and moral issue rather than a medical one (Harding, 1998). This ensured that while mental illness became increasingly medicalised, addiction remained governed by social order, morality, and punishment.

Through the lens of morphogenetic conditioning (T1), these 19th-century developments reinforced institutional separation between mental health and addiction services. The medicalisation of mental illness ensured that psychiatric care became embedded within state-supported institutions, while addiction continued to be regulated through moral governance and legal intervention. These deeply ingrained structures shaped future policy frameworks, making later attempts at service integration structurally and culturally resistant to change.

As state intervention expanded, the late 19th and early 20th centuries saw further legislative and institutional developments that solidified the distinction between medical and criminal responses to distress. The next section explores how these emerging policies further entrenched institutional silos, shaping the systemic barriers that persist today.

2.5 Moral Governance, Economic Interests, and the Evolution of Substance Regulation

The period between 1870 and 1920 saw a significant expansion of state intervention in the regulation of substance use, driven by moral governance, economic priorities, and social control mechanisms. During this period, characterised by structural and cultural conditioning as outlined in Archer's (1995) framework (T1), moral reform movements, state taxation policies, and public health discourses became deeply embedded within legal and institutional structures. These forces of conditioning ensured that substance use, particularly alcohol, remained strictly regulated under state and elite control, further entrenching the historical divide between mental health and addiction services.

Alcohol regulation became a central political issue, shaping public discourse, parliamentary debates, and legislative reforms. Nicholls (2011) highlights how state intervention in alcohol consumption intensified, with governments balancing moral reform pressures, public health concerns, and economic dependence on alcohol taxation. By the early 20th century, alcohol regulation was so politically charged that the British Prime Minister, David Lloyd George, declared alcohol a greater threat to Britain than its wartime enemies (Nicholls, 2011, p.1). This period saw a complex interplay between moral imperatives and economic pragmatism, reinforcing state involvement in governing substance use through restrictive policies rather than health-based interventions.

The roots of alcohol regulation in Britain extend far beyond the 19th and 20th centuries, shaped by deeply entrenched cultural anxieties and class-based governance. The Gin Act of 1736 is a key example of early moral regulation through economic restrictions, imposing strict licensing laws and heavy taxation on gin production. The Act explicitly targeted the working classes, with lawmakers framing excessive gin consumption as a moral failing that led to economic inefficiency and social disorder (Nicholls, 2011). This framing was not just about public health but was deeply tied to labour productivity and elite anxieties over working-class autonomy (White, 2003).

Through a Marxist lens, White (2003) argues that alcohol regulation served as a tool of social control, designed to discipline the working classes while maintaining economic productivity. The regulation of alcohol was not solely about health or morality, but about ensuring that the industrial workforce remained efficient and compliant. The ruling class's framing of gin as a threat to society conveniently distracted from broader economic inequalities and exploitative labour conditions, reinforcing the idea that substance regulation was a matter of moral discipline rather than a response to structural injustices.

This tension between moral governance, economic interests, and public health concerns persisted into the 19th and early 20th centuries, shaping state responses to alcohol and drug use. The temperance movement, while presented as a grassroots moral reform campaign, was deeply intertwined with state and economic agendas, reinforcing the idea that addiction was a personal failing rather than a structural issue (Brown, 1973). This ensured that substance use continued to be governed through moral and legal frameworks, reinforcing morphostasis by preventing medicalisation and institutionalising punitive responses to addiction.

As state intervention expanded, the late 19th and early 20th centuries saw further legislative measures that cemented addiction as a social and legal issue rather than a medical one. The next section explores how these evolving policies and legal mechanisms reinforced the fragmentation between mental health and addiction services, ensuring that substance use remained governed by prohibitionist and punitive frameworks rather than integrated health models.

2.6 The Early 20th Century: Divergent Policy Paths

The early 20th century saw a critical divergence in how mental health and substance use were governed, as state intervention expanded in psychiatric care while addiction remained subject to moral and criminal regulation. In Archer's (1995) terms, this era reinforced existing structural and cultural conditioning (T1), embedding mental illness within state welfare systems while continuing to frame substance use predominantly through criminal justice and moral discourse. These institutionalised divisions solidified the enduring fragmentation between mental health and addiction services.

By the early 20th century, mental health had become more integrated into public health discourse, with governments recognising psychiatric care as a state responsibility. The rise of large-scale psychiatric institutions reinforced the idea that mental illness required structured medical intervention, solidifying the role of asylums as primary sites of treatment (Scull, 1985). The aftermath of World War I further accelerated state involvement, as 'shell shock' (now recognised as PTSD) among soldiers prompted widespread demands for psychiatric care (Jones, 2010). In contrast, substance use remained excluded from medical intervention, with addiction continuing to be positioned as a moral and social transgression rather than a medical condition.

From a morphogenetic perspective (T1), this period marked an expansion of state authority over mental illness, solidifying institutional treatment as the prevailing approach. Psychiatric hospitals became firmly integrated into public health systems, cementing the view that mental illness demanded medical rather than social interventions. However, this institutional framework did not encompass substance use, leaving addiction predominantly managed through prohibitionist legislation and punitive social measures.

The criminalisation of addiction further entrenched this divide. While psychiatric services were incorporated into state welfare frameworks, substance use remained under moral and legal governance, leading to increasingly restrictive policies on alcohol and narcotics. The passage of laws such as the Dangerous Drugs Act (1920) reflected the belief that substance use was a criminal and social threat rather than a medical issue (Berridge, 1999). This reinforced a morphostatic cycle, ensuring that mental health and addiction remained governed by separate institutional logics, preventing their integration into a unified care model.

As the 20th century progressed, these institutional and policy trajectories became further embedded, ensuring that mental illness was increasingly managed through healthcare systems, while substance use continued to be addressed through law enforcement. The next section explores how these evolving policies shaped mid-century developments in psychiatric care and addiction regulation, further solidifying the institutional separation that continues to define contemporary CEMS services.

2.7 Criminalisation of Addiction

The early 20th century saw the consolidation of state control over addiction, as substance use was increasingly positioned within moral and legal frameworks rather than public health. From Archer’s (1995) perspective, this era further entrenched structural and cultural conditioning (T1), solidifying addiction policies within criminal justice institutions and perpetuating established moral perceptions of substance use as socially deviant behaviour. These institutional shifts ensured that addiction was systematically excluded from medical frameworks, reinforcing punitive interventions rather than therapeutic models of care.

The Hague Opium Convention (1912) played a pivotal role in shaping global narcotics control, marking the beginning of international drug regulation. This treaty established state responsibility for restricting the production and distribution of opium, morphine, and cocaine, aligning drug policy with global efforts to suppress illicit trade rather than integrate substance use into public health systems (Berridge & Edwards, 1981). The UK's Dangerous Drugs Act (1920) translated these international commitments into domestic legislation, formalising the criminalisation of addiction and reinforcing morphostasis by ensuring that substance use remained governed through prohibitionist legal mechanisms rather than medical intervention (Coomber, 1985).

Viewed through Archer's (1995) morphogenetic lens (T1), these initial narcotics regulations set legal foundations that defined addiction primarily as an issue of criminal enforcement rather than healthcare. By criminalising substances like opium and cocaine, addiction was entrenched as both a moral failing and legal offence, bolstering state surveillance and punishment over medical care. This critical distinction further institutionalised the divide between mental health and addiction services, creating persistent legal and structural barriers that later integration efforts struggled to overcome.

Alongside the regulation of illicit drugs, the early 20th century also saw increasing state intervention in alcohol consumption, reinforcing addiction as a moral governance issue. The Licensing Acts of 1902, 1904, and 1908 introduced progressively stricter alcohol regulations, expanding police powers, criminalising public intoxication, and restricting access to alcohol for minors (Greenaway, 2003). These laws reflected broader societal anxieties about urban disorder and public morality, reinforcing state control over substance use while maintaining financial interests in alcohol taxation (Nicholls, 2011).

Through these regulatory frameworks, the state positioned substance use as a public order concern rather than a public health issue, embedding addiction policy within criminal justice mechanisms rather than medical systems. This morphostatic cycle ensured that drug users and alcohol consumers were increasingly subjected to legal penalties rather than therapeutic interventions, reinforcing institutional separation between mental health services and substance use policies.

As these criminalising mechanisms became further entrenched, the mid-20th century saw even more restrictive approaches to addiction, ensuring that substance use remained governed by punitive rather than medical frameworks. The next section explores how these evolving policies further solidified the institutional and professional divide between mental health and addiction services, ensuring that substance use remained regulated by criminal justice institutions rather than integrated into state healthcare models.

2.8 Social Control and the Role of the State

The early 20th century saw an intensification of state intervention in mental health and addiction policy, reinforcing social control mechanisms that disproportionately targeted marginalised populations. From Archer's (1995) perspective, this era represented a critical phase of structural and cultural conditioning (T1), in which the regulation of mental health and substance use became deeply integrated into wider systems of moral governance, institutional control, and legal enforcement. These conditioning structures ensured that mental illness and addiction were not only managed as public health concerns but also as instruments of social order and state control.

Through the expansion of psychiatric institutions, compulsory treatment laws, and prohibitionist drug policies, the state reinforced long-standing social hierarchies, using mental health and addiction frameworks to regulate deviant behaviours, suppress dissent, and maintain normative social expectations. These systems of control disproportionately affected women, ethnic minorities, and the working class, embedding mental health and addiction policy within racialised, gendered, and class-based frameworks of social exclusion.

The continued expansion of asylums exemplified this dynamic. While psychiatric care was increasingly integrated into state welfare models, the asylum system remained a site of confinement for individuals deemed socially disruptive (Scull, 1985). Women, in particular, were subject to institutionalisation for behaviours that defied societal norms, such as expressions of sexuality, alcoholism, or resistance to domestic roles (Showalter, 1987). The psychiatric profession played a key role in legitimising these interventions, reinforcing a morphostatic cycle in which the institutionalisation of women and other marginalised groups remained a state-sanctioned form of social discipline (Foucault, 1965).

The criminalisation of addiction served a comparable function, ensuring that substance use remained governed by legal enforcement rather than public health interventions. Drug laws disproportionately targeted the working class and racial minorities, reinforcing economic and racial inequalities under the guise of social protection (Seddon, 2007). The Mental Deficiency Act (1913) further institutionalised this process, providing legal authority for the detention of individuals deemed ‘morally defective', a classification often applied to those struggling with substance use or social nonconformity (Carpenter, 2021).

The racialisation of drug policy further illustrates the state's role in embedding structural discrimination within addiction governance. The Dangerous Drugs Act (1920) was enforced in a racially discriminatory manner, disproportionately targeting immigrant communities, particularly Chinese and West Indian populations (Alexander, 2012). By associating substance use with racialised 'threats' to national identity, the state reinforced social hierarchies through both legal and institutional mechanisms, embedding racial bias within drug enforcement policies.

Through the lens of morphogenetic conditioning (T1), this period established a rigid institutional separation between mental health and addiction services, embedding these systems within broader structures of state discipline, criminalisation, and institutionalisation. While psychiatric care became increasingly integrated into state healthcare systems, substance use remained governed through punitive legal frameworks, ensuring that addiction policy remained a tool of moral and racial governance rather than a component of public health policy.

As these disciplinary structures became further embedded, the mid-20th century saw the expansion of institutionalised social control, ensuring that mental health and addiction services continued to be shaped by legal and institutional mechanisms rather than integrated care models. The next section explores how these evolving policies and state interventions further reinforced the fragmentation between psychiatric and addiction treatment, creating the systemic barriers that persist today.

2.9 The Legacy of Fragmentation: Contemporary Challenges

The historical development of mental health and addiction services has created a deeply entrenched structural and cultural divide, ensuring that these systems continue to function as separate and often conflicting domains. These divisions reflect an enduring phase of structural conditioning (T1), characterised by entrenched institutional silos, professional hierarchies, and exclusionary approaches to managing CEMS. Although recognition of the need for integrated care has grown, these deeply embedded historical structures have continued to perpetuate fragmentation as the dominant model, significantly constraining opportunities for meaningful systemic change.

From their inception, mental health and addiction services evolved along distinct ideological trajectories. Mental health services became medicalised, rooted in psychiatric classification systems and pharmacological interventions, while addiction services remained situated within behavioural and moral frameworks, prioritising abstinence, social control, and harm reduction (Laker, 2006). These early structural and cultural divisions created separate professional identities, service delivery models, and funding mechanisms, ensuring that mental health and substance use treatment remained institutionally divided. Instead of facilitating an integrated care model, this historical bifurcation reinforced systemic exclusion, with individuals experiencing co-existing conditions often deemed ineligible for either service, leading to gaps in care, inconsistent treatment pathways, and inadequate cross-sector collaboration (DoH, 2002).

These institutional separations became further embedded through professional hierarchies and service delivery norms, ensuring that mental health and addiction treatment remained governed by distinct professional cultures. Mental health services often characterised substance use as a complicating factor that undermined psychiatric treatment, while addiction services frequently viewed co-occurring mental illness as beyond their remit. This professional segmentation was reinforced through funding mechanisms, which allocated resources to either psychiatric interventions or addiction recovery, further institutionalising a fragmented system that discouraged cross-sector integration.

Stigma also played a critical role in sustaining these historical divisions, shaping public attitudes, professional practices, and service eligibility criteria. The dual stigma associated with mental health and substance use disorders ensured that individuals with co-occurring conditions faced systemic exclusion from mainstream care (Pescosolido et al., 1999). These stigmas were not simply individual biases but were structurally embedded within service models, leading to inconsistent diagnostic assessments, inappropriate referrals, and rigid eligibility barriers that continue to exclude individuals with complex needs (Livingston, 2020).

From a morphogenetic perspective (T1), these enduring institutional and cultural structures established a prevailing pattern of fragmented service delivery, solidifying the separation of mental health and addiction care into isolated, exclusionary, and complex systems. The deep entrenchment of these structures meant that subsequent policy efforts aiming for integration faced considerable opposition, perpetuating the historical conditioning that still underlies current service limitations.

The next section explores how these structural barriers shaped modern service frameworks, demonstrating how institutional legacies of separation, stigma, and professional silos continue to impede systemic change in co-existing mental health and substance use care.

2.10 Theoretical Perspectives and Frameworks

The historical separation of mental health and substance use services has been shaped not only by policy and institutional structures but also by the dominant theoretical frameworks guiding their development. From the perspective of Archer's (1995) Morphogenetic Framework (T1), these theories represent structural and cultural conditioning, reinforcing entrenched professional divisions, treatment paradigms, and service delivery frameworks. How mental illness and substance use have been conceptualised within medical and biopsychosocial models has directly influenced service structures, funding mechanisms, and clinical practices, perpetuating fragmentation as the default care model. This section critically explores these two influential frameworks, examining how they have reinforced systemic barriers and maintained institutional silos.

2.11 The Medical Model

The medical model has been instrumental in shaping the historical development of mental health services, firmly embedding psychiatric care within biomedical frameworks centred on diagnosis, treatment, and institutional management. Within Archer's (1995) Morphogenetic Framework (T1), the dominance of the medical model represents significant structural and cultural conditioning, reinforcing psychiatric professionalisation, the expansion of institutional care, and the marginalisation of addiction within medical treatment pathways.

In the late 19th and early 20th centuries, psychiatry increasingly adopted a biomedical disease model, positioning psychiatric conditions as neurobiological disorders necessitating medical intervention (Deacon, 2013). This conceptualisation validated psychiatry as a legitimate medical discipline, facilitating the widespread development of psychiatric hospitals, the creation of diagnostic classification systems, and the adoption of pharmacological interventions (Shorter, 2015). These institutional developments reinforced the perception that psychiatric conditions required clinical oversight rather than broader social or moral engagement.

However, significant criticisms of the medical model have emerged, highlighting its reductionist nature and its limited ability to address the social and structural determinants of mental distress. Scholars such as Moncrieff (2008; 2022) and Deacon (2013) argue that the medical model oversimplifies complex mental health experiences by reducing them to biochemical imbalances and discrete diagnostic categories. This reductionism has fostered an over-reliance on pharmacological treatments, often at the expense of more holistic and socially informed approaches. By focusing primarily on symptom management through medication, the medical model neglects critical social factors, such as poverty, trauma, and inequality, that significantly contribute to mental health and substance use difficulties.

Furthermore, while mental health became increasingly medicalised, addiction treatment remained governed by behavioural and moral paradigms, existing largely outside mainstream medical institutions. Diagnostic frameworks such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD) structured service eligibility criteria, systematically excluding addiction from psychiatric treatment models (Pilgrim, 2015). This exclusion reinforced institutional divisions, embedding addiction services within criminal justice and behavioural health domains rather than healthcare systems.

Through the lens of morphogenetic conditioning (T1), the dominance of the medical model thus institutionalised the bifurcation between mental health and addiction, ensuring these domains were governed by separate institutional logics. The expansive growth of psychiatric hospitals and pharmacological treatments reinforced this divide, perpetuating addiction as an issue managed through punitive social control rather than clinical care. Consequently, even as psychiatric care became standardised within national healthcare frameworks, addiction remained largely framed as a behavioural or criminal issue, reinforcing systemic barriers to integrated service provision.

2.12 The Biopsychosocial Model

Introduced by George Engel in 1977, the biopsychosocial model emerged as an alternative to the biomedical approach, advocating a holistic perspective that integrates biological, psychological, and social determinants of health (Engel, 1977). Within Archer's (1995) Morphogenetic Framework (T1), this model represented an attempt to challenge established conceptual foundations underpinning mental health and addiction care. However, despite its holistic intent, the biopsychosocial model ultimately reinforced rather than dismantled institutional fragmentation.

Initially, the biopsychosocial model was well-received within clinical and policy discourse, presenting an opportunity to conceptualise mental health and addiction within a broader framework of interconnected biological, psychological, and social dimensions. Nevertheless, critics such as Pilgrim (2015) and Buckner et al. (2013) highlight significant shortcomings in its practical application. Rather than effectively integrating services, the biopsychosocial model became institutionalised primarily as theoretical rhetoric rather than operational practice. As a result, mental health and addiction services continued operating within separate professional, disciplinary, and funding silos, limiting genuine interdisciplinary collaboration and integration.

Pilgrim (2015) argues that the biopsychosocial model often fails to specify clear methodological and operational criteria, rendering it vague and difficult to implement effectively in practice. Consequently, while healthcare providers frequently reference biopsychosocial principles, their translation into practical care delivery has remained superficial and fragmented. This superficial adoption has led to a paradox: despite advocating for comprehensive care, the model has perpetuated rather than dismantled professional hierarchies and institutional divisions.

From the perspective of morphogenetic conditioning (T1), the biopsychosocial model reinforced institutional fragmentation by becoming embedded as conceptual rather than practical guidance. This has resulted in continued disciplinary boundaries, where psychiatrists, psychologists, and social workers remain confined within distinct professional roles, limiting genuine collaboration. The enduring institutional separation between mental health and addiction services reflects a deeper resistance to change embedded within professional cultures and structural funding models, rather than merely theoretical inadequacies.

Thus, while the biopsychosocial model aimed to provide a more comprehensive understanding of co-existing conditions, it inadvertently maintained the separation of psychiatric and addiction services. It functioned primarily as an aspirational framework rather than a practical solution, ensuring that integration remained conceptually desirable yet structurally elusive.

The dominance of medical and biopsychosocial models within service provision for mental health and addiction illustrates significant structural and cultural conditioning. The medical model's reductionism and the biopsychosocial model's operational ambiguity have reinforced institutional silos and professional hierarchies, perpetuating service fragmentation. Critically examining these models highlights the enduring systemic barriers to integrated care, underscoring the importance of addressing not only theoretical frameworks but also deeply embedded professional practices and institutional structures. Future efforts toward integration must confront these historical legacies to foster genuine systemic reform in CEMS care

2.13 Conclusion

The historical development of mental health and substance use services has been profoundly shaped by structural and cultural conditions, reinforcing longstanding institutional separation, professional silos, and exclusionary treatment practices. Within Archer’s (1995) Morphogenetic Framework (T1), these divisions represent a significant phase of structural conditioning that has fundamentally defined service delivery, diagnostic frameworks, and policy approaches. The separation between mental health and addiction services was not merely an outcome of deliberate policy decisions; rather, it emerged from historical processes that systematically embedded fragmentation into institutional and professional practices.

This chapter has traced the historical evolution of mental health and substance use care, illustrating how early supernatural and moral conceptualisations of distress influenced state interventions, institutional confinement practices, and exclusionary approaches to care. The advent of the medical model in psychiatry firmly positioned mental health within biomedical and institutional care frameworks, while substance use continued to be managed through legal, moral, and behavioural lenses. This historical divergence became institutionalised, creating distinct treatment pathways and reinforcing professional hierarchies that persist within contemporary service provision.

The dominance of the medical model in psychiatry led to the progressive medicalisation of mental illness, embedding psychiatric conditions firmly within healthcare systems. In contrast, addiction was systematically excluded from healthcare frameworks, instead regulated primarily through punitive legal and moral frameworks. The biopsychosocial model, although proposing a more holistic approach to understanding mental health and addiction, ultimately failed to disrupt established professional silos. Consequently, mental health and addiction services remained conceptually integrated but operationally fragmented, reinforcing structural divisions rather than overcoming them.

Examined through the morphogenetic conditioning lens (T1), this chapter highlights how structural and cultural forces have solidified contemporary service fragmentation, maintaining distinct institutional logics for mental health and addiction services. Integration challenges cannot be attributed solely to policy shortcomings; rather, they must be viewed within the context of deeply embedded historical processes that have shaped professional identities, funding allocations, and societal perceptions of co-occurring mental health and substance use conditions.

These historical insights lay a critical foundation for evaluating contemporary research and policy responses to CEMS. The subsequent chapter critically examines the theoretical frameworks, empirical evidence, and policy initiatives that have shaped current understandings of CEMS. It identifies gaps in existing knowledge and assesses the structural and institutional barriers that continue to obstruct systemic integration, highlighting the necessity for comprehensive reform informed by historical analysis.

2.14 Summary

This chapter has shown that the divide between mental health and substance use care is historically produced and institutionally tenacious. Supernatural framings licensed exclusion and punishment; moral reform translated distress into discipline; psychiatric medicalisation secured state-backed asylums; and prohibitionist drug policy relocated substance use to the realm of policing rather than care. Across these shifts, morphostasis dominated: each “advance” reorganised control without dissolving the split. The result is a durable separation in law, funding, workforce identity, and diagnostic practice that still choreographs today’s referral pathways and refusal criteria. Seen from T1, contemporary fragmentation is not an anomaly to be fixed with a toolkit; it is the predictable downstream effect of how Britain built its institutions and justified their authority. This historical account therefore does more than offer context; it provides a causal story for why integration fails on contact with reality. The next chapter moves from longue durée conditioning to late-twentieth-century thought and policy, testing how newer conceptual frames either reproduce or disrupt this inherited separation.

This chapter directly advances the overall aim of developing an understanding of the challenges faced by people with CEMS by identifying the structural and cultural origins of those challenges. It shows how stigma and discrimination were not incidental attitudes but organising logics of policy and practice, thereby speaking to the aim of exploring how stigma shapes treatment and recovery. In relation to the objective of gathering evidence on issues in service provision and ideas for improvement, the chapter provides the foundational evidence of why provision is fragmented, why eligibility barriers recur, and why “no wrong door” rhetoric routinely collapses in practice; it also begins to imply that any solution must be structurally integrated rather than programme-level. While the questions of co-existence, self-medication, and treatment availability are examined empirically later, this chapter clarifies how those very questions were historically framed, constrained, or pathologised, which conditions how people seek support and how services respond. In short, Chapter 2 supplies the conditioning mechanisms your later data will confront, making the link between historical morphostasis and present-day exclusion legible to the reader.

3. The Duality of Despair: Tracing the Evolution of challenges faced by people with CEMS

This chapter examines the evolution of perspectives on co-existing mental health and substance use difficulties (CEMS), moving from the early “dual diagnosis” frameworks of the 1980s toward more critical analyses of medicalisation, stigma, and structural inequality. Within Archer’s (1995) morphogenetic framework, this chapter corresponds to the interplay of culture and structure at T2–T3, where shifting conceptualisations begin to challenge, but also reproduce, entrenched divides. By tracing the emergence of the self-medication hypothesis, the dominance of the medical model, and subsequent critiques from sociology and critical psychiatry, the chapter interrogates how knowledge production has shaped policy, practice, and lived experience.

The central purpose here is not only to review literature but to show how different explanatory paradigms—disease models, choice models, biopsychosocial frameworks, and critical theories—have conditioned the responses available to people with CEMS. This review demonstrates how the language of “dual diagnosis” framed distress as pathology, legitimising professional authority while often silencing lived experience. It also highlights the counter-currents—literary, sociological, and phenomenological—that sought to re-humanise substance use and mental distress. These debates form the intellectual ground on which current challenges in CEMS care stand.

This literature review traces the key developments in conceptualising and treating coexisting mental health and substance use difficulties, examining the debates surrounding medicalisation, social control, and the integration of empirical and humanistic priorities. By mapping the transition from early observational studies to contemporary critiques of biopsychiatric dominance, this review provides insight into how evolving perspectives continue to shape approaches to CEMS. A critical evaluation of historical and emerging theoretical frameworks will establish the foundation for understanding current challenges in research, policy, and practice, highlighting the necessity of integrated and equitable support systems.

3.1 Seeking Solace and Euphoria: The Complex Motivations Behind Psychoactive Substance Use

The use of psychoactive substances presents significant challenges for individuals experiencing CEMS, often acting as critical barriers to their well-being (Fantuzzi and Mezzina, 2020). Understanding the complex motivations behind substance use and misuse is vital, as it illuminates the intricate interplay between mental health conditions and addiction. Such insights inform the development of effective, person-centred treatment strategies that move beyond simplistic or punitive models (ibid.). Examining both historical and contemporary perspectives allows for a deeper understanding of the socio-cultural, psychological, and biological factors that underpin substance use.

This section explores these multifaceted motivations to provide historical context and highlight how past attitudes influence contemporary responses to addiction. Historical narratives, such as those provided by literary figures like Thomas De Quincey in Confessions of an English Opium Eater (De Quincey, 1821), illustrate how substance use has historically been a source of both personal solace and societal stigma. De Quincey's experiences foreshadow contemporary debates around addiction, particularly regarding causality, moral responsibility, and the enduring impact of socio-economic factors. Revisiting these narratives enhances our understanding of persistent themes in addiction discourse, demonstrating the importance of historical contexts in shaping current perceptions.

Contemporary theoretical frameworks, such as Khantzian’s (1985) self-medication hypothesis, extend these historical insights by connecting substance use to coping mechanisms aimed at alleviating psychological distress. This section examines the evolution and critical analyses of these theories to highlight the complexity of addiction, challenging simplistic views that label addiction purely as a disease or moral failing. A nuanced understanding of the motivations behind substance use facilitates the development of integrated treatment approaches for CEMS, accounting for psychological, socio-cultural, biological, and neurological factors.

By critically engaging with these historical and contemporary perspectives, we gain deeper insight into why individuals with CEMS may turn to substance use, the systemic barriers they encounter in accessing support, and how these barriers stem from historical misconceptions and structural failures. This analysis provides a foundation for the subsequent critical examination of the medical model, addressing its limitations in capturing the broader socio-cultural dimensions of mental health and substance use.

The use of psychoactive substances presents a substantial challenge for individuals struggling with CEMS, emerging as a critical barrier in their journey towards well-being. Scholars such as (Milkman and Frosch, 1973; Shelby, 2016; Singhavi et al., 2020) have long been intrigued by the intricate motivations that compel individuals to consume and use these substances, leading to a robust body of research dedicated to unpacking this complex phenomenon (Heather et al., 2022). As Gossop (2018, p.1) aptly notes, ‘people have always used drugs to alter their states of consciousness, and over the centuries, the joys and pitfalls of substance use have been explored and expressed in a range of forms including art, literature, social research and personal testimony.’ Similarly, Plant (2001) vividly describes writing about drugs as an immersion ‘into a world where nothing is as simple or stable as it seems. Everything about it mutates as you try to hold its gaze. Facts and figures dance around each other; lines of enquiry scatter like expensive dust. The reasons for the laws, the motives for the wars, the nature of the pleasure and the trouble drugs can cause, the tangled web of chemicals, the plants, the brains, machines: ambiguity surrounds them all’.

The multifaceted portrayal of substance use throughout history has not only spanned academic inquiry but also deeply influenced literary and personal narratives that capture the nuanced experiences of those who use substances. A compelling example of this is found in the work of Thomas De Quincey, a renowned literary figure of the Romantic era. In 1821, De Quincey unveiled his seminal work, *Confessions of an English Opium Eater*, where he masterfully depicted his own subjective encounters with opium. De Quincey forthrightly divulged how the substance provided both solace from tribulations and a blissful departure from reality. Additionally, he documented his experiences of social ostracism and associated societal stigma, shedding light on the intricate dynamics between psychological alleviation, elation, and societal censure inherent in addiction.

De Quincey's literary works ignited lively sociocultural debates regarding the origins of addiction. Over a century later, Strang's (1990) scholarly exploration asserted that the issues fervently debated in the early 1800s still captivate discussions on psychoactive substances. Strang emphasised topics such as causality, moral responsibility, environmental influence, and sociocultural factors, which remain relevant. He argued that De Quincey meticulously documented public substance use, igniting both fascination and controversy. Strang highlighted the importance of availability, therapeutic addiction, controlled use versus dependence, tolerance, withdrawal, and inherent substance risks. Importantly, he underscored the significant impact of advertising on complex debates, revealing their enduring relevance over time. Revisiting these topics through De Quincey's experiences provides invaluable perspectives on current challenges, as core themes have resurfaced over centuries with evolving details.

Beyond lively sociocultural discussions, De Quincey’s literary works sparked debates on the origins of addiction and its classification as a disease. Challenging the late 19th century notion of addiction as a personal moral failure or an inborn character flaw, De Quincey contended that complex social and economic realities profoundly shaped the development of addictive behaviours. He emphasised how poverty, inequality, and lack of opportunities drive people to substance use. Through remarkable self-exposure and keen observation, De Quincey opened a unique window into marginalised experiences foreign to polite 19th century society, ultimately facing rejection and stigma. His writings not only provided groundbreaking first-hand insights into the motivations behind addiction but also sparked important debates that shaped later academic discourse on the topic. His candid descriptions gave rise to discussions about whether addiction should be considered a disease or a moral failing.

De Quincey’s early literary depictions of opiate use for self-medication closely paralleled the self-medication hypothesis (SMH) proposed by Khantzian (1985) more than a century later in the late 1970s. Khantzian postulated that substance dependence frequently arises from attempts to self-soothe distressing emotional states and underlying psychiatric disorders. This aligns with observational studies in the 1970s by Milkman and Frosch (1973), which found preliminary correlations between opioid, and amphetamine use and psychological distress in small samples of drug users. Despite the lack of strong empirical evidence, these early efforts provided initial credibility to Khantzian's framework and sparked further research.

In the 1980s, Khantzian expanded his hypothesis based on clinical insights and diagnostic findings, proposing links between specific substances and associated psychiatric conditions. For example, he hypothesised that heroin users self-medicated to counter underlying depression, whereas cocaine users alleviated their attention-deficit hyperactivity disorder (ADHD) symptoms. However, rigorous empirical scrutiny of the SMH in the late 1990s and 2000s sowed seeds of scepticism and spurred calls to refine and validate the theory further. The ‘rebound model’ by Blume et al. (2000) suggested that substances initially providing psychological relief can eventually exacerbate symptoms over time. Similarly, other studies have not confirmed a clear link between emotional distress and addiction severity. Consequently, Hall and Queener (2007) criticised the oversimplification of SMH, the neglect of unconscious motivation, and the need for more evidence.

Conversely, later studies such as those by Vujanovic et al (2018), Crum et al. (2013), and Jala et al. (2011) continued to support Khantzian's SMH. Vujanovic’s crosssectional analysis revealed a key role of coping-motivated alcohol use in linking trauma, post-traumatic stress disorder (PTSD), and alcohol problems. Crum et al. (2013) found an increased risk of persistent alcohol dependence among individuals self-medicating with alcohol. Jala et al.'s (2018) analysis of rising drug overdose deaths between 1979 and 2016 highlighted escalating psychological pain, despair, and isolation as likely key drivers of increased opioid abuse, lending credence to Khantzian's view of self-medication as an alleviation of inner anguish. Khantzian's clinical theory echoed De Quincey's (1821) literary descriptions of self-medication, lending credibility to the hypothesis.

In contrast to the medicalised view of addiction as a mental illness proposed by Khantzian, Heyman (2010) contends that addiction is better conceptualised as a consequence of choice and values. He emphasises three key principles underpinning this viewpoint: preferences are dynamic rather than fixed, humans take both immediate and long-term perspectives on choices, and people ultimately opt for what they value most in the moment according to personal priorities. In this choice-focused view, stopping substance use is not seen as overcoming a disease but simply as changing one's preferences and values over time. However, critics have challenged Heyman's (2013) perspective for being overly simplistic and potentially marginalising people with CEMS (Lewis, 2018). Lewis argues that the notion of 'choice' in addiction is highly problematic as it seems to blame afflicted individuals for their circumstances. However, Heyman (2013) maintains that his focus is not on the initial choice to use substances but rather on the ability to choose to stop addictive patterns over time. Heyman (2013) cites the seminal work of Robins (1993) on Vietnam War veterans. Robins' study revealed that a significant proportion of enlisted men who developed heroin addiction during their service in Vietnam ceased use upon returning to the United States. Remarkably, only 5% of those addicted in Vietnam remained addicted a year after returning home, despite the severe dependence observed in the warzone.

Heyman uses Robins' findings to argue that addiction is not an immutable condition and is influenced heavily by social and environmental contexts. In Vietnam, heroin was inexpensive, extremely pure, and widely accessible. Furthermore, the social norms and extreme stress of the warzone created an environment conducive to substance use. Upon returning to the United States, veterans encountered a different social milieu ,one where heroin was less available, its use was stigmatised, and the combat stressors were removed. This drastic environmental shift significantly contributed to their cessation of heroin use.

Robins (1993) explicitly countered alternative explanations for this phenomenon. While detoxification efforts in Vietnam included brief medical interventions, such as a week-long detox for soldiers testing positive before returning home, only one-third of those addicted received this form of treatment. Additionally, fewer than 2% of those who had used narcotics in Vietnam sought treatment upon their return. Robins concluded that the cessation of use was primarily driven by environmental and social changes rather than medical interventions or prescribed medication.

This evidence underpins Heyman's perspective that addiction involves elements of choice, shaped by contextual factors. It challenges the deterministic view of addiction as solely pharmacological, highlighting the importance of social context in both the onset and cessation of substance use. The case of Vietnam veterans underscores the role of environment and individual agency, reshaping conventional beliefs about addiction.

Other scholars, such as Hogarth (2022), highlight addiction's likely goal-oriented nature, driven more by anticipated drug rewards and socioeconomic factors than by automatic biological disease processes. Essentially, he argues that context-dependent choice overrides uncontrolled disease states. However, this perspective minimises the intense physical and psychological grip of addiction, which constrains the capacity for full autonomy and free choice in the conventional sense.

While De Quincey (1821), Khantzian (1985), and Heyman (2010) approach addiction from different angles, they all highlight the complexity of motivations and the interplay of social, psychological, and biological factors that underpin substance use. Hence, the understanding or treatment of the intricate and multifaceted phenomenon of addiction requires a comprehensive analysis of the intricate dynamics among the biological, psychological, and social determinants (Shelby, 2016). Addiction does not manifest exclusively as a result of physiological dependence on a particular substance. The emergence of this phenomenon is not sudden but rather occurs gradually due to a complex interplay within the neurobiological realm. This intricate interaction encompasses various reward pathways, motivational circuits, and specific brain regions responsible for regulating impulse control and self-governance (Volkow et al., 2016).

The correlation between the brain and addiction, as observed by Leshner (1997), signifies a groundbreaking shift, wherein he proposed addiction as a persistent, recurring brain disorder rather than a moral deficiency. Leshner (1997) underscored the enduring impact of prolonged substance use on the structural and functional composition of prefrontal cortical regions, responsible for governing cognitive processes such as judgment, decision-making, and impulse control. However, the exclusive conceptualisation of addiction as a biological brain disorder fails to acknowledge the essential social and psychological factors intrinsic to its emergence and perpetuation (Ross et al, 2022). Ross argues a comprehensive biopsychosocial framework that considered the influence of neural reward learning on addiction. In addition to recognising this factor, Ross argues that addiction can also be attributed to challenges in self-regulation and consistent adherence to personal rules or values at the individual level. Effective treatment modalities should target the underlying neural mechanisms and consider individual agency, motivation, and the sociocultural milieu.

In contrast to the assertions of Hall et al. (2015) and Satel and Lilienfeld (2014), who advocated for addiction as a brain disease, it has been contended that the brain disease model of addiction (BDMA) has failed to fulfil its purported potential in terms of enhancing treatment efficacy and mitigating societal stigmatisation. Satel and Lilienfeld asserted that BDMA exhibits a disproportionate emphasis on neurobiology while concurrently downplaying the significance of psychological, social, and environmental factors. Aligning with Ross et al (2022), Hall et al. (2015) argued that while neuroscience should not be disregarded, it should not solely determine addiction policy and treatment methodologies. Hall et al., (2015) Satel and Lilienfeld (2014), and Ross et al (2022) are proponents of the neuroscientific approach and argue for its merits. However, Alexander (2012) adopted a more audacious stance by advocating for a paradigm shift.

Alexander's (2012) adaptive paradigm represents a departure from the conventional understanding of addiction as an individual pathology. Instead, it posits that addiction is intricately connected to deficiencies present in contemporary society rather than solely attributed to individual pathology. This paradigm aligns with De Quincey's work from 1821, contextualising addiction within the framework of dislocation and inadequacies within the social milieu. De Quincey's work should be regarded as seminal, providing an initial examination that bolsters the perspective of positing addiction as an adaptive response.

This section has highlighted how historical narratives and contemporary theories, such as Khantzian’s self-medication hypothesis, emphasise the complexity of motivations behind substance use, intertwining biological, psychological, and sociocultural dimensions. This comprehensive understanding underscores the need to move beyond simplistic or singular explanations for addiction. In the same vein, the medical model of mental health, which has often dominated both clinical practice and public discourse, tends to reduce complex human experiences to mere biological anomalies, such as chemical imbalances or brain disorders. While these biological factors, including changes in brain structure and function, are undeniably relevant, they represent only a part of the picture.

The forthcoming section will delve into the limitations of this reductionist approach, arguing that a sole focus on biological determinants neglects the equally significant psychological and sociocultural factors that contribute to mental health and substance use challenges. By critiquing the biomedical paradigm, we can more effectively illustrate the pitfalls of over-medicalisation, particularly when it comes to addressing the nuanced and intersectional realities of CEMS. This sets the stage for a broader discussion on how the medicalisation of mental health can obscure the socio-cultural and personal contexts of distress, ultimately advocating for more holistic and integrated models of care.

3.2 Beyond Biological Psychiatry: Challenging Medical Model Dominance in Mental Health and Addiction

The complex interplay between mental health and substance use has emerged as a pivotal area of focus within psychiatry at the start of 1980's (Pepper et al., 1981), which seeks not only to classify and predict mental illness but also to illuminate its obscured origins through rigorous etiological enquiry and thoughtfully develop efficacious interventions (Rogers and Pilgrim, 2021). Historically, these two domains have often been studied separately, but their interconnection is increasingly recognised as essential for a comprehensive understanding of each field.

The origins of psychiatric nosology can be traced back to early 19th century France, where pioneers such as Philippe Pinel and Etienne Esquirol devised the inaugural systematic taxonomies of psychological phenomena. These classification systems organised mental illnesses into discrete syndromes identifiable by constellations of symptoms, laying the groundwork for modern diagnostic criteria (Shorter, 2015).

After World War II, the advent of the Diagnostic and Statistical Manual of Mental Disorders (DSM) was profoundly shaped by the ascendant psychoanalytic theories of the era, which assimilated Freudian concepts, such as childhood repression, into its framework (Turner et al., 2015). As Shorter (2015) explores, the DSM did not emerge directly from the prior statistical classification systems used in mental hospitals. Rather, it originated from a system developed by army psychiatrist William Menninger, head of the psychiatric division in the Surgeon General's Office, known as Medical 203. This highly influential report drew extensively on psychoanalysis, attributing psychoneurotic disorders to the repression of childhood emotional conflict. Echoing the ideas of Freud, it portrayed mental illnesses as psychological reactions, elucidating how overwhelming anxiety could trigger dissociative reactions such as fugue states. Medical 203 subsequently became the predominant framework for American psychiatric classification after the war (Shorter, 2015).

Psychoanalytic theory, while offering a comprehensive explanatory system capable of encompassing all facets of human behaviour through unconscious drives and conflicts

(Davies, 2021), has both strengths and weaknesses in its approach to mental health. On one hand, it provides treatment methods that align with causal theories, proposing that current therapeutic relationships can resolve past psychological injuries (Pilgrim, 2015). However, it tends to psychologise all phenomena, discounting biological or social factors (Rogers and Pilgrim, 2021). Unlike robust scientific theories, psychoanalysis also fails to make accurate predictions (Thomas and Bracken, 2011).

Coexisting with biologically oriented psychiatry, it straddles the boundary between psychiatry and psychology (Shorter, 2015).

During the mid-20th century, critical voices such as Laing (1960), Szasz (1961), Goffman (1961), and Foucault (1965) adopted sociological perspectives on mental health, integrating their views with counterculture and liberation movements. Despite their diversity, these thinkers collectively rejected the dominant narrative of psychiatric progress. Instead, they contended that psychiatry could harm the mentally ill (Bourke, 2021; Scull, 1985).

3.3 Challenging the Medical Model: Critical Perspectives on Mental Illness in the 20th Century

In *Madness and Civilization* (1965), Foucault employed a macro-historical lens to explore evolving conceptualisations of madness across epochs, discerning how shifting definitions are intertwined with power dynamics, ethics, and social controls. Foucault (1965) traced how classifying madness as a mental illness in 17th century France provided justification for authorities to segregate the destitute from the disruptive, marking a departure from religious and humanistic perspectives. He attributed this shift to modernist values of rationality, surveillance, discipline, and control, which marginalised irrationality. Foucault (1988) distinguished the enduring concepts of insanity from the evolving notion of mental illness that began to emerge in the 17th century (Hacking, 2004)

While Foucault (1982) adopted a macro-historical approach, Goffman (1961) conducted an intensive micro-sociological examination of psychiatric institutions. He illuminated how admission procedures, monitoring, restricted communication, and regulations curtailed patients’ autonomy and individuality, correlating these practices with broader social control, stigmatisation, and constrained social membership. Expanding on Goffman’s work, Pescosolido (2015) provides a comprehensive analysis of stigma-shaped social networks, mobility, employment, healthcare access, and participation, emphasising the tendency of institutions to engender stigma. The combined work of Goffman (1961) and Pescosolido (2015) yields a valuable framework for understanding marginalisation stemming from social and institutional dynamics.

In addition, Laing (1960) and Szasz (2010) offered critical perspectives on psychiatry, stemming from their professional foundations in psychoanalysis. Laing (1960) advocated examining the negative consequences of dysfunctional family dynamics on children's development, arguing that mental illness often arises from compromised communication and relationships rather than from personal inadequacies. Laing (1960) focused on contextualising patients' distress within interpersonal experiences, especially in childhood, contrasting with the biological emphasis prevalent in psychiatry. Critics argue that Laing's framework insufficiently examines the neurological factors in schizophrenia

(Coulter and Rapley, 2011). Integrative models emphasise biological vulnerabilities more than psychosocial stressors. However, Laing's lasting impact on dignity, empathy, and social justice is noteworthy (Crichton, 2007; Ferguson, 2018), although some criticise him for potentially downplaying biological aspects (Cooper, 2017).

By contrast, Szasz (1961) rejected the notion of mental illness, arguing that involuntary treatment lacks ethical justification. He discussed the historical transition whereby religious and humanistic views gave way to the excessive medicalisation of existential difficulties as mental disorders, attributing this shift to secularisation, professional self-interest, and paternalism. Szasz (2010) argued that psychiatry's diagnostic inconsistencies and lack of biological markers reflect mental illness as a societal regulation rather than an objective phenomenon (Pies et al, 2011).

Laing (1960) and Szasz (2010), experts in psychiatry and psychoanalysis, scrutinised the field. Laing initially adhered to conventional psychotherapy but became sceptical of psychiatry's dominant perspectives for failing to consider individuals' inner struggles and socioeconomic factors. Laing’s (1960) existential philosophy led him to view madness not just as a medical condition but as grappling with meaning amid estrangement (Burston, 1996). Szasz (2010) and Laing (1960), though both influential figures in the anti-psychiatry movement of the 1960s, approached the field from different perspectives. Szasz (2010) argued that mental illness was a 'myth' and a conceptual error, critiquing psychiatry for lacking clear biological markers and warning against what he saw as 'medical imperialism.' In contrast, Laing (1960) initially worked within the psychiatric establishment before challenging its norms. Despite their differing paths, both incorporated psychoanalytic concepts into their work, critically examining the ways in which psychoanalysis could pathologise human experience. Their respective backgrounds and critiques significantly shaped the anti-authoritarian ethos of the movement. While critiqued for dismissing distress and treatment benefits (Bracken and Thomas, 2011), Szasz (2010) highlighted the risks of expanding psychiatric authority through medicalisation. Despite these challenges, biomedical approaches have assumed dominance (Moncrieff, 2008), aided by scientific advances and preferences for simplified biological models (Rogers and Pilgrim, 2010). The brain disease paradigm has garnered substantial, albeit contested, empirical support for conditions such as schizophrenia (Kendler, 2005). Integrative models recognising biosocial interactions persist, though often with biological determinism.

Some scholars, such as Kinderman (2014) and Timimi (2002), have expanded upon Goffman (1963) and Szasz's (2010) claims challenging reductionism and advocating for the empowerment of mental health service users through psychosocial approaches. These debates remain relevant today as they raise crucial questions about balancing medical authority with humanistic approaches that prioritise dignity and social justice. Despite the dominance of biopsychiatry, integrating neuroscience with social contexts is an ongoing endeavour.

3.4 The Evolution of Psychiatric Diagnosis: From Psychoanalysis to the Medical Model

Psychiatry's ascent in the pivotal 1980s can be attributed to its decisive repudiation of psychoanalysis, a shift starkly evident in the DSM, Third Edition (DSM-III) of 1980. This seminal text, which has shaped mental health assessments for decades since, firmly rejects the once-dominant psychoanalytic framework. As Shorter (2015) notes, Robert Spitzer played a key role as the DSM-III chair, extensively revising psychiatric classification.

He shifted the field toward standardised symptom-based diagnostic practices, seeking consistent symptom clusters to define disorders, marking a significant departure from psychoanalysis’s focus on uncovering the unconscious underpinnings of maladaptive thoughts and behaviours.

The DSM-III's decisive move away from psychoanalysis toward standardised diagnostic criteria marked a pivotal juncture, aligning with and propelling psychiatry's increasingly medicalised view of mental distress. Paris and Phillips (2013) discuss how the DSM-III explicitly sought to establish mental disorders as medical diseases, classifying them based on observable symptoms and signs rather than inferred unconscious dynamics. This shift reflects wider trends toward medical authorities defining and managing health problems, even those without clearly identified biological causes. Conrad (1992) contends that this expanding medical jurisdiction results from a complex interplay between professional interests, consumer demands, and changing norms. Consequently, psychiatry's association with medicine has empowered it to assert expertise and authority over a wide range of human problems, including bereavement, poor sleep, low energy, and sadness, which may now be diagnosed as neurasthenia or depression (Conrad, 1992).

However, many scholars (Moncrieff, 2008; Deacon, 2013; Pilgrim, 2015; Shorter, 2015) have argued that this medical model reduces psychological distress and dysfunction to biological disease categories, lacking validity and specificity. Horwitz (2003) critiques the expansion of the diagnosis of ordinary distress to depression and anxiety disorders, contending that it reflects medical imperialism rather than scientific discovery. Similarly, Deacon (2013) argues that the DSM's expanding symptom-based diagnoses foster biological reductionism, overlooking the social and psychological factors that shape mental distress. These discrete diagnostic labels imply specific biological origins, which lack empirical validation.

Pilgrim (2015) provides a critical realist analysis of psychiatry, challenging the therapeutic effectiveness of its medical model approach to mental health. He argues that psychiatry is grounded in a reductionist biomedical perspective that overemphasises symptomatology , the verbal and behavioural expressions of distress , while showing little therapeutic success. Through a critical realist lens, Pilgrim deconstructs the assumptions of the medical model, highlighting the limitations of its narrow biological focus and advocating for a more holistic understanding of mental health. This perspective integrates social, cultural, and political contexts, offering a richer, more comprehensive view of mental health issues. Pilgrim’s (2015) critique underscores the need to move beyond mere symptom management to address the underlying socio-ethical challenges and causal antecedents of mental health problems.

Pilgrims (2015) analysis reveals the shortcomings of psychiatry’s symptomatic emphasis and medicalised framework, providing a thought-provoking examination of the field's current therapeutic limitations. Pilgrim’s work challenges the profession to rethink its foundational assumptions and to embrace a more integrative approach that acknowledges the complex, multifaceted nature of mental health.

Pilgrim's analysis aligns with those of other scholars such as Moncrieff (2008. 2013; 2014), Moncrieff et al. (2022), and Deacon (2013). Similar to Laing (1960) and Szasz (1962), (2008), who trained as a psychiatrist, broke away from the conventional biomedical stance of psychiatry, focusing on biomedical reductionism and sociopolitical factors. In 2008, she proposed that the biomedical model of psychiatry aligns with neoliberal policies and priorities. For example, she argues that the chemical imbalance theory of mental illness , which claims that chemical imbalances in the brain cause poor mental health and can be corrected by disease-specific drugs , helps promote discontent and aspirations to fuel consumerism. It also frames distress as an individual deficiency rather than a social issue.

Similarly, Deacon (2013) critically analysed the validity and utility of the biomedical model of mental health. He explains that this model assumes that mental disorders such as schizophrenia, major depressive disorder, ADHD, and substance use disorders stem from biological abnormalities in the brain. Deacon (2013 p. 843) cites Engel (1977), who argued that the prevailing paradigm in illness research is the biomedical model, which assumes that diseases can be fully explained by quantifiable biological factors that deviate from norms. However, Engel contends that this framework fails to account for the social, psychological, and behavioural dimensions of illness. The biomedical paradigm views disease as a distinct entity, separate from social behaviour, and elucidates deviations in behaviour by underlying somatic biochemical or neurophysiological dysfunctions.

The theory of chemical imbalances in mental disorders is increasingly questioned. Deacon (2013) argues that there is no credible evidence that mental disorders are caused by chemical imbalances in the brain or that medications work by correcting such imbalances. A decade later, Moncrieff et al. (2022) challenged the notion that low serotonin levels cause depression. Using quantitative methods, they concluded that there is no clear association between serotonin and depression. Therefore, there is no support for the idea that depression is caused by reduced serotonin activity or its concentration in the brain. Overall, the evidence does not seem to support the chemical imbalance theory as an explanation for mental disorders such as depression.

Pilgrim (2015) argues that there is a fundamental problem with psychiatric diagnoses. They consider symptoms, which are transitory phenomena, and reify them as permanent, objective signs of illness. This process of transforming transitory experiences into fixed entities represents an epistemic fallacy (Pilgrim, 2015); psychiatrists confuse their conceptualisation of reality with reality itself. By reifying fluid symptoms as concrete disease signs, psychiatric diagnosis misrepresents ephemeral experiences as permanent illness markers. It objectifies subjective states and treats them as detached realities rather than as part of a living person. Consequently, psychiatric diagnoses fundamentally mistake abstract concepts for objective truths, perpetuating an epistemically fallacious view of mental phenomena.

In summary, the complex interplay between mental health and substance use has often been studied separately, but critical perspectives in the 20th century have challenged the prevailing medical model of psychiatry. Foucault (1988) explored the historical conceptualisations of madness, while Goffman (1961) examined the impact of psychiatric institutions. Laing (1960) emphasised familial contexts, and Szasz rejected mental illness as a valid concept. Despite ongoing debates on reductionism, biological psychiatry still dominates.

The evolution of psychiatric diagnoses marked a shift away from psychoanalysis toward standardised symptom-based criteria. The DSM-III aligns psychiatry with medicine by classifying mental disorders as medical diseases. However, scholars (Rapley, Moncrieff and Dillon, 2011; Thomas and Bracken, 2011; Pilgrim, 2015; Rogers and Pilgrim, 2021) criticise this expanded medicalisation for lacking validity and overlooking social factors. Analyses have revealed the therapeutic limitations of psychiatry, particularly its narrow biological focus. Arguments against chemical imbalance theories further dispute biomedical models (Shorter, 2015). Psychiatric diagnoses have been criticised for reifying transient symptoms as permanent illness entities. Nonetheless, the interplay between mental health and substance use has persisted as an evolving area of study. CEMS has garnered increasing recognition, though critical perspectives have analysed systemic and social factors. Ongoing debates focus on the complex intricacies of this interface.

3.5 The Evolution of Perspectives: From Dual Diagnosis to Critical Analysis

This section provides an overview of evolving perspectives on the relationship between mental health and substance use. It traces the progression from early CEMS concepts that viewed these issues as a straightforward duality (Pepper et al., 1981), to more critical analyses revealing the complex, multidimensional interplay between mental health and substance use (Hamilton, 2014). The section touches on key developments, such as the emergence of the CEMS classification in the 1980s and its aims to improve care coordination (Lehman and Myers, 1989). However, critiques have emerged on how CEMS expands psychiatric authority and medicalisation (McKeown et al., 1998). Thus, there has been a push to move beyond the dichotomy of dual diagnosis to understand the sociocultural forces that shape these facets of human experience (Robert, 2010). It is also crucial to honour the diverse lived experiences of individuals with coexisting mental health and substance use difficulties (Guest and Holland, 2011). Examining salient models and theories can provide insights into addressing the needs of affected individuals in a holistic and empowering manner.

The notion of duality, intricately interwoven with simplicity, suggests a profound connection between mental well-being and substance use within the realm of psychiatric medicine (Moncrieff 2008; Heather et al., 2022). However, within the realm of this simple dichotomy, perplexity arises and fosters the arduous predicament confronted by individuals grappling with the intricacies of these dual hardships (Guest and Holland, 2011). The inherent elegance of duality, while captivating, regrettably neglects too fully grasp the intricate tapestry of existence within which individuals find themselves entangled (Hamilton, 2014). According to Hill et al. (2016), an individual's life often unfolds within a multifaceted realm that exerts formidable forces, forcing them to navigate through a labyrinth of divergent mental states that fluctuate in intensity and discordance.

3.6 The Emergence of Duality: Early Conceptualisations in the 1980s

The concept of duality emerged from influential works by Caton (1981), Pepper et al. (1981), and Bachrach (1982) in the United States during the era of deinstitutionalisation as discussed in chapter 2 Pepper et al. (1981) conducted an observational study to identify a cohort of young adults with psychiatric and social impairment. In stark contrast to a previous generation of institutionalised individuals, these individuals faced considerable challenges in achieving typical developmental milestones. Pepper et al.'s (1981) and Bachrach's (1982) findings align with those of Caton (1981), who employed a similar methodology.

Caton's study shed light on the prevalence of 'chronic mental patients' (Caton, 1981, p.475) residing in the streets and obscure corners of prominent urban areas. In their respective works, Caton (1981) and Pepper et al. (1981) delved into the pervasive issue of substance use in this demographic. They observed that 37% of the individual's used alcohol, while an additional 30% used various substances, including heroin, methadone, and marijuana.

Furthermore, Caton et al. (1981) proposed that these individuals resorted to selfmedication with substances as a coping mechanism to navigate the complexities of mental health disorders and the myriad stressors that arise in their lives. By contrast, Bachrach (1982) presented a counterargument to the perspectives of Caton (1981) and Pepper et al. (1981). Bachrach challenged the notion that substance use merely distorts symptomatology and complicates the treatment requirements.

Similarly, Gelberg and Lawrence (1989) conducted a quantitative exploration of the homeless population in the United States. Their study, which included a sample size of 529 individuals, revealed that 79% of the participants had engaged in alcohol consumption within the past month. Furthermore, 58% of participants used illicit drugs during the same period. These results resemble those of previous studies by Caton (1981), Pepper et al. (1981), and (Gelberg and Linn, 1989), who found that homeless people turn to substance use as a means of self-reflecting on their mental health problems and the multitude of difficulties they face in their lives.

Furthermore, empirical research conducted by Lehman and Myers (1989) sheds light on the significant challenges that clinicians face in addressing the coexistence of mental health issues and substance use. This co-occurrence is more frequent than what would be expected by random occurrence or 'mere chance,' as evidenced by data from the Epidemiological Catchment Area (ECA) study. Lehman and Myers (1989) argued that the ECA study provided valuable epidemiological data on the lifetime prevalence of substance use and psychiatric disorders among the general population. Estimates from the ECA study indicate that between 15% and 18% of individuals experience a substance use disorder during their lifetime (12%–16% abusing alcohol and 5%–6% abusing other drugs), while 19%–30% experience a psychiatric disorder. Notably, the ECA study found that the likelihood of substance use disorders co-occurring with various mental disorders is significantly higher than what would be expected if these conditions were independent of one another. This suggests a complex, interconnected relationship between substance use and mental health issues, underscoring the need for integrated and comprehensive treatment approaches.

These population-based epidemiological findings align with further studies by (Robins et al., 1984; Rounsaville et al., 1979) from both mental health and substance use research, which have consistently reported high rates of psychiatric symptoms among those with substance use disorders as well as heightened levels of substance use among psychiatric patients.

Therefore, the coexistence of mental health and substance use poses a formidable obstacle for health care professionals. Lehman and Myers (1989) were pioneering figures who introduced the phrase ‘dual diagnosis’. A diverse group of individuals characterised by variances in psychiatric categorisation and substance use was alluded to, with the contention that effective care for individuals with dual diagnoses depends on the establishment of meaningful categorisation (ibid). Essentially, they espouse the notion that treatment planning and research should be approached as an iterative process in which the classification is consistently reassessed considering emerging treatment outcome data.

3.7 Expanding Knowledge in the 1990s: Correlations Between Specific Diagnoses and Substance Use

Research conducted in the 1980s by scholars (Bachrach, 1982; Caton, 1981; Pepper, Kirshner and Ryglewicz, 1981; Lehman and Myers, 1989), laid the groundwork for the dual-diagnosis concept by identifying the prevalence of co-occurring mental health and substance use issues. However, these studies were largely observational and sought to demonstrate the existence of this phenomenon. Building directly on these initial dual diagnosis formulations, research in the 1990s began to delve deeper into the correlations between specific mental health diagnoses and substance-use patterns. For instance, Mueser et al. (1990) and Dixon et al. (1991) focused their investigations specifically on individuals diagnosed with schizophrenia to uncover the links between alcohol use, cannabis use, and symptom severity.

Studies in the 1990s aimed to move beyond merely identifying a dual diagnosis to delineate the intricate connections between psychiatric disorders and the motivations for self-medication. While dichotomous dual-diagnosis terminology persisted, this decade's empirical findings revealed a complex interplay between the co-occurring mental health and substance use challenges. Research in the 1990s endeavoured to advance our understanding of this relationship beyond the preliminary documentation of comorbidities in the past decade (Farmer *et al.*, 1990; Mueser *et al.*, 1990; Dixon *et al.*, 1991; Cuffel, Heithoff and Lawson, 1993).

In a notable example, Mueser et al. (1990) embarked on a study that adhered to the epidemiological paradigm, with a specific emphasis on individuals who had been diagnosed with schizophrenia. Mueser et al. (1990) discovered that 50% of participants had a documented history of alcohol consumption, which is consistent with the findings of Dixon et al. (1991). Similarly, 40% of individuals used cannabis. In their analysis, the researchers also made a noteworthy discovery about the influence of demographic variables, namely age, race, and socioeconomic status, on substance use patterns. For example, males were observed to exhibit a greater proclivity to indulge in alcohol and cannabis use. In contrast, younger individuals showed a higher inclination towards stimulant substances such cocaine and amphetamines. Moreover, there appears to be disparity when considering the preferences of different racial groups. Specifically, individuals of Caucasian descent were found to use alcohol and sedatives, whereas those of African descent used cannabis. These observations shed light on the intricate interplay between the demographic factors and substance consumption.

Mueser et al. (1990) revealed a correlation between alcohol consumption and increased symptom severity, whereas cannabis use was associated with milder manifestations. Similarly, Dixon et al. (1991) expounded on these findings, positing that individuals with schizophrenia report substance use to alleviate their feelings of depression and achieve relaxation. This implies a form of self-medication aimed at addressing the specific symptoms.

In contrast to the findings of Mueser et al. (1990) and Dixon et al. (1991), Cuffel et al. (1993) conducted a study on individuals with schizophrenia and found no significant evidence supporting the expected link between specific symptoms and self-medication. They argued that the SMH, which posits that substance use patterns are driven by the pharmacological effects of different drugs, lacks empirical support.

Shifting from Cuffel et al.'s (1993) positivist approach, McKeown et al. (1998) provided a compelling critique of psychiatry's growing influence, particularly in the context of dual diagnosis. They argued that the dual-diagnosis classification system grants substantial power to medical and psychiatric professionals, enabling them to prescribe treatments and assert control over individuals while potentially downplaying the importance of social factors and personal agency. This perspective highlights the complex interplay of power and control within the dual-diagnosis framework

Using this particular modality, external control naturally becomes integrated into an individual's being, allowing psychiatry to explore new dimensions of previously untouched human experience. McKeown et al. (1998) suggested that this dual diagnosis phenomenon possesses a remarkable ability to enhance surveillance capabilities and bolster social control mechanisms. Despite the persuasive argument presented by McKeown et al. (1998) the relentless march of medicalisation continued to remain unabated and persisted well into the 20th century.

3.8 21st Century Dual Diagnosis or Co-existing Mental Health and Substance Use Difficulties

In their examination of the developments in the field of dual diagnosis between 1985 and 2000, Drake and Wallach (2000) noted that the phrase 'dual diagnosis' has remained resilient over time, consistently emphasising individual mental health challenges in conjunction with concurrent drug use. Although the concept of dual diagnosis appears straightforward, Drake and Wallach (2000) acknowledge the tendency to prioritise biological and pharmacological perspectives, which can inadvertently suggest that substance use issues are inherent to the individual, thereby downplaying the significance of social influence.

Moreover, Crawford et al. (2003) conducted a thorough investigation of the intricate link between mental health and substance use in their comprehensive literature review and concluded that comparing research on comorbidities presents a significant challenge. This challenge arises from the multitude of factors that contribute to task complexity. These factors include, but are not limited to, the existence of varying definitions, diagnostic criteria, study settings, interventions under investigation, patient populations included or excluded from studies, and regional variability in substance use patterns.

In contrast, Gregg et al. (2007) adopted a positivist perspective akin to that of Dixon et al. (1991), who delved into the phenomenon of increased substance use within the population of individuals with schizophrenia. Similar to the findings of Dixon et al. (1991) and Gregg et al. (2007) observed that a significant proportion of individuals with schizophrenia simultaneously engage in substance use. This co-occurrence, referred to as comorbidity, was found to be related to less favourable outcomes for these individuals.

In departure from previous studies, Gregg et al. (2007) presented a novel perspective by proposing four distinct explanatory models to elucidate the phenomenon of increased substance use. They argued that it could not be asserted that substance use causes schizophrenia because the relationship is far more intricate than a simple linear progression. Rather, it is a delicate dance in which substance use, and schizophrenia engage in a symbiotic relationship that influences and perpetuates one another. It is common to identify the risk factors that underlie both substance use and schizophrenia.

Gregg et al. (2007) argued that these shared vulnerabilities create a fertile ground for the convergence of these two phenomena. However, it is crucial to recognise that this convergence is not a mere coincidence but rather a manifestation of the intricate interplay between the two. As substance use and schizophrenia intertwine, their interaction becomes a powerful force that sustains coexistence. It is a dynamic process in which substance use can exacerbate the symptoms of schizophrenia, which can drive people toward substance use as a means of self-medication or escape.

In stark opposition, Robert (2010) presented a compelling argument advocating departure from the positivist standpoint of biological reductionism. He posited that the constraints of dual diagnosis lie in its inherent biological orientation. Roberts (2010) posits, from a discerning perspective, that professionals artfully crafted the conceptualisation of dual diagnosis, akin to the study conducted by McKeown et al. (1998). Roberts (2010), however, directed his attention towards the intricate process of recovery. He contends that the journey toward recovery must commence by delving into the profound and personal encounters of the individuals involved, thus advocating for a paradigm shift towards a perspective that places greater emphasis on the richness and authenticity of lived experiences.

In addition, Guest and Holland (2011) proposed a shift in terminology by asking why mental health services persist with the term ‘dual diagnosis’. They erroneously presented the concept of dual diagnosis, assuming a uniform collective with indistinguishable requirements, whereas, in reality, a multifaceted continuum of interrelated needs exists. Furthermore, the concept of dual diagnosis has become synonymous with serious afflictions, complex requirements, and unacceptable behaviours, leading to stigmatisation and unfavourable designation. Guest and Holland (2011) proposed the adoption of more refined terminology when addressing individuals grappling with mental health and substance use challenges. They suggested referring to these individuals as having coexisting mental health and substance use difficulties. They argued that it is more inclusive and represents a spectrum of difficulties compared to the two discrete diagnoses. The acronym of this term has subsequently been used in this thesis.

3.9 Conclusion

This literature review traced the intricate evolution of perspectives on the relationship between mental health and substance use over recent decades. What originated as a straightforward ‘dual diagnosis’ dichotomy in the 1980s (Caton, 1981; Pepper et al., 1981) has since developed into a more nuanced understanding of the complex interplay between these facets of human experience. While the dual diagnosis concept aimed to improve care coordination, it has propagated problematic biomedicalisation and dichotomisation according to critical scholars (McKeown et al., 1998).

Subsequent research has revealed intricate motivations underlying substance use as self-medication, including links between specific psychiatric disorders and drug preferences (Dixon et al., 1991; Mueser et al., 1990). However, some studies disputed the proposed self-medication hypotheses, underscoring the need for rigorous empirical testing (Cuffel et al., 1993). Contemporary thinkers increasingly advocate holistic paradigms situating mental health and addiction issues within sociocultural contexts rather than focusing narrowly on hypothesised biological mechanisms (Kinderman, 2014; Ross et al, 2022). More inclusive terminologies, such as coexisting difficulties, better capture the spectrum of challenges (Guest and Holland, 2011).

Tensions persist between biological models seeking to classify phenomena and critical efforts to honour lived experiences and challenge stigma (Rogers and Pilgrim, 2021; Hamilton, 2014). Purely reductionist biopsychiatric approaches face criticism regarding their therapeutic limitations and lack of validity (Moncrieff et al., 2022; Pilgrim, 2015). For instance, chemical imbalance theories of mental disorders lack robust empirical support (Deacon, 2013; Moncrieff et al., 2022). However, biological psychiatry retains dominance despite ongoing debates over balancing empirical insights with humanistic values (Rogers and Pilgrim, 2010).

Moving forward requires balanced approaches that thoughtfully integrate biological knowledge into psychological, social, and cultural dimensions (Crichton et al., 2007). As perspectives continue to develop, maintaining humility, compassion, justice, and empowerment becomes paramount (Roberts, 2010). By learning from this conceptual evolution, researchers and practitioners can provide both empirically sound and socially conscious care. Appreciating the nuances and tensions within the literature provides vital insights into equitably supporting individuals facing co-occurring difficulties.

Critical examination of the sociocultural context reveals the considerable influence of neoliberal ideology on our understanding of mental health and addiction issues. As Moncrieff (2008) discussed, the ascendancy of neoliberalism from the late 1970s aligned with the growth of biopsychiatry and its disease model of emotional distress and problematic behaviours. The notion of mental ‘illnesses’ corrected by disease-specific medications resonates with neoliberal values of productivity, self-sufficiency, and personal responsibility. Framing distress as a brain disorder locates problems within individuals rather than the wider socioeconomic inequities produced by neoliberal policies (McKeown et al., 2014).

Problematising behaviours as illnesses also expanded opportunities for pharmaceutical companies to market medications as ‘solutions’ in line with neoliberal privatisation and faith in corporate efficiency (Moncrieff, 2008). However, critics argue that the neoliberal model is depoliticising as it obscures societal causes of distress, instead promoting medicalisation and ‘quick fixes’ benefitting powerful institutions over marginalised groups (Mills, 2014; Friedli, 2009). The brain disease paradigm portrays addiction as a chronic relapsing illness, and critics argue that unfairly condemns affected individuals as having incurable conditions requiring lifelong medication adherence (Hall et al., 2015).

Challenges for people with co-existing difficulties are exacerbated by individualism and responsibilities central to neoliberal rationality (Teghtsoonian, 2009). Neoliberal discourse emphasises self-reliance and personal blame, rather than collective support. People with mental health and substance use issues face stigma and discrimination when their struggles are viewed as failures of individual willpower and discipline, rather than understandable responses to adverse circumstances (Canvin et al., 2013). The dominance of biomedical models deflects attention from social determinants, obscuring how emotional distress and addictive behaviours frequently arise from trauma, neglect, inequality, and scarcity produced by political and economic forces (Mills, 2014).

Although neuroscience offers valuable insights, purely reductionist biological models struggle to capture the lived realities shaped by complex sociocultural contexts. As Hamilton (2014) discussed, truly addressing the needs of people with co-existing difficulties requires looking beyond medicalised labels and exclusions to nurture social justice. Criticisms of the role of neoliberal ideology in the pathologisation of mental distress align with calls for more holistic, socially conscious paradigms situating health issues in their broader determinants (Kinderman, 2014).

Counterbalancing biologism with critical perspectives reveals how blaming individuals masks systemic causes of suffering. The way forward must shift from paternalism to empowerment and collective support that enables resilience (Friedli, 2009). As perspectives develop, integrating empirical insights into humanistic values is vital. However, this must occur in conjunction with contesting dominant discourses that privatise distress and addiction while obscuring their social origins. Appreciating how neoliberal rationality shapes the conceptual landscape provides a crucial context for equitably upholding the dignity and agency of people facing co-existing difficulties.

3.10 Summary

This chapter has traced the move from simple dual diagnosis to a more contested and layered understanding of CEMS. Early prevalence studies confirmed that mental distress and substance use frequently co-occur, yet they translated that fact into parallel care pathways that rarely met. The 1990s brought person-centred explanations of use as coping, alongside sceptical findings that exposed the limits of tidy pharmacological matching. With DSM-III, psychiatry consolidated a medicalised authority that narrowed the range of legitimate explanations and anchored policy to diagnostic management. Critical voices, from Foucault and Goffman to Moncrieff and Pilgrim, exposed how classification can produce stigma, license control, and mistake transient experiences for fixed disease entities. Recent scholarship has argued for models that hold biology together with trauma, inequality, and the wider determinants of health, yet the gravitational pull of biomedical organisation remains strong. In morphogenetic terms, morphostasis has kept the split alive through institutions, funding, and discourse, even as counter-currents push towards change. That tension explains why people with CEMS still face eligibility traps, fragmented offers, and reputational harm when seeking care. The next chapter turns from these conceptual currents to the theoretical architecture you will use to analyse them, specifying how structure, culture, and agency will be handled in the argument.

Chapter 3 advances the overall aim of understanding the challenges faced by people with CEMS by showing that many obstacles are produced upstream by the concept's services use to define problems and ration help. It addresses the role of stigma and discrimination by demonstrating how diagnostic expansion and brain-disease rhetoric have often pathologised ordinary suffering, displaced social causes, and legitimised exclusion. It clarifies what people encounter when seeking support by explaining how the language of dual diagnosis and comorbidity has created thresholds that demand abstinence, tidy labels, or impossible readiness before care is offered. It meets the objective concerning co-existence by reviewing the epidemiological evidence that established high rates of overlap; it meets the objective concerning self-medication by examining both the hypothesis and its criticisms, situating use as coping within constrained contexts; it meets the objective concerning treatment availability by showing how medical and managerial frameworks have multiplied programmes while leaving integration largely rhetorical. In short, the chapter explains how ways of knowing became ways of governing, and why any solution must rework foundations rather than decorate the façade.

4. Archer's Morphogenetic Framework in Understanding CEMS

This chapter establishes the theoretical scaffolding of the study. It explores Margaret Archer's morphogenetic framework in depth, tracing its intellectual origins, key concepts, and subsequent applications, before demonstrating how it can be used to analyse the complex realities of co-existing mental health and substance use difficulties (CEMS). Within the architecture of the thesis, this chapter provides the conceptual lens through which later empirical findings will be examined, moving from the historical conditioning described in Chapter 2 and the conceptual debates outlined in Chapter 3 into a coherent theoretical model for analysis.

The focus is twofold. First, it clarifies the principles of the morphogenetic framework, including its commitment to analytical dualism, the interplay of structure, culture, and agency, and its temporal cycle of morphogenesis and morphostasis. Second, it demonstrates why this approach is particularly well suited to CEMS, where lived experience is constrained by institutional fragmentation, cultural stigma, and systemic inequalities, yet where agency and adaptation remain powerful forces for resilience and change. By integrating Archer's work with transcendental phenomenology, the chapter develops a dual lens: one that can hold structural determinants and subjective experience in the same frame. This integration ensures that the study does not reduce individuals to products of social forces, nor social systems to collections of personal narratives, but rather shows how both are dynamically entwined.

4.1 Background to Archers Morphogenetic Framework

This section explores the historical and intellectual foundations that informed Archer's development of the morphogenetic framework, situating her work within a broader scholarly dialogue. Her theoretical model did not emerge in isolation but was shaped through engagement with several key thinkers whose insights helped crystallise her understanding of the relationship between social structures and human agency. Among the most influential of these figures are Buckley (1998), Lockwood (1964), Popper (1979), and Bhaskar (2008), each of whom contributed conceptual tools that enriched Archer's theoretical construction.

Buckley's (1998) systems theory was particularly significant in introducing Archer to the idea of feedback mechanisms in social systems. Buckley proposed that social life consists of interconnected elements that influence one another through cycles of feedback ,both positive, which can drive change, and negative, which tends to preserve stability. This dynamic model helped Archer articulate her concept of the morphogenetic cycle: a temporal process in which social structures, cultural systems, and agency interact over time, sometimes reinforcing the status quo and at other times leading to transformation (Brock et al., 2017).

Lockwood's (1964) neo-Weberian analysis offered another important insight, especially in his distinction between social integration and system integration. Social integration refers to the ways individuals relate to one another ,how social bonds are formed and maintained ,while system integration focuses on how institutions and structures function together as part of a coherent system. This distinction provided

Archer with a way to differentiate between interpersonal relationships and structural arrangements, allowing her to explore how social systems shape the practices they also depend upon, and how those practices in turn feed back into the system.

Popper's (1979) philosophy contributed further depth to Archer's theoretical approach, particularly through his notion of the 'third world' ,a conceptual domain distinct from both physical reality (World 1) and personal experience (World 2). World 3, as Popper described it, consists of human-made products such as theories, cultural artefacts, and institutional knowledge. These elements exist independently of any single individual's beliefs and can exert influence over social behaviour. Archer (1995) drew on this concept to argue that cultural systems have their own causal powers ,distinct from individual intentions and material conditions. This enabled her to develop a framework in which culture is not merely reflective of human consciousness but is also an active force in shaping social outcomes (Popper, 1979).

Bhaskar's (2008) critical realism provided the ontological and epistemological grounding for Archer's sociological project. He argued for the existence of an objective reality that operates independently of human perception, while also recognising that our knowledge of this reality is always mediated by historical and social context. His emphasis on identifying underlying mechanisms ,rather than merely describing surface-level events ,resonated with Archer's commitment to uncovering the deep relational processes that underpin social life. This foundation proved essential to her analysis of complex social issues, including the entangled domains of mental health and substance use, where understanding underlying structural and cultural dynamics is key to explaining persistent inequalities and institutional failure.

Through the synthesis of these theoretical perspectives, Archer (1995) was able to construct a framework that is both conceptually robust and practically applicable. Buckley's (1998) systems theory offered a model of dynamic interaction; Lockwood's (1964) work clarified the dual dimensions of agency and structure; Popper (1979) provided a way to theorise culture as an autonomous force; and Bhaskar's (2008) critical realism grounded the framework in a philosophy of social science capable of explaining both structure and change. Together, these contributions enabled Archer to develop a sophisticated lens through which to analyse the evolution of social systems ,one that is particularly valuable when applied to contexts such as mental health and substance use, where structure, culture, and agency collide in often unpredictable and deeply consequential ways.

4.2 Core Concept of the Morphogenetic Framework

The morphogenetic framework, as developed by Archer (1995), provides a valuable way of understanding how social life unfolds through the continuous interaction between people and the structures they live within. Drawing from realist social theory, it avoids falling into the trap of either focusing solely on individual behaviour (what some call methodological individualism) or, conversely, attributing everything to large, impersonal systems (holism) (Archer, 1995; 2013; Brock et al., 2017). Instead, Archer presents what she terms non-conflationary theorising ,a way of seeing individuals and social structures as distinct, but deeply interconnected, components of the social world

(Archer et al., 1998). This distinction is crucial because it helps us trace how change actually occurs, without reducing it to a single cause.

At the centre of this framework is the concept of Analytical Dualism, which proposes that individuals (agents) and social structures (contexts, rules, institutions) must be understood as separate but interacting layers of reality. Rather than collapsing them into one or suggesting that one always determines the other, analytical dualism invites us to study the relationship between them. It encourages a view of people as active beings who are shaped by their circumstances but also capable of shaping those very circumstances. For instance, someone working within a rigid and under-resourced mental health system may feel constrained by policy and funding pressures, but their everyday decisions, advocacy, and resistance can slowly reshape practice norms or influence structural reform.

Archer's framework emphasises that social structures pre-exist individuals but are not set in stone. They provide the conditions within which people act ,offering opportunities, imposing limitations, and shaping expectations. But as people act, over time, they can reinforce, resist, or transform those structures. This interplay between conditioning and change is at the heart of social life and critical to understanding why things stay the same in some contexts while shifting radically in others (Brock et al., 2017).

Complementing this is the idea of structural and cultural conditioning. Archer distinguishes between structural conditioning ,those influences stemming from economic, legal, or political systems ,and cultural conditioning, which relates to the values, beliefs, and assumptions shared within a society (Archer, 1996). Structural conditioning might include unequal access to healthcare or housing, while cultural conditioning might involve prevailing attitudes toward addiction or mental illness. Both influence how people live and what options they feel are available to them. However, people are not passive recipients of these forces. They interpret them, challenge them, and navigate them in unique and creative ways.

It is precisely because of this interpretive and responsive capacity that Archer insists on analysing structure and culture separately. Although they often appear fused in lived experience, examining their unique roles allows for a more precise understanding of their influence and their potential to be changed (Archer, 1996; 2016). For example, we may see a lack of access to mental health support for people who use substances as both a structural issue (linked to policy or funding) and a cultural one (linked to stigma or outdated beliefs about recovery). Untangling these threads makes it possible to address them more effectively.

This brings us to the idea of social elaboration, a concept Archer develops to describe how people and their environments shape each other over time (Archer, 2004). Individuals are not just passive inhabitants of social worlds ,they are active participants, constantly responding to, reshaping, and being reshaped by their surroundings. Social elaboration refers to this dynamic: how people contribute to cultural and structural change while also being influenced by the very contexts they are trying to navigate.

Consider how frontline workers or activists may push for reforms in a system that marginalises individuals with coexisting mental health and substance use needs. Their efforts might gradually lead to new practices, policies, or narratives ,demonstrating how agency can alter the structures people live within. At the same time, these individuals are themselves shaped by the constraints and possibilities of their environments, highlighting the reciprocal nature of the relationship.

This mutual shaping process is further unpacked through Archer's discussion of the interplay between structure and agency. She outlines this as a three-part sequence. First, people are born into and encounter social conditions they did not create. These preexisting structures and cultural norms influence what they can do, how they are perceived, and what choices appear available. For example, someone growing up in poverty or facing systemic stigma may encounter barriers that significantly shape their life chances.

Second, individuals respond to these conditions based on their own concerns , what matters to them, what they value, and how they see the world. These concerns are shaped by personal history, social context, and ongoing experiences. Two people facing the same external constraints may respond very differently depending on what they prioritise or believe to be possible.

Third, individuals engage in reflexive deliberation. They think through their options, weigh their hopes against their realities, and make decisions based on how they interpret their situations. This is where human agency becomes most evident. Through reflection, planning, and intentional action, people shape the paths they take and influence the environments they inhabit (Archer, 2004).

Agency, in this sense, is not just about having free will ,it is about the capacity to reflect, adapt, and act with purpose in the face of social pressures. It involves not only responding to a situation but engaging with it critically, often with the goal of bringing about change. All of this is captured in what Archer calls the morphogenetic/morphostatic cycle, a tool for tracing how social change unfolds over time. This cycle is divided into four stages. The first stage describes the existing structures and cultural conditions before individuals act. The middle stages focus on how individuals interact with those conditions

,how they respond, resist, adapt, or conform. The final stage reflects the outcome of those interactions: either a transformation of the social structures (what Archer terms *morphogenesis*) or their continuation (*morphostasis*).

To give a practical example, consider a social care organisation that historically excluded people who use substances from accessing mental health support. Initially, the exclusionary policies and attitudes represent the starting conditions. Over time, staff, service users, or advocates might push for change ,perhaps through research, pilot projects, or challenging dominant narratives. Eventually, this could lead to new policies that promote integrated care. In this case, the cycle has resulted in morphogenesis ,a structural and cultural shift.

This model is not just an abstract theory. It offers a concrete way to analyse how social systems function and evolve. Whether applied to policy development, institutional reform, or frontline practice, the morphogenetic framework enables us to understand both stability and change. It shows that people do not act in a vacuum, but nor are they entirely at the mercy of systems. Change emerges through the ongoing, dynamic relationship between structure and agency ,between the world as it is, and the world as people imagine, challenge, and strive to make it.

4.3 Application of the Framework in Social Theory

This section considers how the morphogenetic framework has been applied in contemporary social theory, particularly through the work of Al-Amoudi (2017), Hofkirchner (2016), and Archer herself (2013; 2016; 2017; 2021). These contributions demonstrate the framework's continued relevance in understanding how individuals and collectives make sense of, respond to, and shape societal change.

Al-Amoudi (2016) draws on the morphogenetic approach to explore the challenges agents face when interpreting and enacting social rules. His work is especially pertinent to contexts marked by rapid cultural transformation, such as those characteristic of Late Modernity ,a period defined by accelerated social, technological, and cultural shifts that disrupt long-standing norms and institutions. In these conditions, Al-Amoudi argues, individuals are required to interpret ambiguous or evolving rules with limited guidance from established tradition. The framework, in this case, becomes a valuable tool for analysing the tensions between inherited structures and emergent practices.

Building on this, Al-Amoudi (2017) critically engages with the concept of social integration ,the process by which individuals become connected to and embedded within their social environments. He argues that this process is not automatic or passive but requires active reflection and engagement. Individuals must interpret their social context, negotiate their roles within it, and make decisions about how to act. This emphasis on reflection and responsiveness aligns with Archer's (1995) own articulation of agency within the morphogenetic cycle, where individuals are understood as capable of evaluating their circumstances and shaping their responses accordingly.

In differentiating between social integration and system integration, Al-Amoudi (2016) draws directly on the earlier work of Lockwood (1964). While system integration refers to the coordination of institutional functions and processes across a society, social integration focuses on the development of shared values and mutual understanding among individuals. Al-Amoudi (2017) argues that this distinction is essential when examining how people interpret and adapt to societal rules, particularly in periods of cultural flux. Lockwood’s (1964) critique of normative functionalism is invoked here to challenge overly static or harmonious views of society, making room for a more dynamic account of how norms are produced, contested, and internalised.

Al-Amoudi (2017, p. 68) also cites the work of Hofkirchner (2017), who applies the morphogenetic framework to explore contemporary ethical and normative questions. Hofkirchner’s analysis traces the moral complexities introduced by global neoliberalism, examining how economic rationality and market logics increasingly shape individual behaviours and social expectations. His work highlights how adopted norms ,such as those rooted in competitiveness or individualism ,feed back into human agency, influencing not only how people act but also how they understand their moral obligations. This feedback loop between norms and agency is central to the morphogenetic approach, which seeks to uncover the deeper interplay between structure, culture, and action.

Recent contributions from Archer herself have continued to evolve the application of the framework to contemporary issues. Archer et al. (1999, p. 356), building on Lockwood’s (1964) earlier distinctions, discuss the growing fragmentation of societies under the pressures of global capitalism and digital innovation. Archer (2016) observes large-scale transformations, such as changes in the ethos of political parties, the bureaucratisation of public life, and the increasing reliance on performance indicators in institutional governance. These developments are presented as evidence of shifting structural logics that alter the conditions in which agency is exercised.

At the same time, Archer (2017) turns attention to the micro level, exploring how social media is reshaping modes of expression, identity, and interpersonal interaction. These platforms, while opening up new forms of communication, also impose new pressures and expectations ,often blurring the boundaries between private and public life.

This reflects the ongoing concern of the morphogenetic framework with the interdependence of structure and agency, especially in the context of accelerating social change.

Hofkirchner's (2017) broader application of the framework within ethics and normativity further illustrates its versatility. His work navigates the contemporary moral landscape, drawing attention to how social systems and cultural expectations intersect with personal values and choices. By tracing how moral norms emerge, evolve, and shape individual conduct, Hofkirchner exemplifies the framework's capacity to interrogate both the stability and volatility of social life.

Together, these scholarly contributions demonstrate the enduring relevance and adaptability of the morphogenetic framework. Al-Amoudi's (2017) work sheds light on how individuals actively engage with social rules and navigate complex social environments, particularly in a late-modern context. His distinction between system and social integration, grounded in Lockwood's (1964) critique, deepens our understanding of how structures and cultures influence the development of shared meanings and practices.

Hofkirchner's (2017) analysis expands the framework's reach into the ethical domain, showing how neoliberalism reshapes not only institutions but also personal values and behavioural expectations. His exploration of the mutual influence between structural forces and moral agency reinforces the core principles of the morphogenetic approach.

Meanwhile, Archer's more recent work (2013; 2016; 2017; 2021) applies the framework to new domains, from global politics to digital life. Her analysis of institutional shifts and technological change highlights how morphogenesis and morphostasis continue to operate at multiple levels, shaping both individual agency and broader social systems.

By tracing these dynamics, she illustrates how the framework can be used to diagnose fragmentation and make sense of the new forms of connection and disconnection that define contemporary life.

In conclusion, the application of the morphogenetic framework in contemporary theory ,through the work of Al-Amoudi, Hofkirchner, and Archer ,offers a compelling lens for understanding the complexities of social life in the twenty-first century. Whether exploring rule interpretation, ethical ambiguity, or societal fragmentation, these scholars demonstrate the framework's capacity to reveal the layered, reciprocal relationship between structure, culture, and agency. In doing so, they confirm the framework's utility not only as a theoretical model but as a practical guide to analysing the evolving conditions of human interaction and social change.

4.4 The Application of The Theoretical Frameworks in the Current Study

Archer's (1995) morphogenetic framework offers a valuable analytical lens for exploring the intersection of mental health and substance use. As discussed in Chapter 4, this framework helps to untangle the complex relationship between individual experiences and the broader societal structures that shape them. It supports an approach that is neither purely individualistic nor wholly structural, but one that recognises the interplay between agency and context. Pilgrim's (2015) critical positioning between the dominance of psychiatric consensus and post-structuralist critiques complements this view. His work, like Archer's (1995), calls for a more nuanced understanding of mental health ,one that considers how structural conditions constrain or enable personal agency.

In this thesis, the framework is used to examine four interrelated dimensions of mental health and substance use. The first phase, explored in Chapter 7, focuses on how structural and cultural factors shape individual lives. This corresponds to the T1 stage of Archer's (1995) cycle, where pre-existing societal conditions ,such as public policy, institutional norms, or cultural stigma ,condition the situations people must navigate. In the context of mental health and substance use, this includes how service availability, funding models, or dominant narratives (e.g., the medicalisation of distress) influence individual trajectories.

This analysis then moves to the lived experience of individuals: how these broader structures are interpreted and responded to. Here, the focus is on how people perceive their own struggles, make sense of mental health diagnoses, and adopt coping strategies ,including, at times, the use of substances. This stage highlights the influence of personal histories, identity, and meaning-making processes, while also reflecting on the accessibility and quality of support services. The historical development of mental health and substance use discourses, discussed in Chapter 2, provides critical context ,tracing the evolution from supernatural beliefs to biological models and institutional care. These legacies continue to shape contemporary attitudes, often reinforcing stigma and exclusion.

The study then turns to the dynamic interaction between individuals and social systems, aligning with the T2–T3 stages of the morphogenetic cycle. At this stage, the focus is on how people engage with, resist, or adapt to structural and cultural conditions. This includes how those experiencing coexisting mental health and substance use challenges negotiate stigma, access services, or challenge dominant discourses. The integration of Moustakas' (1994) transcendental phenomenology, as outlined in Chapter 5, deepens this analysis by offering insight into the subjective, lived realities of participants. When combined with Archer's (1995) framework, this allows for a richer understanding of how experience is shaped by ,and also shapes ,social norms, expectations, and systemic responses. Chapter 3's critique of dual diagnosis models and biologically deterministic frameworks further contextualises this phase, highlighting how individuals may turn to substance use as a form of self-medication in response to unaddressed trauma or unmet psychological needs.

Chapter 5 also details the methodological approach, which focuses on capturing the social interactions and meanings that inform everyday experience. In the final stage of analysis (T4), the research explores how these individual and collective engagements may contribute to broader cultural and structural change. This includes shifts in how mental health and substance use are understood ,not just within services, but also within public discourse and policy. The findings point toward a move away from narrow clinical definitions and towards more holistic, relational, and compassionate understandings that better reflect the complexity of human experience.

In summary, Archer's (1995) morphogenetic cycle provides a coherent and adaptable framework for navigating the intertwined social, cultural, and experiential dimensions of mental health and substance use. Beginning with the historical and structural shaping of these concepts, the analysis moves through the layers of lived experience and social engagement, culminating in the potential for systemic transformation. This approach not only maps the existing landscape but also identifies openings for change ,supporting more inclusive and context-sensitive responses to some of the most pressing challenges in mental health practice today.

4.5 Transcendental Phenomenology and Archer's Morphogenetic Approach

Integrating transcendental phenomenology with Archer's (1995) morphogenetic framework presents important methodological challenges, largely due to their divergent philosophical foundations, analytical methods, and focal points. Transcendental phenomenology, developed by Husserl (in Mohanty, 2008) and further advanced by Moustakas (1994) and Finlay (2009), is concerned with the exploration of subjective consciousness and lived experience. Its aim is to uncover the essence of phenomena as perceived by individuals, privileging first-person perspectives and intentionality.

This contrasts with the critical realist underpinnings of Archer's (1995) framework, which asserts the existence of an objective social reality that shapes ,and is shaped by , individual actions and cultural processes. Where phenomenology seeks to bracket preconceptions and attend to meaning as it emerges in consciousness, Archer's model analyses the causal interplay between agency, structure, and culture across time. These foundational differences create methodological tensions, particularly in reconciling phenomenology's emphasis on subjective meaning with critical realism's focus on structural conditioning and social mechanisms.

A key challenge lies in balancing phenomenology's focus on lived experience with the morphogenetic framework's concern for the structural and cultural dimensions of social life. Phenomenology typically employs qualitative methods such as in-depth interviews and narrative analysis (Moustakas, 1994), seeking to access deep insights into individuals' perceptions and emotional worlds. In contrast, Archer's approach ,especially in its revised 2003 iteration (Archer, 2004) ,accommodates both qualitative and quantitative methods to trace how agents engage with, reproduce, or transform societal systems over time.

Despite their differences, these two approaches can be brought into productive dialogue ,particularly in research addressing complex and layered social issues such as CEMS. In this study, transcendental phenomenology, as outlined in Chapter 5, was used to explore participants' subjective experiences of living with mental health and substance use challenges. This approach illuminated how individuals perceive and give meaning to their conditions, interactions with services, and broader social realities. It enabled a close analysis of emotions, beliefs, and internalised social narratives.

These individual accounts were then situated within the wider structural and cultural context through the lens of the morphogenetic framework. Archer's approach provided a means to examine how personal experiences are shaped by pre-existing social structures ,such as health service configurations, institutional logics, and cultural stigma ,and how these structures are, in turn, reinforced or challenged through individual and collective action. This dual approach allowed for an investigation of the reciprocal relationship between social context and personal agency, extending the analytical reach of the research.

The methodological process is described in more detail in Chapters 5. Sub-section 4.1 outlines the core principles of Archer's morphogenetic framework, including its temporal structure and focus on analytical dualism. Chapter 5 introduces the main tenets of Moustakas's transcendental phenomenology and details how these informed the research design. Through this dual theoretical grounding, the study adopts a clear epistemological stance ,acknowledging both the subjective reality of lived experience and the objective influence of social structures. As Larsen and Adu (2022) emphasise, subjective experiences, including perceptions, emotions, and meaning-making, are vital components of social reality. At the same time, Bhaskar (2008) reminds us that objective social structures exert influence regardless of individuals' awareness of them.

In practice, the research unfolded in two analytical phases. The first involved conducting in-depth interviews and applying phenomenological methods to interpret participants' experiences. This stage generated rich, nuanced data on how individuals make sense of their mental health and substance use in relation to their personal histories and social interactions. The second phase, drawing on Archer's morphogenetic framework, examined how these experiences reflect wider structural and cultural dynamics. This included analysis of how participants navigate systems of care, experience stigma, or resist institutional expectations. In some instances, further contextual data on service provision, policy environments, and cultural narratives was incorporated to support this analysis and trace patterns across time.

In summary, while integrating transcendental phenomenology with the morphogenetic framework presents conceptual and methodological complexities, the combined approach allows for a more holistic understanding of CEMS. It acknowledges the importance of individual meaning-making while also situating these meanings within the layered fabric of societal structures and cultural norms. In doing so, the study bridges subjective experience with social theory, offering insights not only into how individuals live through mental health and substance use challenges, but also into how these challenges are shaped ,and potentially transformed ,by the world around them.

4.6 Summary

This chapter has established the theoretical foundations for the study, situating Archer's morphogenetic framework as the central tool for examining the interplay of structure, culture, and agency in CEMS. The intellectual lineage of the framework was traced through Buckley's systems theory, Lockwood's distinction between social and system integration, Popper's notion of World 3, and Bhaskar's critical realism. Together, these influences ground Archer's model in a realist ontology that explains both social continuity and social change. The core principles of the framework, especially analytical dualism and the morphogenetic cycle, were then outlined and applied to the challenges of mental health and substance use care, showing how entrenched structures condition action but do not fully determine it.

The chapter also engaged with contemporary applications of the framework, highlighting its adaptability to modern contexts, from digital transformation to neoliberal restructuring. Finally, it demonstrated how the morphogenetic approach will be integrated with transcendental phenomenology in this thesis. By holding together structural conditioning and lived experience, this combined framework allows for a fuller account of how people with CEMS experience stigma, negotiate fragmented systems, and sometimes reshape the very conditions that constrain them.

Chapter 4 strengthens the overarching aim of the study by providing a theoretical model capable of explaining the challenges faced by people with CEMS in terms of both systemic barriers and individual experiences. It advances the exploration of stigma and discrimination by showing how these are not merely interpersonal prejudices but cultural forces with causal power, embedded in structures that restrict access to care and shape recovery trajectories. The objective of understanding the difficulties people face when seeking support is addressed through the framework's focus on structural and cultural conditioning, which illuminates why services impose eligibility thresholds, why narratives of non-engagement persist, and why agency is often constrained but never erased. The objectives relating to co-existence, self-medication, and treatment provision are given a conceptual basis here: the framework provides the tools for analysing how these issues are conditioned historically and institutionally, and how they emerge in lived experience. In short, Chapter 4 ensures that the research is not only descriptively rich but theoretically rigorous, equipping the study to move from literature and history into methodology and empirical analysis.

5. Navigating Methodological Challenges

This chapter sets out the methodological spine of the study. It explains how a hybrid stance, pairing Archer's morphogenetic critical realism with Moustakas' transcendental phenomenology, allows the research to hold structural conditioning and lived experience in the same field of view. Critical realism supplies ontological depth for analysing how policies, institutions, and culture shape what is possible over time; phenomenology secures an intentional focus on first-person meaning, so the analysis does not collapse into system talk that forgets the person. The study therefore proceeds with a dialogical rather than a syncretic integration, treating the tension between frameworks as a productive space for insight rather than a problem to be engineered away. Methods follow from this stance. Unstructured, participant-led interviews capture the textures of experience for people living with co-existing mental health and substance use needs and for professionals working inside fragmented systems. Freedom of Information requests to NHS mental health trusts provide a macro-level view of capacity, eligibility, funding, and accountability, not as a separate quantitative strand but as contextual scaffolding that grounds the narratives. A cost-consequence analysis is used pragmatically to make visible the trade-offs inherent in implementing the Integrated Morphogenetic Care Model, linking financial inputs to human consequences without reducing the study to metrics. The chapter then accounts for reflexivity and positionality, details the data collection and analysis procedures, and sets out the ethical architecture that protects participants while keeping the inquiry honest about its limits. In short, this chapter is the bridge between theory and findings, specifying how the research asks its questions, who is asked, what is gathered, and how meaning is made.

5.1 Aims and Objectives

The methodological approach adopted in this thesis is shaped by the overarching aims and objectives of the study. These aims were formulated to address the central research question: *what are the challenges faced by people with co-existing mental health and substance use difficulties (CEMS), and how do these challenges impact on treatment and recovery?*

The study has four interconnected aims: to develop a deeper understanding of the challenges faced by people with CEMS; to explore how stigma and discrimination shape both treatment and recovery; to identify the difficulties experienced by individuals with lived experience when seeking support; and to examine current systemic issues in order to propose possible solutions for more effective services.

To achieve these aims, three core objectives were established. The first is to conduct interviews with both service users and professionals to generate insight into how stigma and discrimination operate in practice and influence care outcomes. The second is to produce evidence of systemic limitations in service provision and to explore practitioner and service-user perspectives on opportunities for reform. The third is to develop a detailed understanding of how individuals navigate services, including whether substance use is experienced as self-medication, how co-existing conditions are recognised or excluded within current systems, and whether treatment is accessible to those with complex needs.

These aims and objectives directly inform the methodological decisions outlined in this chapter. The use of qualitative interviews captures the depth and nuance of lived experience, while Freedom of Information requests provide macro-level evidence of systemic structures and service disparities. Together, these data sources allow for an exploration of both the experiential and structural dimensions of CEMS care. Analysed through the combined lens of transcendental phenomenology and Archer's morphogenetic framework, the methodology ensures that individual accounts are not treated in isolation but are situated within the broader social, cultural, and institutional contexts that shape them.

5.2 Methodological Positioning: Theoretical Frameworks

The methodological positioning of this study is underpinned by a critical realist ontology, aligning with Archer's (1995) Morphogenetic Framework, and an interpretive epistemology, drawing from transcendental phenomenology (Moustakas, 1994). This integration enables an analysis that accounts for both the structural and cultural barriers embedded in CEMS care systems and the lived experiences of individuals navigating them. By applying these frameworks, the study moves beyond reductionist explanations of service fragmentation and instead examines the interplay between macro-level systemic conditions and micro-level personal agency.

Archer's morphogenetic framework provides a structured lens to analyse how service fragmentation in CEMS has persisted despite policy interventions. It allows for a distinction between structural and cultural conditioning (T1), where historical policies and professional silos have shaped service provision, and social interaction (T2-T3), where professionals and service users attempt to navigate or resist these barriers. Structural elaboration (T4) examines whether past attempts at integration have resulted in meaningful change or whether entrenched funding models and institutional resistance have sustained the existing division between mental health and substance use services (Christie, 2017). By applying this framework, the study situates systemic failures in historical and policy contexts while also recognising how individuals and professionals interact with, adapt to, or challenge these constraints.

While morphogenetics provides the macro-level analytical framework, phenomenology ensures that individual agency and experience remain central to the study. Transcendental phenomenology (Moustakas, 1994) is particularly relevant because it foregrounds the lived experiences of individuals with CEMS, allowing their narratives to reveal how structural constraints impact access to care, recovery pathways, and personal well-being. This methodological approach emphasises epoché, or bracketing, which requires the researcher to set aside personal biases to engage with participants' experiences on their own terms. This is particularly important in CEMS research, where stigma and exclusionary practices often shape both institutional responses and self-perceptions of service users (Pinderup, 2018).

The integration of morphogenetics and phenomenology ensures that this study captures both macro-level systemic influences and micro-level lived realities. Structural fragmentation in CEMS care has often been examined through policy analysis and service evaluations, but there has been less emphasis on how these fragmented systems are experienced by individuals attempting to access support (Harris et al., 2023; Hughes et al., 2024). This study builds on existing research by demonstrating how individuals experience and respond to service barriers, highlighting not only institutional constraints but also forms of agency exercised by service users and professionals.

This study employs a multi-method qualitative approach rather than a mixed methods design. According to Creswell and Creswell (2018), mixed methods research involves the explicit integration of qualitative and quantitative approaches, where both strands meaningfully inform each other at multiple stages ,data collection, analysis, and interpretation. In contrast, a multi-method qualitative approach utilises multiple qualitative techniques without incorporating an independent quantitative strand.

Although Freedom of Information (FOI) requests generate numerical data (e.g., service capacity, funding levels, workforce statistics), they are not used as standalone quantitative data but rather to contextualise qualitative findings. The study does not employ statistical analysis, nor does it integrate FOI data as a separate quantitative research strand. Instead, FOI findings serve to highlight systemic disparities and structural barriers within mental health and substance use services (Walby & Larsen, 2012). This approach aligns with Creswell and Creswell (2018) concept of document analysis within qualitative research, where numerical or factual records are used thematically rather than statistically.

A qualitative, interpretive approach is the most suitable methodology for studying CEMS because it allows for an in-depth, nuanced exploration of how individuals engage with systemic barriers. While quantitative research can highlight disparities in service provision or funding allocation, it does not fully capture the experiential dimensions of exclusion, marginalisation, or resilience. Qualitative inquiry enables the study to examine structural constraints without overlooking the voices of those directly impacted. Given the complexity of CEMS, an approach that centres lived experience alongside institutional analysis provides a more comprehensive and humanised understanding of service fragmentation.

This methodological positioning informs the study's research design, which combines Freedom of Information (FOI) requests and qualitative interviews. While FOI data provide macro-level insights into service structures, funding, and workforce capacity, qualitative interviews foreground the personal narratives of individuals with CEMS. This multi-method qualitative approach ensures that systemic challenges are examined not just as policy failures but as tangible realities experienced by service users and professionals.

By applying a framework that integrates morphogenetics and phenomenology, this study moves beyond static descriptions of service fragmentation and instead captures the complex, evolving nature of CEMS care. The next section explores the researcher's reflexivity and positionality, critically engaging with the influence of personal and professional experience on the research process and interpretation of findings.

5.3 Reflexivity and Researcher Positionality

Reflexivity is a critical component of qualitative research, requiring the researcher to acknowledge how their own experiences, assumptions, and biases influence the research process (Berger, 2015). Given the highly sensitive and complex nature of CEMS, it is essential to critically engage with the researcher's positionality, recognising the ways in which professional background, personal beliefs, and methodological choices shape data collection and analysis. This study employs transcendental phenomenology (Moustakas, 1994), which explicitly requires the researcher to practice epoché, or bracketing, to set aside preconceived assumptions and ensure that participant voices remain central. However, complete neutrality is unattainable; rather than striving for an impossible objectivity, reflexivity allows the researcher to continuously interrogate their role within the research process (Finlay, 2009).

The researcher's professional background in mental health social work has shaped a deep understanding of the systemic failures and bureaucratic constraints affecting individuals with CEMS. While this experience provides valuable insights into the realities of service provision, it also presents a potential risk of reinforcing institutional perspectives rather than fully engaging with participant narratives on their own terms. To mitigate this, the study prioritises participant-led narratives, allowing individuals to frame their experiences without the imposition of professional interpretations. This is particularly important given that individuals with CEMS often experience exclusion and marginalisation within the very systems designed to support them (Pinderup, 2018). By employing open-ended, non-directive questioning in interviews, the research ensures that participants retain control over how their experiences are articulated and understood.

Engaging in epoché has been central to this process. This involves consciously identifying and suspending pre-existing beliefs about service provision, professional roles, and systemic effectiveness (Moustakas, 1994). The researcher maintained a reflexive journal throughout the study, documenting instances where assumptions or biases emerged and actively working to reframe analysis through participant perspectives. Reflexivity is particularly important in ethically significant moments, where the researcher must make decisions about how to interpret and represent participant narratives without reinforcing existing power imbalances (Guillemin & Gillam, 2004). For example, initial assumptions regarding service refusal as a result of workforce shortages were challenged by participants who described experiences of being actively excluded due to stigma and rigid eligibility criteria (Christie, 2017). These reflections not only helped minimise interpretive bias but also ensured that structural barriers were examined as experienced by service users, rather than solely as perceived by professionals.

Beyond individual reflexivity, power dynamics in the research process were critically examined. As a researcher with both academic authority and professional expertise, there exists an inherent imbalance between interviewer and participant, particularly when engaging with individuals who have experienced service-related trauma or exclusion. To address this, efforts were made to create a non-hierarchical research environment, ensuring that participants felt empowered to speak openly without fear of judgment. This was facilitated through collaborative interview techniques, where participants were encouraged to shape the direction of discussions rather than responding passively to pre-set questions. Additionally, participants were given the opportunity to review and modify their transcripts, ensuring that their narratives were accurately represented without unintended distortions (Tindall, 2009).

The impact of researcher identity was also considered in relation to professional participants, whose insights into service delivery form a crucial part of the study. Having worked within similar systems, the researcher shares common professional knowledge and experiences with interviewees, which could have led to assumptions of shared understanding rather than fully unpacking the complexities of systemic constraints. To counteract this, interviews with professionals were conducted with a conscious effort to ask exploratory, clarification-based questions, ensuring that their descriptions of service provision, organisational culture, and funding mechanisms were fully articulated rather than implicitly understood. This was particularly important given the study's focus on institutional inertia within CEMS care, where frontline professionals may experience tensions between policy expectations and on-the-ground realities (Department of Health, 2002).

Despite these efforts, it is important to acknowledge that no research can be entirely free from the researcher's influence. The process of thematic analysis inherently involves interpretation, and the selection of which themes to emphasise reflects both participant narratives and the researcher's analytical framework. However, by embedding reflexivity throughout the research process, including engagement with peer debriefing, critical discussions with supervisors, and revisiting transcripts from multiple perspectives, the study aims to maintain transparency and integrity in how findings are constructed (Horsburgh, 2003).

Recognising and addressing the researcher's positionality is not a limitation but a necessary step in producing ethically responsible and critically engaged research. By remaining reflexive, applying epoché, and actively challenging interpretive biases, this study ensures that the voices of individuals with CEMS are foregrounded in ways that reflect their lived realities rather than institutional narratives. The following section transitions from methodological considerations to the specific research methods used, detailing how the study's data collection techniques operationalise these epistemological commitments.

5.4 Freedom of Information Requests: A Macro-Level Data Source

This study employs Freedom of Information (FOI) requests as a method for capturing macro-level insights into the systemic and institutional structures shaping CEMS service provision. The use of FOI requests allows for a structured analysis of how NHS mental health trusts in England organise, fund, and deliver care for individuals with coexisting mental health and substance use needs. While qualitative interviews offer a firsthand exploration of lived experiences, FOI requests provide empirical evidence of systemic barriers, illustrating how policy decisions, funding allocations, and workforce limitations contribute to the fragmentation of services. This dual approach strengthens the study's ability to bridge individual narratives with broader structural realities, ensuring that findings are both experientially grounded and institutionally informed.

FOI requests serve as a supporting data source rather than forming a separate quantitative study. Their primary role is to contextualise qualitative findings by identifying systemic trends, rather than producing statistically generalisable results. The focus remains on thematic analysis, where FOI data is integrated to highlight disparities in service provision, inconsistencies in commissioning, and the bureaucratic constraints faced by both professionals and service users. This aligns with the study's qualitative, interpretive methodology, ensuring that structural insights complement rather than overshadow participant narratives.

The rationale for using FOI requests stems from the well-documented gaps in public accessibility to mental health and substance use service data. Previous research has identified that CEMS care pathways, funding structures, and performance evaluations are often obscured by institutional opacity (Christie, 2017). By requesting official data from NHS mental health trusts, this study seeks to uncover how service provision is structured in practice, revealing the extent to which policy recommendations translate into tangible care pathways. This approach aligns with Walby and Larsen's (2011) argument that FOI requests provide an essential tool for examining state and institutional accountability, offering insights that may be difficult to obtain through interviews alone.

The FOI requests were submitted to all 54 NHS mental health trusts in England, targeting key areas relevant to service accessibility, integration, and funding. The specific information requested included:

- The existence and structure of CEMS-specific services or pathways within each trust.
- Eligibility criteria and referral processes, identifying whether individuals with co-occurring needs face systemic exclusion.
- Service capacity and utilisation data, capturing trends in how many individuals' access CEMS services over time.
- Workforce composition and training, assessing whether staff are adequately trained to work with individuals experiencing both mental health and substance use challenges.
- Funding allocation for CEMS services, revealing disparities in financial support across different trusts.
- Performance monitoring and evaluation frameworks, determining whether trusts systematically assess the effectiveness of CEMS interventions. Of the 54 trusts contacted, 33 provided full responses, resulting in a 61% response rate. While some trusts offered detailed breakdowns of service provision, funding, and workforce structures, others provided minimal responses, citing exemptions under the Freedom of Information Act. This variation in transparency reflects broader challenges in accountability within the NHS, where significant disparities in service quality and availability remain hidden from public scrutiny. The data obtained from FOI requests,

> therefore, serves not only as a research tool but also as a means of challenging institutional opacity, reinforcing the study's commitment to highlighting systemic failures within CEMS care.

FOI requests also allow for a comparative analysis of best practices and systemic failures, identifying which trusts have developed integrated care models and which continue to operate within siloed, exclusionary frameworks. For example, Nottinghamshire Healthcare NHS Foundation Trust reported a significant expansion in its Coexisting Mental Health and Substance Use Pathway, supporting 288 individuals in 2024 compared to just 32 in 2022. In contrast, other trusts reported no specific CEMS provision, relying on external partnerships or general mental health and addiction services, which often exclude individuals with dual needs (Pinderup, 2018). These disparities underscore the lack of a unified, standardised approach to CEMS care, reinforcing the importance of policy reform and targeted resource allocation.

The thematic analysis of FOI data was conducted alongside the qualitative interview findings, allowing for a cross-comparative approach where structural insights informed the interpretation of lived experiences. For example, waiting times, eligibility restrictions, and funding limitations identified in FOI data were often mirrored in participant accounts of service exclusion and bureaucratic hurdles. This method of triangulation ensures that the study does not rely solely on self-reported narratives but grounds these accounts in verifiable institutional data, enhancing the credibility and validity of findings (Savage & Hyde, 2012).

While FOI requests provide valuable macro-level insights, their limitations must also be acknowledged. The variability in response rates and levels of transparency means that the data obtained cannot provide a fully comprehensive national picture of CEMS service provision. Furthermore, quantitative data on service capacity and funding allocation, while useful, cannot fully capture the experiential dimensions of service fragmentation. As such, FOI data is used to contextualise rather than dictate the study's conclusions, ensuring that structural insights support rather than overshadow the voices of individuals with lived experience.

By integrating FOI requests into a qualitative, phenomenologically informed study, this research ensures that the realities of CEMS service provision are examined at both institutional and individual levels. The findings from FOI requests will be analysed in depth in Chapter 6, where they will be compared against qualitative accounts to provide a comprehensive assessment of the systemic barriers and opportunities within CEMS care. The following section transitions to qualitative data collection methods, specifically detailing the design and implementation of semi-structured interviews, which form the core of the study's empirical findings.

5.5 Consequence Cost Analysis (CCA)

Cost-Consequence Analysis (CCA) is a form of economic evaluation that systematically presents both the costs and multiple consequences of an intervention in a disaggregated manner, allowing decision-makers to assess trade-offs between financial inputs and broader qualitative outcomes (Drummond et al., 2015). Unlike other economic evaluation methods such as cost-effectiveness analysis (CEA) or cost-benefit analysis (CBA), which reduce multiple outcomes into a single measure (e.g., cost per quality adjusted life year), CCA provides a transparent and flexible approach that accommodates both monetary and non-monetary outcomes (Turner et al., 2021). This flexibility is particularly relevant when assessing complex interventions where diverse outcomes , such as patient well-being, service integration, and system-level efficiencies ,are equally important alongside financial costs (Mauskopf *et al.*, 1998).

This study integrates CCA as a supplementary method to enhance the analysis of the Integrated Morphogenetic Care Model (IMCM)**.** Specifically, CCA is employed to evaluate both the economic and non-economic consequences of implementing IMCM, ensuring that structural, cultural, and individual-level impacts are transparently presented. Given that this research adopts a multi-method qualitative approach**,** CCA serves as a pragmatic tool to bridge the gap between quantitative financial considerations and qualitative experiential insights**.** By doing so, it aligns with the critical realist and phenomenological foundations of this study, allowing for a more holistic exploration of how financial investments correlate with service-user experiences and systemic transformation (Knapp and Wong, 2020).

While the methodological foundation of this research remains qualitative, the incorporation of CCA ensures that economic considerations are explicitly acknowledged without reducing the analysis to purely numerical metrics. This aligns with recent calls for economic evaluations in mental health and substance use research to incorporate contextual, ethical, and experiential dimensions (Hartfiel and Edwards, 2019).

Chapter 10.12 presents the application of CCA within this study, systematically outlining the costs associated with implementing IMCM and juxtaposing them with the anticipated benefits, including service integration, workforce training, and improved service-user outcomes. Readers seeking a detailed discussion of how CCA is employed in evaluating IMCM should refer to Chapter 10**.**

5.6 Qualitative Interviews: Capturing Lived Experience

Unstructured interviews were chosen as the primary method for capturing the lived experiences of individuals with CEMS and professionals working within the system. This approach aligns with transcendental phenomenology (Moustakas, 1994), which emphasises allowing participants to express their experiences in their own words, free from pre-imposed structures or leading questions. Unlike structured or semi-structured interviews, unstructured interviews enable an open-ended, participant-led conversation, ensuring that the most salient, personally significant themes emerge organically rather than being dictated by the researcher's preconceptions. This method is particularly valuable when exploring stigmatised and marginalised experiences, as it allows individuals to share their narratives in a way that reflects their priorities, interpretations, and sensemaking processes (Tindall, 2009).

Participant selection followed purposive sampling to ensure a diverse range of perspectives from both service users and professionals. The study recruited twelve individuals with lived experience of CEMS and twelve professionals working in frontline service provision, policy, or related roles. Inclusion criteria for service users required that they had at least five years of experience navigating mental health and substance use services and were currently or previously engaged with formal support structures. Exclusion criteria were designed to ensure participant well-being, particularly for those experiencing acute mental health crises or cognitive impairment that might prevent meaningful participation.

Recruitment was carried out through local NHS trusts, charities, and community support organisations, using posters, online outreach, and direct engagement with service providers. Professionals were approached through their workplaces, with email invitations sent to service managers, who then disseminated information to their teams. Individuals with lived experience were recruited through charities and homeless outreach programs, with direct engagement to explain the study's aims and provide reassurance regarding confidentiality. Participants were given detailed information sheets and the opportunity to ask questions before deciding to take part, ensuring that informed consent was genuinely voluntary.

The diverse sample ensured a broad representation of perspectives, capturing the institutional, policy, and frontline service challenges professionals face alongside the everyday struggles, adaptations, and resilience strategies of service users. By using unstructured interviews, the study was able to explore how individuals construct meaning from their experiences, allowing for a rich, in-depth understanding of how systemic barriers impact daily life and service interactions.

5.7 Data Collection Process

Interviews were conducted both face-to-face and online, depending on participant preference and logistical constraints. The COVID-19 pandemic necessitated adaptations, with many interviews initially conducted via Microsoft Teams or telephone to comply with public health guidelines (Keen et al., 2022; Cornejo *et al.*, 2023). While online interviews provided flexibility and safety, they also posed barriers for individuals with limited digital access or discomfort with virtual formats. Consequently, once restrictions allowed, inperson interviews resumed for service users, particularly those experiencing homelessness or precarious housing, ensuring equitable access to participation.

Face-to-face interviews were conducted in private, neutral settings, such as community centres, support service offices, or participants' homes, depending on individual preference. Ensuring participant comfort and safety was paramount, particularly when discussing trauma-related experiences. Time and location flexibility were prioritised, allowing participants to feel in control of the interview process, which is critical in research involving historically marginalised groups (Guillemin & Gillam, 2004).

Ethical considerations were rigorously upheld throughout the data collection process. Informed consent was obtained in writing before each interview, with participants reminded that they could withdraw at any time without providing a reason. Participants were also explicitly informed about the limits of confidentiality, particularly concerning disclosures that indicated a risk of harm to themselves or others. Interviews were audio-recorded with participant consent, transcribed verbatim, and anonymised to protect identities. To further safeguard confidentiality, all identifiable details were removed from transcripts, and pseudonyms were assigned.

Recognising the potential for distress when discussing traumatic experiences, participants were offered debriefing sessions after interviews, and information on support services was provided where needed. In cases where participants became visibly distressed, interviews were paused or redirected based on their comfort levels, ensuring that their well-being remained the primary concern (Horsburgh, 2003). The study was designed to uphold the highest ethical standards, ensuring that participation was safe, voluntary, and affirming rather than extractive.

5.8 Data Analysis Approach

Interview transcripts and FOI data were analysed using thematic analysis, a qualitative approach that enables the identification, interpretation, and synthesis of key patterns across datasets (Braun & Clarke, 2022). This method aligns with the study's phenomenological focus, allowing for participant narratives to guide the formation of themes rather than imposing pre-existing analytical categories. Thematic analysis was chosen over quantitative or statistical methods, as the study prioritises depth, context, and individual meaning-making over numerical generalisability.

The analysis followed Braun and Clarke's (2022) six-phase approach:

1. Familiarisation with the data – Interview recordings were transcribed verbatim and re-read multiple times to immerse the researcher in participants' narratives.
2. Initial coding – Data was open-coded line by line, with particular attention to how participants framed their own experiences rather than imposing external categories.
3. Searching for themes – Codes were clustered into recurring patterns, focusing on how participants described systemic barriers, service interactions, and personal coping mechanisms.
4. Reviewing themes – Themes were refined to ensure that they accurately represented both commonalities and divergences in participant experiences.
5. Defining and naming themes – Themes were articulated in a way that captured the essence of participants lived realities, ensuring their voices remained central.

6. Producing the final analysis – Themes were synthesised into a coherent narrative, integrating structural insights from FOI data with personal experiences from interviews.

FOI data was analysed alongside interview findings using a cross-comparative approach, where structural conditions identified through institutional data were juxtaposed with lived experiences. For example, while FOI data highlighted long waiting times and restrictive eligibility criteria, qualitative interviews revealed the real-world consequences of these barriers, such as individuals being excluded from support, experiencing crises, or engaging in self-medication. This integration of data sources provided a more comprehensive understanding of systemic failures, demonstrating how policy decisions translate into tangible service limitations for individuals navigating CEMS care.

To enhance rigour and credibility, coding and theme development were subjected to peer debriefing, where initial interpretations were discussed with research supervisors and qualitative research peers. This process helped mitigate potential researcher bias, ensuring that findings were grounded in participant narratives rather than preconceived assumptions (Berger, 2015). Additionally, participant validation was used where possible, with selected participants reviewing key themes to confirm that their experiences were accurately represented.

By employing thematic analysis and a comparative integration of FOI data, the study provides a multi-layered, empirically grounded understanding of CEMS care. The next section explores how these themes were synthesised into findings, examining the structural, organisational, and personal dimensions of systemic exclusion and resilience within CEMS services.

5.9 Ethical Considerations

Ethical considerations were central to the design and execution of this study, given the sensitive nature of CEMS and the vulnerabilities of the participant population. Conducting research with individuals experiencing co-existing mental health and substance use conditions requires a rigorous ethical framework to ensure their safety, dignity, and autonomy are upheld throughout the research process. This study adhered to the ethical guidelines set by Staffordshire University, the NHS Health Research Authority (HRA), and the Research Ethics Committee (REC), securing approvals from all relevant institutions before participant recruitment commenced.

Securing NHS and HRA approvals was a rigorous, multi-stage process that ensured the study met the highest ethical and safeguarding standards. The university's ethics approval was obtained first, establishing compliance with institutional research governance frameworks. Following this, the study underwent NHS REC review, which involved panel assessments and formal ethical scrutiny, particularly regarding the recruitment of individuals with lived experience of CEMS. The HRA's final approval, granted in December 2020, came after a nearly two-year process, reflecting the depth of due diligence required for studies involving vulnerable populations.

Participant safeguarding was a key ethical priority, particularly in interviews where participants might disclose traumatic experiences, discrimination, or distressing interactions with services. To mitigate potential harm, participants were provided with detailed information sheets explaining their rights, confidentiality protections, and the voluntary nature of participation. Written informed consent was obtained before each interview, with participants explicitly informed that they could withdraw at any time without providing a reason. The research adhered to British Sociological Association (BSA) ethical standards, ensuring that all interviews were conducted with empathy, sensitivity, and participant agency at the forefront (Guillemin & Gillam, 2004).

To protect participant confidentiality, all interviews were audio-recorded with consent and transcribed verbatim, with identifiable details removed. Pseudonyms were assigned, and data were stored securely on encrypted university systems to prevent unauthorised access. Anonymisation extended to FOI data, ensuring that individual NHS trusts were not directly named when reporting systemic failings, focusing instead on broader trends in service provision.

Given the potential for emotional distress, participants were offered post interview debriefing and provided with information on relevant support services. In two instances where participants became distressed during professional interviews, sessions were paused, and participants were given the choice to discontinue or reschedule. These cases were handled with sensitivity, ensuring that participation remained voluntary and non-extractive. Informed by Whitney and Evered's (2022) Qualitative Research Distress Protocol (QRDP), the study took a participant-led approach to managing emotional responses, prioritising well-being over data collection.

For participants recruited from homeless services or addiction support programmes, additional ethical precautions were taken. Service professionals, including Care Coordinators, were consulted in advance to assess the appropriateness of participation for individuals in unstable circumstances. This approach ensured that the research did not place individuals in situations of heightened vulnerability or risk.

Conducting research during COVID-19 introduced further ethical challenges. Inperson interviews were initially restricted, and online methods were employed where possible. However, recognising that many individuals with lived experience of CEMS lack digital access, face-to-face interviews were prioritised as soon as restrictions eased, ensuring that participation remained equitable and inclusive. For these interviews, COVID-19 safety measures, including PPE and risk assessments, were implemented, balancing public health guidelines with ethical research engagement.

By embedding ethics into every stage of the research process, this study ensured that participation was safe, voluntary, and respectful, creating an environment where individuals could share their experiences without fear of stigma or retraumatisation.

5.10 Challenges and Limitations

This study encountered several methodological and practical challenges, which, while not undermining the research's validity, shaped the scope and depth of findings. One of the most significant limitations was the variability in FOI data collection. While 33 of 54 NHS mental health trusts responded (61% response rate), the quality of responses varied. Some trusts provided comprehensive breakdowns of service provision, while others offered minimal information or cited legal exemptions under the Freedom of Information Act (2000). This inconsistency reflects broader issues of institutional opacity within CEMS care, where data on service pathways and funding is not uniformly recorded or shared (Walby & Larsen, 2012).

Another challenge was recruitment difficulties, particularly among individuals with lived experience of CEMS. While professional participants were relatively easy to engage through direct workplace outreach, recruiting service users required collaboration with charities and community organisations. Many potential participants expressed interest but later disengaged, reflecting the transient and often precarious circumstances that characterise CEMS service user populations. Additionally, the digital divide exacerbated by COVID-19 restrictions meant that some individuals who might have participated in face-to-face interviews lacked the resources or comfort to engage in online interviews. To address this, recruitment was extended over several months, and multiple contact points were established to maintain engagement without coercion.

The unstructured interview approach, while methodologically justified, introduced challenges in data management and analysis. Unlike structured interviews, where themes are pre-determined, unstructured interviews generate large volumes of complex, nonlinear data (Tindall, 2009). This required iterative coding and continuous re-engagement with transcripts, ensuring that themes emerged naturally from participant narratives rather than being imposed artificially. While this approach captured rich experiential insights, it also made thematic synthesis more time-consuming and demanding than in studies using structured methodologies.

Another limitation was the lack of longitudinal engagement, meaning that findings reflect a snapshot rather than long-term trajectories of CEMS experiences. While interviews captured immediate experiences of service provision, future research could benefit from follow-up interviews or extended ethnographic engagement to explore how participants' interactions with services evolve over time.

Finally, while efforts were made to recruit a diverse sample, the gender distribution was imbalanced, with nine out of twelve service user participants identifying as male. This reflects broader gender disparities within substance use services, where men are more likely to engage in formal treatment than women (Pinderup, 2018). However, it also suggests that additional research is needed to capture gender-specific experiences within CEMS, particularly regarding women's barriers to accessing support.

Despite these challenges, the study successfully captured a rich, multi-layered dataset, revealing systemic and lived-experience perspectives on CEMS care. While methodological constraints shaped how data could be collected and interpreted, the findings remain robust, credible, and reflective of real-world service conditions.

5.11 Conclusion: Connecting Methods to Findings

This chapter has provided a transparent account of the study's methodological and ethical considerations, ensuring that the research process remains credible, rigorous, and ethically sound. By integrating transcendental phenomenology with Archer's (1995) morphogenetic framework, the study ensured that macro-level systemic barriers were analysed alongside micro-level lived experiences.

The use of Freedom of Information (FOI) requests provided institutional insights into service fragmentation, funding disparities, and workforce limitations, reinforcing findings from participant interviews. Ethical considerations were rigorously upheld, with safeguards in place to protect participant welfare, ensure confidentiality, and navigate recruitment challenges. While barriers in data collection, recruitment limitations, and the challenges of unstructured interviews shaped the research process, these did not undermine the study's validity or its contribution to understanding systemic failures in CEMS care.

As the research transitions into Chapter 6, the FOI data will be analysed in detail, providing a macro-level evaluation of structural constraints and service inconsistencies across NHS mental health trusts. This analysis will contextualise the barriers and disparities identified through participant interviews, reinforcing the systemic failures that continue to undermine integrated care for individuals with co-existing mental health and substance use needs.

5.12 Summary

This chapter has established a clear methodological through-line from your theoretical commitments to your empirical practice. By anchoring the study in critical realism and transcendental phenomenology, you have shown how structural and cultural conditioning at T1 can be analysed alongside the interpretive labour of agents at T2 and T3, with space to examine whether outcomes tend towards morphogenesis or morphostasis at T4. Unstructured interviews have been justified as the best way to surface lived complexity in a stigmatised field; FOI material has been positioned as institutional context that corroborates, challenges, or sharpens those accounts; and cost-consequence analysis has been framed as a transparent way to place economic realities next to experiential consequences. Reflexive practice, ethical safeguards, and a transparent account of limitations make the evidential base credible without pretending to omniscience. The chapter therefore prepares the reader for Chapter 6, where FOI analysis maps structural gaps and uneven commissioning, and for Chapter 7, where lived experience shows how those gaps feel and what people do to survive them.

Chapter 5 moves the project from aspiration to mechanism. It advances the overall aim of understanding the challenges faced by people with co-existing mental health and substance use needs by making those challenges empirically approachable at two levels at once: system and subject. It addresses the exploration of stigma and discrimination by setting out how phenomenological interviews will elicit accounts of exclusion and labelling, while FOI data will show how these are patterned by eligibility rules, workforce capacity, and funding choices. It clarifies the difficulties people face when seeking support by specifying how sampling, interviewing, and thematic analysis will trace referral dead ends, abstinence thresholds, and reputational barriers across cases. It engages the aim of examining systemic issues and proposing solutions by tying findings to a cost-consequence reading of the Integrated Morphogenetic Care Model, so policy suggestions are not free-floating principles but grounded in institutional and financial facts. In doing all this, Chapter 5 shows exactly how the study will test whether substance dependence co-exists with mental illness in practice, whether self-medication is a salient explanatory frame in lived accounts, and whether treatment is meaningfully available once the rules of the game are made explicit. The result is a design that can speak to dignity and agency without losing sight of budgets, rotas, and gatekeeping.

6. Mapping the Gaps: Insights from FOI Data on Dual-Diagnosis Services in England

This chapter uses Freedom of Information responses from NHS mental health trusts to map where co-existing mental health and substance use care actually exists, where it merely pretends to, and where it vanishes altogether. The point is simple: when you stop reading policy and start reading returns, you see the system's real shape. FOI provides a macro lens on commissioning, pathways, eligibility, capacity, workforce, funding, monitoring, and partnerships, exposing how morphostasis is reproduced through budgets, job descriptions, and referral rules rather than through slogans. The chapter moves from provision and integration to access and eligibility, then through capacity, workforce, funding, performance, and collaborations, so the reader can follow the chain from structure to consequence without getting lost in managerial fog.

This analysis builds directly on Chapter 5's method and sits upstream of lived experience in Chapter 7. The response rate is uneven, and transparency varies by trust, but the signal is strong enough to show pattern. Where trusts have built integrated pathways, demand reveals itself at once; where they have not, exclusion is baked in and then rationalised. Read what follows as the institutional weather report that explains the storms service users and practitioners describe later.

Of the 54 trusts contacted, 33 responded, yielding a response rate of 61%. While the responses varied considerably, they collectively painted a picture of an incoherent and inconsistent system of care. Some trusts provided detailed descriptions of integrated pathways, such as Nottinghamshire Healthcare's Coexisting Mental Health and Substance Use Pathway, while others indicated that no specific provision for CEMS care existed. This variability underscores a systemic challenge: the absence of a unified approach to addressing co-existing needs. This challenge has long been recognised in national policy but remains largely unresolved despite decades of research and guidance, including the DoH (2002) and Christie (2017).

Examining this issue through the lens of FOI data is critically significant, as it provides unique insights into systemic structures and service provision that are often inaccessible through traditional research methods. FOI requests provide access to organisational-level data that offer insight into how systemic barriers manifest in practice (Walby and Larsen, 2012). The data gathered through this process provide a macro-level view of the structural factors that perpetuate inequalities in care. These findings, when combined with qualitative research on the lived experiences of individuals with CEMS, allow for a comprehensive analysis that bridges the gap between policy, practice, and personal experience.

This chapter begins by exploring service provision and integration, highlighting the disparities between trusts that have adopted integrated models and those reliant on fragmented systems. It then delves into access and eligibility, examining the barriers individuals face when trying to engage with services. The discussion progresses to service capacity and utilisation, revealing how resource constraints and underreporting hinder the effectiveness of care. Workforce challenges are addressed, focusing on the critical need for specialised training and professional development. The chapter also considers the significant disparities in funding across trusts, linking these to broader trends of disinvestment in mental health services. Finally, the chapter evaluates performance monitoring and partnerships, identifying the gaps in accountability and the potential for collaborative approaches to enhance care delivery.

By analysing these themes, this chapter provides a foundational understanding of the systemic and organisational barriers that individuals with CEMS encounter. The findings not only highlight critical gaps in service provision but also offer valuable insights into how these gaps can be addressed through targeted reforms. This analysis sets the stage for the results chapter, which will delve deeper into the cultural, organisational, and personal dimensions of these systemic issues, drawing on qualitative data to offer a holistic perspective on the challenges of CEMS care. The transition to the results chapter connects the macro-level insights presented here with the micro-level experiences of individuals navigating these fragmented systems, emphasising the urgent need for integrated, person-centred approaches.

6.1 Service Provision and Integration

The FOI responses reveal a fragmented and inconsistent approach to service provision for individuals with CEMS across England. Of the 33 trusts that responded, only 12 (36%) reported having dedicated CEMS services. These findings highlight a systemic failure to prioritise integrated care for this vulnerable population, despite national guidance advocating for joined-up approaches (Christie, 2017; DoH, 2002). 64% of trust's continue to operate within siloed systems, with mental health and substance use services managed separately and often with little collaboration.

Nottinghamshire Healthcare NHS Foundation Trust provides an example of good practice with its Coexisting Mental Health and Substance Use Pathway. This integrated model supported 288 individuals in 2024, a significant increase from just 32 in 2022. Similarly, Gloucestershire Health and Care NHS Foundation Trust's COMHAD programme addresses co-occurring needs by combining mental health and substance use interventions within a unified care plan. Leicestershire Partnership NHS Trust also demonstrates an integrated approach, with co-existing mental health and substance use teams operating across inpatient and community settings. These teams deliver assessments, therapeutic interventions, and harm minimisation strategies. Additionally, Leicestershire has policies guiding naloxone use, opioid substitution therapy, and harm reduction, underpinned by plans to expand community worker integration. These examples collectively highlight the potential effectiveness of integrated models when adequately resourced and strategically implemented. However, the 64% rely heavily on external partnerships to fill gaps in service provision. Organisations such as Change Grow Live and Turning Point are often commissioned to provide substance use services, while NHS teams focus solely on mental health. This separated approach creates significant barriers for individuals navigating the system. For example, individuals with severe mental health conditions who also use substances may be excluded from accessing mental health services due to strict eligibility criteria or stigma surrounding substance use (Alsuhaibani *et al.*, 2021). This disconnect often leaves individuals with co-occurring needs falling through the cracks, unable to access the comprehensive care they require (Frieh, 2020).

The data also highlight significant regional disparities in service provision. While trusts like Nottinghamshire, Leicestershire and Gloucestershire demonstrate integrated care models, many others report a lack of specific CEMS pathways. This variability reflects a broader issue of inconsistent commissioning practices and a lack of standardisation across the country. Trusts in less resourced regions are particularly affected, with several indicating that CEMS services are not commissioned at all, forcing individuals to rely on general mental health or substance use services that are ill-equipped to address their complex needs (Pinderup, 2018).

Another critical aspect of integration is the presence of shared care plans, which enable different services to collaborate and coordinate care effectively. However, few trusts reported using such plans systematically. The absence of shared care plans not only perpetuates gaps in care but also places additional burdens on individuals to navigate disconnected services. This lack of coordination undermines the principle of person-centered care and often results in poorer outcomes for individuals with CEMS (Hamilton, 2014).

These findings underscore the urgent need for a unified, integrated approach to CEMS care. National policy frameworks, such as the DoH (2002) policy, have long called for mental health and substance use services to be delivered in tandem, recognising the interplay between these conditions. Yet, the FOI data reveal that implementation remains inconsistent and incomplete. While some trusts have taken steps towards integration, the majority continue to operate within a siloed system that fails to meet the needs of individuals with co-existing conditions.

The next section explores access and eligibility, examining how these structural barriers to integration translate into challenges for individuals seeking support. By analysing eligibility criteria, referral pathways, and waiting times, the discussion will highlight the ways in which systemic fragmentation limits accessibility and perpetuates inequities in care.

6.2 Access and Eligibility

The FOI responses highlight significant challenges in accessing services for individuals with CEMS. Access is often hindered by restrictive eligibility criteria, fragmented referral pathways, and inconsistent service provision across trusts. These systemic barriers create a complex and inequitable landscape for individuals seeking care, further exacerbating the difficulties faced by this vulnerable population.

One of the most striking findings from the FOI data is the variability in eligibility criteria across trusts. While some trusts, such as Leicestershire, allow self-referrals to their dual-diagnosis pathways, the majority require referrals through primary care or other associated services. This dependency on external referrals often delays access to care, as individuals must first navigate a complex web of gatekeeping processes. Additionally, individuals who present with co-existing needs but do not meet strict thresholds for either mental health or substance use services are frequently excluded, falling into a gap between the two systems (Christie, 2017). This exclusionary practice is particularly problematic for individuals with moderate needs who, without timely intervention, are at risk of escalating crises.

Waiting times also emerge as a significant barrier to access. The average waiting time for an initial assessment is between 2.4 and 3 weeks, with an additional 4 weeks required to commence treatment. These delays are particularly concerning for individuals in acute crisis, where the window for effective intervention is often narrow. For example, Nottinghamshire Healthcare, despite its integrated pathway, reported similar delays, reflecting systemic inefficiencies even within well-structured models. Such waiting times not only prolong distress but also increase the likelihood of disengagement from services, particularly for individuals already marginalised by stigma and discrimination.

The referral pathways highlighted in the FOI responses further illustrate the complexity of accessing care. Many trusts (60%) rely on separate referral processes for mental health and substance use services, which adds an additional layer of difficulty for individuals with co-existing needs. For example, some trusts indicated that referrals for mental health services must come through primary care, while substance use referrals are often directed to third-sector organisations. This disjointed approach can result in individuals being bounced between services, with neither taking responsibility for their care (Adams et al., 2022). This lack of accountability is particularly damaging for individuals experiencing co-occurring conditions, who require integrated, seamless pathways to effectively address their needs.

Additionally, stigma remains a pervasive issue influencing access to services (El Hayek *et al.*, 2024). Several FOI responses implicitly indicated that individuals with substance use conditions are often deprioritised within mental health services, reflecting a deep-seated cultural bias. This aligns with national reports, such as Christie's 2017 guidance, which emphasises the need for "No Wrong Door" approaches to care. Yet, the FOI data suggest that such approaches are far from being universally implemented, with many individuals encountering multiple "closed doors" instead.

These systemic barriers are compounded by the lack of standardised access criteria across trusts. While some regions, such as Nottinghamshire, have implemented integrated pathways with relatively inclusive criteria, others lack CEMS-specific services entirely. This disparity underscores the broader issue of regional inequities in care provision, where access to services is often determined by geographic location rather than clinical need.

The findings also highlight the absence of robust mechanisms for ensuring that individuals remain engaged with services once they enter the system. Trusts with integrated care models, such as Gloucestershire's COMHAD programme, reported higher levels of retention, suggesting that streamlined and collaborative approaches are more effective in maintaining engagement. However, such examples remain the exception rather than the rule.

The challenges outlined here reveal a systemic failure to design services that are accessible, inclusive, and responsive to the needs of individuals with CEMS. Eligibility criteria and referral processes often function as barriers rather than enablers of care, while long waiting times exacerbate existing vulnerabilities. The next section builds on this discussion by examining service capacity and utilisation, exploring how resource constraints and systemic inefficiencies further limit the ability of services to meet demand effectively.

6.3 Service Capacity and Utilisation

The FOI data reveals significant variability in the capacity and utilisation of services for individuals with CEMS. While some trusts demonstrate a growing demand for integrated care models, others report limited-service capacity or a lack of available data to measure utilisation effectively. This inconsistency reflects broader systemic challenges in aligning resources with the needs of this population.

One of the most notable findings is the disparity in reported service capacity. Nottinghamshire Healthcare NHS Foundation Trust provides a clear example of how demand for integrated care can grow when pathways are accessible and inclusive. Their

Coexisting Mental Health and Substance Use Pathway supported 32 individuals in 2022, rising to 216 in 2023 and 288 in 2024. This ninefold increase over two years demonstrates the unmet need for integrated dual-diagnosis services and highlights the importance of expanding capacity to meet demand. However, such growth is an exception rather than the norm. Most trusts were unable to provide explicit data on service capacity, reflecting a lack of systematic monitoring and reporting mechanisms.

Leicestershire's inpatient services, by contrast, support approximately 30 users per month, equating to 360 individuals annually. While this indicates consistent utilisation, the absence of comparative data from other trusts makes it difficult to determine whether this figure aligns with regional demand. Furthermore, without clear metrics on maximum capacity, it remains unclear whether these services are operating at full potential or are constrained by resource limitations.

The FOI responses also highlight the underutilisation of services in some areas, often due to restrictive eligibility criteria and a lack of awareness among potential service users. Trusts that operate fragmented care models, relying on separate mental health and substance use services, reported lower utilisation rates. This reflects the challenges individuals face in navigating disjointed pathways and suggests that integrated models are more effective in engaging individuals with co-existing needs. For example, Gloucestershire's COMHAD programme, which integrates mental health and substance use interventions, reported higher engagement levels compared to trusts with siloed systems.

Resource constraints are a recurring theme, with many trusts citing insufficient funding and staffing as barriers to expanding capacity. For instance, while Nottinghamshire's pathway has demonstrated significant growth, its ability to scale further may be limited by financial and workforce pressures. Similarly, some trusts indicated that the absence of CEMS-specific services is due to commissioning gaps, leaving individuals reliant on general mental health or substance use services that are not equipped to address their complex needs.

The lack of comprehensive data on utilisation also reflects broader issues of accountability and transparency. Few trusts provided detailed figures on the number of individuals accessing CEMS services over time, making it difficult to assess trends or identify areas of unmet need. This absence of data not only hinders strategic planning but also limits the ability to advocate for additional resources or service improvements.

The findings underscore the importance of aligning service capacity with demand to ensure equitable access to care. Trusts with integrated care models and robust monitoring systems, such as Nottinghamshire and Gloucestershire, provide valuable examples of how capacity can be optimised. However, the overall picture remains one of inconsistency and under-resourcing, with many trusts struggling to meet the needs of individuals with CEMS effectively.

The next section examines workforce and training, exploring how staffing limitations and gaps in expertise further constrain the capacity of services and impact the quality of care provided. By linking service capacity with workforce challenges, the discussion will highlight the interconnected nature of systemic barriers to CEMS care.

6.4 Workforce and Training

The FOI data highlights significant workforce challenges and gaps in training as critical barriers to providing effective care for individuals with CEMS. While some trusts report dedicated and specialised teams, others rely on general mental health or substance use practitioners who may lack the expertise required to address the complex needs of this population (Pinderup, 2018). This inconsistency reflects broader systemic issues in workforce development and resource allocation.

The composition of teams varies widely across trusts. Nottinghamshire Healthcare NHS Foundation Trust, for instance, provides a comprehensive workforce structure within its integrated pathway, including a service manager, team leader, five substance use practitioners, three mental health practitioners, and six peer support workers. This multidisciplinary approach enables the trust to deliver holistic and coordinated care. Similarly, Gloucestershire's COMHAD programme integrates mental health professionals and substance use specialists, fostering collaboration and shared expertise. However, such examples remain the exception. Most trusts indicated a reliance on general staff who may not have received specialised training in CEMS care.

Training gaps are a recurring theme in the FOI responses. Few trusts reported mandatory or comprehensive training programmes for staff working with individuals with co-existing needs. Where training does occur, it often focuses on specific skills such as motivational interviewing, harm reduction techniques, or naloxone administration. While these are valuable, the absence of broader training on the interplay between mental health and substance use limits the ability of staff to provide integrated care. This reflects findings from national reports, such as Public Health England's 2017 guidance, which emphasises the importance of continuous professional development to enhance workforce capacity.

The reliance on peer support workers also emerges as a key feature of CEMS care in some trusts. Peer workers bring lived experience to the workforce, offering unique insights and fostering a sense of connection with service users. However, the FOI data suggests that these roles are often under-resourced and lack the structural support necessary for long-term sustainability. While peer workers are an important component of CEMS care, they cannot replace the need for adequately trained clinical and professional staff.

Staffing shortages further compound these challenges. Many trusts reported difficulties in recruiting and retaining staff, particularly in roles requiring dual expertise in mental health and substance use. This aligns with broader workforce issues across the NHS, where high vacancy rates and burnout have been well-documented (Iacobucci, 2021). Trusts that do not prioritise dual-diagnosis-specific roles often struggle to build the capacity required to meet the needs of this population, leaving existing staff overstretched and under-supported.

The FOI data also highlights the lack of strategic workforce planning. Few trusts provided evidence of efforts to build or expand their CEMS workforce, reflecting a reactive rather than proactive approach to service development. This lack of planning is particularly concerning given the increasing demand for integrated care models, as evidenced by the significant growth in utilisation reported by trusts like Nottinghamshire. Without a clear strategy for workforce development, many trusts risk falling further behind in their ability to deliver effective care.

The findings underscore the urgent need for investment in workforce training and development. Trusts with integrated care models, such as Nottinghamshire and

Gloucestershire, demonstrate the potential benefits of multidisciplinary teams and targeted training programmes. However, these examples are not replicated consistently across the system. Addressing workforce and training gaps is essential for improving the capacity and quality of CEMS services, ensuring that staff are equipped to meet the complex needs of individuals with CEMS.

The next section examines funding and resources, exploring how financial constraints intersect with workforce challenges to further limit the ability of services to provide comprehensive and equitable care.

6.5 Funding and Resources

The FOI data reveals significant disparities in funding and resource allocation for services addressing CEMS. These disparities underscore the broader systemic inequities in how mental health and substance use services are prioritised and resourced, with many trusts struggling to secure adequate funding for CEMS care. This variability in funding directly impacts service capacity, workforce development, and the quality of care provided to individuals with CEMS.

Among the responding trusts, Nottinghamshire Healthcare NHS Foundation Trust stands out as a rare example of dedicated funding for CEMS services. The trust reported a budget of £788,303 for its Coexisting Mental Health and Substance Use Pathway in 2024/25, representing a significant increase from £477,689 in 2022/23. This 65% rise reflects incremental investments to meet the growing demand for integrated care, with the pathway supporting 288 individuals in 2024, up from just 32 in 2022. Such targeted funding demonstrates the potential for strategic investment to enhance service provision and accessibility.

However, the 52% of trusts reported no dedicated budgets for dual-diagnosis care, instead relying on general mental health or substance use funding streams. This lack of financial specificity often results in fragmented care models, where dual-diagnosis needs are addressed as an adjunct to primary services rather than as a core focus. The reliance on external organisations, such as Change Grow Live and Turning Point, further reflects this underfunding, with trusts outsourcing substance use interventions to third-sector providers while retaining mental health services in-house. While partnerships can enhance service delivery, the absence of sustained internal funding risks perpetuating the systemic fragmentation of care.

Resource constraints were a common theme across many trusts, with several indicating that funding limitations hindered their ability to develop or expand dual diagnosis services. For example, some trusts reported that the lack of commissioning for specific dual-diagnosis pathways left them unable to offer targeted support for individuals with co-existing needs. This aligns with broader findings from national reports, such as Docherty and Thornicroft's (2015) analysis of mental health services, which highlighted a reduction in local authority funding for mental health services by 48% over the past decade. Such systemic disinvestment has compounded the challenges of addressing complex needs, particularly in regions with historically underfunded health systems.

The FOI data also highlights the absence of robust financial monitoring. Few trusts provided detailed breakdowns of their budgets or evidence of financial planning specific to dual-diagnosis care. This lack of transparency makes it difficult to assess whether resources are being allocated effectively or to advocate for additional funding.

Furthermore, the lack of standardised financial reporting across trusts reflects a broader issue of accountability within the system, where disparities in funding often go unchallenged.

The implications of inadequate funding extend beyond service capacity to directly impact workforce development and training. Trusts with limited budgets are often unable to invest in specialised staff or comprehensive training programmes, compounding the challenges of delivering integrated care. For example, while Nottinghamshire and Gloucestershire reported dedicated funding streams that supported workforce expansion and peer support roles, most trusts indicated that funding constraints restricted their ability to recruit or retain staff with dual expertise.

The findings highlight the urgent need for sustained and equitable funding to support dual-diagnosis services. National policy frameworks, such as the DoH's Dual Diagnosis Good Practice Guide (2002), have long emphasised the importance of securing adequate resources to deliver integrated care. However, the FOI data reveal that these recommendations remain largely unfulfilled, with significant gaps in funding and resource allocation persisting across the system.

The next section explores performance and outcomes, examining how the lack of robust financial monitoring intersects with the absence of comprehensive evaluation mechanisms. By linking these systemic issues, the discussion will provide a deeper understanding of the barriers to improving service quality and accountability for individuals with CEMS.

6.6 Performance and Outcomes

The FOI data reveals a significant lack of systematic performance monitoring and evaluation mechanisms within CEMS services across England. This absence of comprehensive metrics for measuring effectiveness reflects broader challenges in accountability and transparency, further complicating efforts to improve service quality for individuals with CEMS.

55% of the trusts were unable to provide detailed information on how they evaluate the performance of their dual-diagnosis services. While some, like Nottinghamshire Healthcare NHS Foundation Trust, reported the use of service user feedback and outcome measures such as the Recovering Quality of Life (REQOL) scale, these practices are not widely implemented. Nottinghamshire's approach includes monthly performance reports submitted to a transformation board, offering a model for continuous monitoring and iterative improvement. However, such examples remain rare, with 70% of trusts indicating little or no routine evaluation of CEMS care.

The absence of key performance indicators (KPIs) is a recurring theme. Many trusts rely on anecdotal evidence or informal feedback rather than structured metrics to assess service effectiveness. This lack of standardised performance measures makes it challenging to compare services across regions or identify best practices. Moreover, without robust KPIs, it is difficult to hold services accountable for outcomes, leaving systemic issues such as fragmentation and underutilisation unaddressed.

Where performance evaluations do occur, they tend to focus on narrow aspects of service delivery. For example, some trusts highlighted naloxone distribution as a marker of success within substance use pathways. While this is an important harm reduction strategy, it represents only a fraction of the broader care required by individuals with coexisting needs. Similarly, trusts that rely on external partnerships often lack access to detailed performance data from third-sector providers, further limiting their ability to evaluate the overall effectiveness of care.

The lack of comprehensive auditing is another significant gap. Few trusts reported conducting formal evaluations of their CEMS pathways, and those that did often cited resource constraints as a barrier to more extensive auditing. This aligns with findings from national reports, such as Docherty and Thornicroft's (2015) analysis of mental health services, which highlighted systemic underinvestment in evaluation mechanisms as a key barrier to service improvement.

Service user feedback, while valuable, is inconsistently collected and utilised. Trusts like Gloucestershire's COMHAD programme reported efforts to engage service users in co-designing care pathways, offering a promising example of participatory evaluation. However, most trusts provided little evidence of structured approaches to gathering or acting on service user feedback. This inconsistency undermines the potential for services to adapt and evolve based on the lived experiences of those they support.

The FOI data also highlight the absence of longitudinal studies or follow-up mechanisms to track outcomes over time. Without this data, it is difficult to determine whether interventions result in sustained improvements in mental health, substance use, or overall quality of life. This lack of long-term evaluation further limits the evidence base for CEMS care and hinders the development of effective, evidence-informed practices.

The systemic failure to prioritise performance monitoring reflects broader challenges in how dual-diagnosis services are valued and resourced. Trusts that do engage in comprehensive evaluations, such as Nottinghamshire, demonstrate the potential benefits of structured performance monitoring. These practices not only enhance service quality but also provide a basis for advocating for additional resources and support. However, without widespread adoption of these approaches, the ability to address systemic gaps and inequities remains limited.

The next section examines partnerships and collaborations, exploring how interagency working and external partnerships influence the delivery and evaluation of dual diagnosis services. By linking these collaborative efforts with the gaps in performance monitoring, the discussion will highlight opportunities for improving accountability and integration within CEMS care.

6.7 Partnerships and Collaborations

The FOI data underscores the critical role that partnerships and collaborations play in the delivery of services for individuals with CEMS. While some trusts demonstrate effective inter-agency working and external partnerships, these arrangements often reflect a reliance on third-sector organisations to address systemic gaps within NHS provision. This reliance, while enhancing service delivery in the short term, raises concerns about sustainability and accountability in the longer term.

Collaborations with external organisations such as Change Grow Live and Turning Point are frequently cited as essential components of service delivery for substance use needs. Trusts like Nottinghamshire Healthcare and Gloucestershire Health and Care NHS Foundation Trust exemplify how these partnerships can support integrated care. For example, Nottinghamshire's Coexisting Mental Health and Substance Use Pathway benefits from partnerships with organisations such as Double Impact and the Nottingham Recovery Network, which provide additional expertise and resources for addressing substance use challenges. Similarly, Gloucestershire's COMHAD programme integrates academic collaborations with the University of Gloucestershire to enhance training and research.

These partnerships often enable trusts to extend the scope of their services, particularly in areas where funding and workforce constraints limit internal capacity. For instance, several trusts rely on external partners to deliver harm reduction initiatives, such as naloxone distribution or peer support programmes. However, this reliance also highlights the fragmented nature of CEMS care, with many trusts outsourcing key components of service delivery rather than developing in-house expertise. This fragmentation can result in disjointed care pathways, where individuals are required to navigate separate systems for mental health and substance use support.

The FOI data also reveal varying levels of collaboration between NHS mental health services and local authorities. While some trusts reported effective joint working arrangements, others indicated minimal cooperation, particularly in regions where CEMS services are not explicitly commissioned. This variability reflects broader challenges in achieving integrated care across organisational boundaries. Trusts that do engage in collaborative commissioning often report more cohesive service models, suggesting that partnerships at the commissioning level are key to overcoming systemic fragmentation.

Training and joint initiatives are notable areas where partnerships can enhance service quality. For example, Gloucestershire's partnerships with third-sector organisations and academic institutions have supported the delivery of specialist training for staff, equipping them to address the complex needs of individuals with CEMS. Such initiatives demonstrate the potential for partnerships to foster workforce development and knowledge exchange, addressing some of the training gaps identified in the FOI data.

Despite these positive examples, the sustainability of such partnerships remains a concern. The reliance on external organisations is often tied to short-term funding streams, which can limit the continuity and stability of care. For instance, some trusts reported that partnerships with third-sector providers were contingent on time-limited contracts, raising questions about what happens to service users when these arrangements end. This reliance also shifts responsibility for CEMS care away from NHS services, potentially undermining efforts to build internal capacity and accountability.

The FOI responses also highlight the need for stronger governance frameworks to support partnerships (Hughes et al., 2024). Few trusts provided evidence of formal agreements or shared accountability structures between NHS services and external partners. This lack of governance can lead to inconsistencies in care delivery and limit the ability to evaluate the effectiveness of partnerships. Moreover, the absence of shared care plans further exacerbates these issues, as it hinders coordination between services and places additional burdens on individuals to manage their care across multiple providers.

Overall, partnerships and collaborations play an essential role in addressing the systemic gaps identified in CEMS care. However, the reliance on external organisations and the lack of robust governance frameworks highlight the need for more sustainable and integrated approaches. By fostering stronger relationships between NHS services, local authorities, and third-sector organisations, and embedding these partnerships within a cohesive governance structure, CEMS care can move closer to achieving the integration and accountability required to support individuals with CEMS effectively.

The next section examines future developments in dual-diagnosis care, exploring planned expansions, innovations, and the persistent gaps that require urgent attention. This discussion will link the insights from partnerships and collaborations to broader strategies for improving service provision and achieving systemic reform.

6.8 Future Developments in CEMS Care

The FOI data reveals a mixed picture regarding future developments in dual diagnosis care. While some trusts reported plans to enhance services and adopt more integrated approaches, many indicated no immediate changes or lacked clear strategies for addressing the persistent gaps in care. This variability underscores the systemic challenges in achieving a unified, forward-looking approach to improving services for individuals with CEMS.

Nottinghamshire Healthcare NHS Foundation Trust stands out for its proactive approach to expanding CEMS care. The trust reported plans to increase community worker integration within its Coexisting Mental Health and Substance Use Pathway, as well as efforts to enhance acute care pathways. These initiatives reflect a recognition of the growing demand for integrated services, as evidenced by the pathway’s significant increase in utilisation, from 32 individuals in 2022 to 288 in 2024. Such forward-thinking strategies highlight the potential for trusts to address unmet needs through targeted investments and strategic planning.

Similarly, Gloucestershire Health and Care NHS Foundation Trust reported plans to expand training initiatives for staff working with co-occurring conditions, building on its successful COMHAD programme. This emphasis on workforce development demonstrates an understanding of the critical role that staff expertise plays in delivering effective CEMS care (Pinderup, 2018). By equipping staff with the necessary skills and knowledge, the trust aims to enhance service quality and improve outcomes for individuals with CEMS.

However, these examples are exceptions rather than the norm. The 60% of trusts indicated no immediate plans for developing or expanding CEMS services. Many responses cited funding constraints, workforce shortages, and commissioning gaps as barriers to future development. This lack of forward momentum is particularly concerning given the systemic issues identified in the FOI data, including fragmented care, restrictive eligibility criteria, and long waiting times. More troublingly, these trusts appear to maintain their positions despite clear national guidance and evidence from studies such as Hughes et al.'s RECO study, which provides a robust framework for integrated care models. The RECO study emphasises the critical importance of leadership, workforce development, and collaborative pathways in addressing the complexities of dual diagnosis care (Hughes et al., 2022). Ignoring such guidance risks perpetuating systemic inequities and further disadvantaging individuals with co-existing needs.

National policy and guidance also provide a framework for potential developments, but the FOI data suggest that implementation remains inconsistent. Christie (2017) guidance on co-occurring conditions emphasises the importance of "No Wrong Door" approaches and integrated pathways, yet few trusts reported plans to adopt these principles systematically. Similarly, the DOH’s Dual Diagnosis Good Practice Guide (2002) outlined recommendations for mainstreaming CEMS care within mental health services, but these remain largely unfulfilled in many regions.

The reliance on external partnerships further complicates the picture of future developments. While collaborations with organisations such as Change Grow Live and Turning Point have enhanced service delivery in some areas, the sustainability of these arrangements is often tied to short-term funding streams. Trusts that depend on external providers to fill gaps in CEMS care may struggle to maintain these services without secure, long-term contracts. This uncertainty limits the ability to plan and implement lasting improvements.

Another critical issue is the lack of comprehensive data on service utilisation and outcomes. Without robust monitoring and evaluation mechanisms, it is difficult for trusts to identify areas for development or to advocate for additional resources. This lack of evidence also hinders efforts to build a national case for reform, leaving CEMS care fragmented and under-prioritised within the broader healthcare system.

Despite these challenges, the FOI data reveal some opportunities for innovation and reform. Trusts that have implemented integrated care models, such as Nottinghamshire, Leicestershire and Gloucestershire, provide valuable examples of how targeted investments and strategic planning can improve service delivery. Expanding these approaches to other regions could help address the systemic gaps identified in the FOI responses. Additionally, the emphasis on workforce development in trusts like Gloucestershire highlights the potential for training initiatives to drive improvements in care quality and accessibility.

In conclusion, while there are pockets of innovation and proactive planning, the overall picture of future developments in CEMS care is one of inconsistency and limited progress. Trusts that do not plan to expand their services fail to align with evidence-based guidance such as the RECO study, Public Health England's frameworks, and national policy recommendations. Addressing these systemic barriers requires a coordinated, national effort to prioritise CEMS services, secure sustainable funding, and invest in workforce development. The final chapter of this section synthesises the insights from this and preceding sections, offering recommendations for achieving systemic reform and advancing integrated, person-centred care for individuals with CEMS.

6.9 Conclusion: Bridging Systemic and Lived Experiences in CEMS Care

This chapter has provided a macro-level analysis of the systemic challenges, disparities, and opportunities in care for individuals with CEMS. Drawing on FOI data, it highlights significant gaps in service provision, with only 36% of responding trusts offering dedicated dual-diagnosis services and even fewer implementing fully integrated models. The reliance on external organisations to fill these gaps demonstrates both the potential of partnerships and the persistent inadequacies of internal NHS capacity. These findings illustrate how fragmentation, restrictive eligibility criteria, and resource constraints continue to impede access to timely, person-centred care.

Despite these systemic challenges, the FOI data reveal promising innovations that could serve as models for integration. Nottinghamshire's Coexisting Mental Health and Substance Use Pathway and Gloucestershire's COMHAD programme highlight the potential of investment in structured pathways, workforce development, and cross-sector collaboration**.** However, the sustainability of these approaches remains uncertain in the absence of secure funding and robust governance frameworks**.** The findings underscore the urgent need for system-wide reforms to ensure that integrated care models become the norm rather than the exception.

Crucially, these structural insights set the stage for the next phase of this thesis: exploring the lived experiences of individuals navigating these fragmented systems and the professionals striving to support them. The macro-level challenges identified in this chapter , service silos, access barriers, and systemic under-resourcing ,are not abstract policy concerns; they directly shape the daily realities of those affected. The qualitative data will provide a human-centred perspective, illustrating how these structural constraints translate into tangible struggles for service users and professionals alike.

For individuals with CEMS, these barriers contribute to cycles of exclusion, unmet needs, and systemic neglect, exacerbating both substance use and mental health vulnerabilities. For professionals, working within underfunded and disjointed services necessitates constant navigation of constraints, workarounds, and ethical dilemmas. By bridging these perspectives, this thesis seeks to illuminate both the structural roots of these challenges and the urgent need for reform that prioritises integration, sustainability, and person-centred care. The following chapter moves beyond the macro-level analysis to explore the lived realities behind these systemic gaps, offering a nuanced, grounded understanding of CEMS care in practice.

6.10 Summary

The FOI picture is clear enough to be uncomfortable. A minority of trusts have created recognisable CEMS pathways; most have not, and still operate separate mental health and substance use tracks with mismatched thresholds and responsibility-shifting referral rules. Access is throttled by eligibility games and waits measured in weeks for problems that escalate in days. Capacity is either insufficient or unmeasured, which is a quieter way of saying the same thing. Workforce is patchy, with a few multidisciplinary teams and too many generalists asked to do specialist work without the training, supervision, or time it requires.

Funding tells the same story. Where money is specifically allocated, services grow and people get seen; where it is not, "partnerships" mean outsourcing core functions to short-term contracts with thin accountability. Performance monitoring is the missing organ; without shared indicators, longitudinal follow-up, or user-led evaluation, there is nothing to drive improvement except local leadership will. The partnerships that do exist can work, but without shared care plans and governance, they make coordination the service user's burden. In morphogenetic terms, the structures and cultures that produced fragmentation remain firmly in place; the pockets of integration are proof of possibility, not proof of system change. The next chapter turns to what this looks and feels like on the ground, showing how these organisational decisions become crises, refusals, and workarounds in real lives.

Chapter 6 advances the overall aim of understanding the challenges faced by people with co-existing needs by showing those challenges are not mysterious; they are designed into the system via commissioning gaps, exclusionary criteria, insufficient capacity, and absent accountability. It addresses the role of stigma and discrimination by revealing how bias is institutionalised in access rules that deprioritise people who use substances and in practices that require abstinence or diagnostic tidiness as the price of help. It clarifies the difficulties people face when seeking support by tracing the exact points where pathways split, referrals bounce and waits accumulate. It supports the objective of evidencing problems in service provision by grounding claims in organisational returns rather than rhetoric, and it begins to sketch solutions by identifying where integration, ring-fenced funding, multidisciplinary teams, shared care plans, and performance frameworks already work. It does not answer whether co-existence, self-medication, or treatment availability are merely theoretical; it shows how they are shaped and sometimes foreclosed by the way trusts build, fund, and audit services.

7. Integrative Analysis of Interviews on Co-Existing Mental Health and Substance Use Issues

This chapter moves from institutional weather maps to the weather inside people's lives. It presents the analysis of twenty-four interviews with professionals and with individuals who live with co-existing mental health and substance use difficulties, using a dual lens that keeps faith with experience while naming the structures that press upon it. The first movement is phenomenological, attending to texture, feeling, and meaning, and letting language organise itself into themes without forcing it through managerial categories. The second movement is morphogenetic, reading those themes against the grain of structure, culture, and agency over time, so the findings do not float free of the systems that make them likely. Together, these movements show how stigma, thresholds, waiting, and workarounds are not only felt as shame, fear, and fatigue, they are also produced by rules, funding, and professional silos. What follows is not a catalogue of quotes, it is a patterned account of how people navigate, resist, and sometimes reshape a system that often asks for tidiness before it offers help.

7.1 Employing Transcendental Phenomenology Analysis

As discussed in chapter 4 and chapter 5 central to this investigation is the principle of transcendental phenomenology, articulated to uncover the quintessential nature of human experiences (Mohanty, 2008). Employing this analytic framework has been exceptionally beneficial for this study, enabling a deep exploration into the subjective inner worlds of individuals living with CEMS. The preliminary stage of this research engaged with Moustakas' (1994) structured approach to phenomenological data analysis comprising a sequence of methodological steps: phenomenological reduction, horizontalisation, textural description, imaginative variation, and culminating in intuitive integration.

Commencing with phenomenological reduction, epoche was used as discussed in chapter 5 In part this was because the researcher's professional practice involves working with individuals with CEMS, it became imperative to employ epoché, thereby setting aside their previous experiences, perceptions, and judgments, to approach the studied phenomenon with an unbiased perspective. This approach facilitated the articulation of the essences of participants' experiences while minimising the influence of the researcher's subjectivity. Despite the inherent challenge that certain aspects of prior knowledge and personal experience are difficult to completely set aside, every effort was made to minimise their influence as rigorously as possible (Moustakas, 1994). This process, known as epoche or bracketing, involved consciously suspending personal biases and preconceptions to engage with the data in an open and objective manner. By striving to adopt this stance, the research sought to maintain the integrity of the participants' narratives and ensure that the findings accurately reflected their lived experiences.

To effectively implement epoché, the researcher utilised various techniques throughout the study. Initial steps included exploring and documenting personal biases , beliefs, emotions, and preconceived notions regarding CEMS , through reflective journaling. This process facilitated the recognition of specific biases that necessitated bracketing prior to engagement with the analytical process. Notably, the researcher harboured an assumption that stigma and discrimination are predominant challenges faced by those with CEMS. Documenting this supposition enabled the researcher to avoid projecting a discriminatory narrative onto all practitioners and services and, instead, remain open to the entirety of the participants lived experiences. Prior to delving into the essence of participants' accounts, the researcher recorded their personal conjectures, thereby averting the premature drawing of objective inferences. This preliminary act of journaling biases ensured heightened awareness and receptivity to the full scope of phenomena.

Upon the initiation of the epoché, the subsequent stage was identified as transcendental phenomenological reduction. Within this context, Schmitt (1967 cited in Moustakas 1994, p. 34), describes the concept as transcendental in that it transcends the everyday, enabling a fresh perception of the world from the perspective of the pure ego. This state allows phenomena to be experienced as if for the first time. The term phenomenology arises from the transformation of the world into a constellation of phenomena. Additionally, it is termed a reduction due to its capacity to guide the inquirer to the fundamental origins of meaning and existence within the experienced world.

Therefore, in line with transcendental phenomenological reduction, each interview was first transcribed verbatim, ensuring that every word and nuance of the participants' expressions was captured accurately. Following transcription, each transcript was reviewed with close attention to the language, tone, and context of each participant's narrative, which, as Moustakas (1994) argues, is essential to grasp the full depth of the lived experience being conveyed.

7.2 Horizontalisation

Horizontalisation is the subsequent phase in transcendental phenomenological reduction, a pivotal process wherein each participant's statement is accorded equal potential significance. This involves extracting salient statements directly from the interview transcripts, with each offering insight into the lived experience of individuals with CEMS. At this juncture, the researcher's approach was non-hierarchical, treating each statement as if it could illuminate the essence of the phenomenon. The horizontalisation process then yielded meaning units, which constituted the foundation for further phenomenological reduction. These units were subsequently aggregated into themes that underpinned the textural descriptions of the experiences related to CEMS.

The analysis employed an immersive approach, engaging deeply with both the audio recordings and their corresponding transcripts to ensure a thorough understanding of the conveyed meanings and nuances. This method aimed to capture the full depth of participants’ expressions, allowing for the most authentic and precise representation of the data. By meticulously revisiting the audio alongside the text, the analysis sought to preserve the integrity of the participants' narratives, ensuring that the subtleties of their experiences were accurately reflected in the final dataset. The transcripts were deconstructed into horizon statements , self-contained units of meaning which could range in length from a single word to full paragraphs. In scrutinising each horizon, the researcher critically considered, 'Does this represent a discrete idea, and at what juncture does it segue into another?' Although the entire transcript was still encompassed, it was at this stage partitioned into these discrete meaning units. For example, the horizontalisation process identified the following statements made by NHS12:

1. The stigmatisation of clients with substance use and mental health needs
2. Challenges in accessing mental health support for clients, leading to a reliance on substances as self-medication.
3. The importance of holistic approaches and multiagency work to support clients.
4. The critical role of compassion and understanding in treating clients, as opposed to viewing them solely through the lens of their substance use.

7.3 Constructing Invariant Constituents

Following Moustakas' (1994) process by narrowing down the horizon statements into the unique and meaningful invariant constituents of the phenomenon. To identify the predominate horizons, the researcher asked two questions: (a) Does it contain a moment of the experience that is necessary and sufficient for understanding it? and (b) Is it possible to abstract and label the horizon? The horizons that remained after this process were deemed the essential invariant constituents for understanding the experience of the phenomenon. Each horizon statement was then categorised as either invariant constituents or irrelevant/repetitive horizons, which were set aside for the across-case analysis. Participants contributed between 100 and 160 invariant constituents each.

Using the example of NHS12 in section 8.4 from those specific statements the following invariant constituents were extracted:

1. Stigmatisation and its impact: clients facing both mental health and substance use challenges are often stigmatised, affecting their willingness and ability to seek help.

2. Holistic and multi-agency approaches: there’s a need for comprehensive support that address both mental health and substance use involving various service providers.
3. Compassion and understanding emphasising the human aspect of clients, beyond their issues with substance use, is crucial for effective treatment.

7.4 Clustering Toward Meaning Units

After identifying the invariant constituents, data was grouped together into common thematic labels or meaning units, representing the 'core themes of the experience' (Moustakas, 1994, p. 121). MAXQDA software was used to cluster and construct the meaning units, in line with the subjective nature of phenomenological reduction knowledge (Lincoln et al, 2011).

Moustakas (1994) did not specify how to move from invariant constituents to meaning units. To address this, analytical qualitative methods were used. As Vaismoradi et al. (2016) noted, the process of thematic development in qualitative research involves compiling invariant constituent statements, identifying common words or ideas, and continuously constructing knowledge and meaning. The units shift and take shape as the researcher examines each invariant constituent to determine its theme, only placing it within a meaning unit if it is consistent with others (Lincoln and Guba, 1985).

Preliminary meaning units were labelled to reflect participants' own words and ideas, often using phrases instead of single terms to capture the complexity of their experiences. For example, rather than simply categorising a cluster of responses under 'substance misuse,' labels such as 'education,' 'complexity,' and 'shame' were used to encapsulate the nuanced understanding and multifaceted nature of participants' knowledge and experiences of CEMS. This approach ensured that the depth and richness of their narratives were authentically represented.

The researcher followed Moustakas' (1994) recommendation by initially clustering invariant elements into meaning units and subsequently validating the themes through application to the entire transcript. constructed meaning units were clearly understood, textural descriptions of the phenomena were generated for each participant, adhering to the guidelines set forth by Moustakas (1994) and Raffanti (2008). The essence of the CEMS experience was captured in these descriptions, using participants' own words to authentically represent their lived experiences.

This was done by including verbatim quotes to maintain their unique perspective meaning. Textual descriptions grouped meaningful units into concise, interconnected segments of significance for each individual. This process involved generating textual descriptions consistent with the original dialogue without revising for clarity or distilling the description. The researcher referred back to the transcripts to verify the descriptions accurately reflected the links in the original interviews.

Common textural descriptions emerged in three areas: (a) repeated meaning units, (b) consistent connections between units throughout the discourse, and (c) cases where numerous units logically grouped under a broader description (Moustakas, 1994).
For example, several participants expressed a connection between ‘shame’ and their CEMS experience. Another textual category was 'access to support services,' encompassing emotions like rejection, self-loathing, and worthlessness.

Again, using the example outline in Chapter 5 the invariant constituents were group into broader themes:

1. Systemic barriers: stigmatisation, lack of holistic support, and insufficient multi-agency collaboration pose significant obstacles to effective care.
2. Human-centric approach: the need for compassion, understanding, and seeing clients as individuals beyond their conditions as paramount

7.5 Imaginative Variations

Imaginative variation refers to creatively modifying or altering existing ideas, concepts, or narratives. It involves using structural descriptions to elucidate the fundamental features of an experience. These descriptions uncover the necessary conditions for the experience to occur (Moustakas, 1994). Structural descriptions provide a framework for textural descriptions by exploring potential interpretations through imaginative thinking, altering viewpoints, and examining the phenomenon from diverse perspectives, positions, or roles. The goal is using multiple perspectives to generate comprehensive structural descriptions and identify the fundamental, triggering components explaining the phenomenon (Moustakas, 1994). Moustakas stated that structural descriptions illuminate the 'what' of an experience by detailing the 'how' and context.

Within imaginative variation Moustakas (1994) guides the researcher to not only describe but to transform - to look beyond what is said to what could be. A framework by Moere-Urdahl and Creswell (2004) complements imaginative variation extending the concept into a concrete, step by step process. This process includes the following four steps:

1. Deliberately manipulating potential structural attributes underlying each participant's descriptions to thoroughly scrutinise their experiences.
2. Identifying the fundamental structural motifs or contextual factors contributing to the phenomenon.
3. Contemplating universal frameworks potentially underlying the phenomenon, like temporal, spatial, corporeal, material, causal, self-referential, or interpersonal dynamics.
4. Identifying vivid examples illustrating the invariant structural themes.

In their ripple effect study, Moere-Urdahl and Creswell (2004) identified structural elements influencing when individuals seek mental health and drug services. Participants described their lives as being governed by services as their sole support. Rejection was associated with declining hope and reverting to previous negative patterns.

Integrating Moere-Urdahl and Creswell's (2004) framework allowed the researcher to operationalise Moustakas's concept. Providing a way to systemically apply imaginative variation, to identify the vivid examples that illustrate the invariant structural themes. Universal structures were examined, such as methods and motivations for seeking services, reasons for substance use and mental health difficulties, and professionals' experiences providing support. While not exhaustive, these structures allowed for a flexible yet focused analysis on CEMS. Detailed examination of meaning units and invariant elements revealed specific examples demonstrating these themes. For instance, the data from NHS12 highlighted that despite systemic barriers, a compassionate, human-centric approach can significantly impact clients' lives. This illustrates the belief in empathy and integrated care to counteract stigma and support those facing complex challenges.

7.6 Theme Development

The final aspect of transcendental phenomenological reduction focuses on developing themes. At this stage, MAXQDA software was used as it enabled a more enhanced and efficient process of developing themes. MAXQDA is widely recognised as a robust software tool for organising coding, and analysing data, and can be instrumental in systematically ordering meaning units through the identification of themes as they emerge. The software has the capacity to process large data amounts and complex coding systems and play a critical role in interpreting data from in-depth interviews and audio recordings from the participant (Woolf and Sliver, 2017). All interviews and audio recordings used in the analysis were uploaded into MAXQDA. Two different folders were set up in MAXQDA; one for data from the interviews with professionals and another for data from interviews with people who have lived experience. This enabled coding in a systematic manner in which similar meaning units were coded in aligned code groups. Using the MAXQDA Code Browser, meaning units were analysed hierarchically (see appendix 1), to develop a listing all code groups. The data was then analysed using the Code Relations Browser to demonstrate the co-occurrence of data coded based on the implemented system (see Appendix 2). The data was then structured using the Creative Coding Feature in MAXQDA to provide a structured way to classify the data under a distinct theme. From these analyses, two main themes emerged that explain the factors that make it harder for people with CEMS to access services, these were:

1. Systemic challenges: encompassing the structural and institutional barriers that impeded access to care and services for individuals with CEMS. It, therefore, addressed the organisational, policy and service design issues that create obstacles.
2. Experiential challenges: highlighting the personal and subjective experiences of individuals with CEMS in attempting to access care. This theme focuses on the practical difficulties, emotional responses, and perceptions that affect their journey through the healthcare system.

Once the main codes were identified the code frequencies tool in MAXQDA was used to identify subcodes based on the criteria within the main codes. Following this analysis the following five subcodes were identified for systemic challenges (see appendix 3):

1. Integrated care deficiencies: representing the systemic lack of integrated health services, addressing the fragmentation of services, the absence of a cohesive multidisciplinary approaches, and the complexity of navigating the healthcare system. This subcode highlights the core challenges of the need for a streamlined, patient-centre system where services are not only co-located but also delivered in a coordinated manner.
2. Long waiting time for mental health assessment and treatment: representing the challenges people with CEMS face when attempting to access service but are then faced with significant waiting times. It also represents contacting mental health services in crisis and having to wait on the phone for a certain amount of time.

Equally, it represents practitioners' frustrations when referring people to CEMS for treatment and having to wait significant lengths of time for treatment.

3. Limited availability of specialised professionals in CEMS**:** representing the professional and lived experience challenges of trying to access services who have a specialised professional awareness of the challenges faced by people with CEMS.
4. Economic barriers**:** representing the challenges of accessing or attempting to access services that are poorly funded or have substantial cuts, which have impacted their ability to provide appropriate care, support, and treatment.

The next six sub-codes are in relation to the main code of Experiential Challenges **(s**ee appendix 4**):**

1. Fear and Judgment and Stigma from Society and Healthcare Professionals: referring to people with CEMS apprehensions about accessing services due to fear of being judged or due to having been previous judged for their use of substances. From a societal perspective this code refers to current and historical societal stereotypes and prejudices that often discourage people from accessing support.

2. Negative Attitudes Towards people with Substance Use: referring to a broader bias that people with CEMS face due to using substances. Such bias often manifests as discrimination effecting the quality of care offered.

3. Misconceptions About the Necessity of Being Substance-Free Before Accessing Mental Health Services: referring to the common misunderstanding that people must overcome their substance use difficulties before they can receive mental health care.

4. Challenges in Accessing Services: referring to the difficulty people have when trying to access the right services. It also highlights that many fall between the cracks of service provision.
5. Lengthy Timeframes for Appointments: referring to the significant waiting times people must endure to access treatment. Which in turn often leads to them relapsing and then being discharged from the service.
6. Experience of Burnout and Lack of Solutions: referring to the challenges faced by professionals, such as high caseload, emotional fatigue which can affect their ability to offer support. Often leaving people to feel like there is no real help available.

In conclusion, this chapter has identified two primary themes: systemic challenges and experiential challenges. Systemic challenges encompass organisational and policy related obstacles that both individuals with CEMS and professionals face. It sheds light on issues such as the lack of integrated care, long waiting times, limited specialised support, and economic constraints. Experiential challenges, on the other hand, centres on the subjective difficulties faced by people with CEMS, highlighting pervasive levels of stigma and discrimination from society and healthcare providers, negative attitudes towards substance use, and pervasive misconceptions that one must be substance-free to receive mental health support. Each theme is underpinned by a series of sub-codes. Which narrate the story of the difficulties faced from the stigmatisation that shadows individuals with CEMS, leading to a hesitance to seek help, to the systemic inadequacies that result in lengthy waiting periods and potential relapses. Furthermore, they reveal the burnout experienced by healthcare professionals, which inadvertently impacts the quality of care and support available. The following chapter will focus on the experiential challenges faced by people with CEMS and will discuss the above sub-codes in more detail. Chapter 8 will then discuss the systemic challenges in more detail.

7.7 Summary

The interview analysis reveals two entwined fields. One is systemic: fragmented pathways, eligibility hurdles that punish complexity, thin capacity disguised as neutrality, underdeveloped multidisciplinary practice, insecure funding, and weak feedback loops that make poor performance hard to see and harder to change. The other is experiential: anticipatory shame, fear of being judged or turned away, beliefs that abstinence is the entry fee for care, long delays that turn hope into relapse, and practitioner burnout that narrows curiosity and shortens patience. Read together, these fields describe a choreography in which people with co-existing needs are required to become simpler than they are. Where integrated teams, shared care plans, peer roles with proper support, and humane gatekeeping exist, engagement holds and outcomes improve; where they do not, people fall between doors and staff learn to live with that as background noise. In morphogenetic terms, the findings show morphostasis at the level of institutional habit, and pockets of morphogenesis where leadership, training, and funding create different conditions for action. The next two chapters separate the strands for depth, taking the experiential challenges first, then returning to the systemic architecture that keeps producing them.

Chapter 7 advances the study's overarching aim by showing, in lived detail, what the challenges are and how they harm treatment and recovery, while also identifying the small conditions under which harm lessens. It addresses stigma and discrimination not as abstractions, but as narrated exclusions at assessment, as reputational labels that travel across services, and as rules that make abstinence a precondition for care. It clarifies what people with lived experience encounter when seeking support, tracing the path from first contact to referral deflection, to waits that outlast resolve, and it shows how professionals absorb the moral injury of working inside these constraints. It contributes evidence of service-level problems and points toward solutions by linking better experiences to specific features, such as integrated pathways, trained multidisciplinary teams, supported peer roles, and accountable follow-up. It speaks to co-existence and self-medication by showing how substance use is often an intelligible response to distress and delay, and it tests treatment availability by documenting where offers are real, where they are conditional to the point of unusable, and where they are absent. In short, this chapter converts structures into stories without losing sight of causation, preparing the ground for a focused treatment of experience in Chapter 8 and a hard look at system design in Chapter 9.

8. Challenges faced by Individuals with CEMS

This chapter turns the lens fully toward lived experience. It follows people with co-existing mental health and substance use needs through the ordinary frictions of seeking help, and the extraordinary consequences when help is delayed, conditional, or withheld. Drawing on interview material, it traces how three experiential pressures braid together in practice: the abstinence-first myth that functions as a hidden eligibility rule, the arithmetic of time that converts waits into relapse and discharge, and the steady undertow of stigma that makes every doorway feel like a test. Alongside service users' accounts, it attends to the emotional economy of practice, where practitioners carry high caseloads, thin supervision, and repeated refusals until empathy frays and moral injury sets in.

Read in morphogenetic terms, these are T2–T3 interactions where agents interpret, improvise, and endure within conditions they did not choose. The detail matters, because it shows how structural features mapped in Chapter 6 are translated into shame, avoidance, anger, and fatigue at the point of contact. The aim here is not to rehearse deficits, but to name the precise moments where experience changes when pathways are integrated, where abstinence is not a gate but a goal, and where first contact is timely and humane. Chapter 9 will return to the system architecture; this chapter stays with the people inside it.

8.1 Challenges in Accessing Mental Health Services

Over the past four decades, the relationship between substance use and mental health has garnered considerable attention from researchers and clinicians. Among the earliest to academically write about this relationship were Pepper et al. (1981), who documented a 37% prevalence of problematic drug and alcohol use within their services. Notably, they observed that this issue emerged alongside the introduction of community care in the USA, a model subsequently adopted in the UK. Decades later, Christie (2017) estimated that between 70% and 86% of individuals accessing these services have CEMS needs. Despite such high prevalence, CEMS often remains underdiagnosed and poorly managed within mental health services, leading to prolonged suffering and inadequate care due to the system's inability to effectively address the complex, intertwined challenges presented by CEMS (Livingston, 2020).

These challenges are poignantly illustrated by service users. For instance, LE11 shared:

> I have been referred to so many different professionals. Mental health services assess me and then tell me to contact substance use services ,they assess me, offer support with my drinking, but provide no support for my mental health. Yet, mental health services won’t take me on until I stop drinking. But I drink because of my mental health. It’s hopeless.

Similarly, LE8 reflected:

> ‘I find it so ironic ,all these professionals say they want to help you, but as soon as they refer you to someone else, they disappear. I’ve had four alcohol detoxes now and still haven’t received any mental health support. And guess what? I’m drinking again.’

These accounts underscore the gaps and contradictions in current service provision, highlighting the urgent need for integrated care that simultaneously addresses both mental health and substance use issues (Hughes et al., 2024).

8.2 Misconceptions about the necessity of being substance-free before accessing mental health services.

These challenges are articulated through the narratives of individuals with lived experiences of CEMS, as well as the professionals who support them. For example, LE1 shared his difficulties in accessing mental health services:

> ‘I was referred to mental health services by my GP following a suicide attempt. I'd been drinking [alcohol] for ten years ,and despite several detox attempts, I could not manage the anxiety and would always resume drinking. Mental health services advised me to stop drinking first. I never returned’.

The insistence on abstinence as a prerequisite for treatment, first formalised in the USA as highlighted by Smith and Hucker (1993), poses significant challenges for individuals with CEMS, who are more susceptible to relapse. Phillips (1998) criticises this approach, and Brigitte et al. (2009) argues that the dynamic interaction of CEMS complicates the achievement of abstinence, which is not always perceived as beneficial progress. Moreover, using days of abstinence as the sole marker of recovery neglects essential psychosocial aspects of the recovery process, potentially alienating those who view themselves as recovering but do not meet the abstinence criteria.

Additionally, Van Hagen et al. (2019) argue that high rates of anxiety and depression not only reduce the likelihood of achieving abstinence but also adversely affect therapy compliance. They caution against overestimating the impact of these mental health issues on the prospects of abstinence. Despite these insights, the emphasis on abstinence persists, as echoed by LE7:

> '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'.

This treatment approach extends beyond alcohol abstinence. LE5 expresses similar frustrations:

> 'I started using dust [monkey dust] to help me come off heroin. I've had loads of mental health diagnoses from bipolar, schizophrenia, and now drug-induced psychosis. The only team that helped me was the Early Intervention team, but they can't support you forever. Now all I get is stop using dust. If only it was that easy.'

Similarly, LE3 recounts:

> 'I've used cocaine for years; it helps my anxiety. Without it, I can't leave the house or talk to anyone. I've tried so many times to get help from mental health services, but they just say stop using cocaine first'.

Furthermore, mental health symptoms such as depression and anxiety are predictive factors for non-abstinence, as the severity of these symptoms can impede recovery from substance use. Van Hagen et al. (2019) suggest that this may be due to the coping role substances play for individuals with depression and anxiety. This observation aligns with Khantzian's (1985) SMH, which posits that individuals engage in substance use as a means to manage underlying emotional distress or psychiatric symptoms. This hypothesis is supported by first-hand accounts: LE4 remarks, ‘Heroin blocks it all out, it helps me to sleep and keep warm, while LE1 shared, now alcohol is the only thing that stops my mind racing. I know that feeling doesn’t last, that’s why I drink all day and night’.

Therefore, as Nathan and Lewis (2021) argue, substances are often consumed for specific reasons. These reasons typically revolve around meeting certain needs and deriving perceived benefits. Specifically, Nathan and Lewis identify motivations that resonate with the experiences of LE4 and LE1, noting that individuals often use substances to relax, alleviate negative emotions, and facilitate social interactions.

8.3 Waiting times and interactions with healthcare professionals.

In addition to the challenges associated with mandatory abstinence, individuals with CEMS often face significant delays in receiving support once accepted into mental health services. A poignant example is provided by participant LE6, who shared their experiences:

After being diagnosed with PTSD following years of sexual abuse, I sought help from various services but was continually redirected to mental health specialists. Once accepted by a community team, I faced a seven-month wait for the psychological support I desperately needed. Unable to manage my intrusive thoughts during this period, I resumed drinking [alcohol] and was eventually discharged as alcohol dependent.

Corroborating LE6’s experiences, NHS4 shared a similar story:

‘I recently worked with a gentleman diagnosed with schizophrenia. After completing a detox in March, he was referred to a community mental health team but could not secure an appointment until September. It was not surprising when he returned for another detox in June'.

Furthermore, LE6 explained:

'I was sent to a crisis team by my GP as I'd tried to kill myself. I've recently lost my wife and started drinking too much. I'd stopped because I was told to. Mental health services referred me to the Wellbeing service who gave me an appointment 3 months later. But because I started to drink again, they discharged me. I've had three admissions to hospital since then due to taking overdoses'.

In addition to long waiting times for appointments, others have encountered significant delays when trying to contact mental health services. LE2 shared:

'I remember calling the crisis team when things had just become too overwhelming, and I didn't want to drink and hadn't for days. They always tell you to call. I was on hold for thirty minutes before I could speak to someone. When I finally got through, they just told me to have a cup of tea and take a bath. I ended up drinking instead. I just don't think they understand'.

This narrative underscores not only the inefficiencies in emergency response systems but also a profound disconnects between service advice and the urgent needs of those seeking help. As well as considerable waiting times, interactions with healthcare professionals can often present significant challenges for individuals with CEMS. For instance, Avery et al. (2016) discovered that psychiatrists frequently develop negative attitudes toward people with CEMS. This bias was personally experienced by LE5, who recounted a troubling encounter:

'I remember sitting there, and the doctor was okay until I mentioned that I use dust. He changed immediately. He started to lecture me about the dangers of dust and how it was

> the dust that was causing my mental health problems. He seemed to forget that I'd just told him I'd been abused by a gang of men'.

This incident highlights not only the prejudice faced by individuals with CEMS but also a significant disconnect in the understanding of the complex interplay between substance use and traumatic experiences'.

This was highlighted in a survey of medical students and residents, where a notable trend emerged, showing increasingly negative attitudes among residents towards individuals diagnosed with alcoholism (Geller et al., 1989). A parallel study examining medical student and resident attitudes towards patients with alcohol and drug abuse diagnoses revealed even more concerning results. Despite respondents feeling adequately trained to care for patients with substance use disorders, their satisfaction in treating these patients consistently declined throughout their years of training (Lindberg et al., 2006). Additionally, there was a growing belief among these medical professionals that such patients excessively utilise healthcare resources.

Moreover, these negative attitudes appear to persist, and possibly worsen, beyond training periods. A comprehensive European study encompassing a wide range of clinicians , including psychiatrists, physicians, psychologists, nurses, and social workers , found a pervasive lower regard for individuals using substances compared to those diagnosed with depression or diabetes (Gilchrist et al., 2011). Interestingly, the study highlighted an intriguing trend related to the length of service among healthcare staff. It revealed that personnel with fewer than 10 years' experience exhibited a higher regard for individuals who used drugs compared to their more seasoned counterparts. This difference might not only reflect variations in recent training methodologies or perspectives on addiction but could also suggest that prolonged exposure to the field might lead to professional burnout. Over time, the continuous stress and challenges associated with managing complex cases in addiction medicine can lead to emotional exhaustion. This, in turn, might cultivate more cynical or detached attitudes towards patients, particularly as positive outcomes can be less immediately visible compared to other medical fields.

8.4 Experiences of burnout and lack of solutions from service providers.

Individuals with CEMS are often characterised as some of the most challenging clients in clinical settings. This complexity leads to professional frustration, feelings of helplessness, and the development of negative attitudes among healthcare providers (Schulte et al., 2010). Further supporting these findings, Pinderup (2017) observed that mental health professionals frequently display counterproductive attitudes toward patients with CEMS, which can significantly undermine the therapeutic relationship and treatment outcomes. This dynamic contributes to increased feelings of frustration and hopelessness among staff, escalating the risk of burnout (Schulte et al., 2010).

The accounts provided by professionals working with individuals with CEMS illuminate the depth of these challenges. One vivid example is provided by NHS4:

> ‘I’ve worked with a lady now for a year. She’s alcohol dependent but has a diagnosis of PTSD. I’ve tried to refer her to secondary mental health services, but all I’m told is she’s too complex, she needs to stop drinking first. Or we don’t have the services to support her. I ended up quitting that job last month; I just couldn’t continue to battle the services’.

Such frustrations are compounded by systemic rigidity, as described by NHS Participant 09, who noted:

> ‘As soon as you mention alcohol or drugs, doors shut, and patients lose trust in the system. It’s a constant battle to keep patients motivated when the system itself is so dismissive’.

These systemic inadequacies leave professionals feeling isolated and unsupported. NHS3 shared a similar *sentiment*:

> ‘I’ve got three patients with a dual diagnosis on my caseload of 40. They literally take all of my time up. They are so complex it's impossible to get them the support they need. I often go home at night thinking tomorrow will be the day one of them is found dead. It’s starting to affect my own life now; it makes me feel so helpless’.

These emotional tolls and the potential for burnout among professionals working with people with CEMS have been linked to compassion fatigue, which negatively impacts the quality of care and treatment outcomes (Anandan et al., 2024). This issue is exacerbated by the stigma and judgment described by NHS12, who stated:

> ‘I’ve spoken to people who feel rejected and unworthy because services tell them to sort out their alcohol use before they can get mental health support. They’re left feeling abandoned, and it’s heartbreaking to witness’.

NSW 2 elaborated on her experience:

> ‘Working in the private sector is really challenging. I’ve got 8 people on my caseload with CEMS, and trying to get them mental health support is like running a marathon non-stop without a finish line. It exhausts you. On several occasions, I’ve found myself cancelling visits as I just can’t face telling them I can't help’.

The frustration and exhaustion among professionals often stem from their inability to address the complex needs of individuals with CEMS within existing service structures. PO4 highlighted how systemic fragmentation exacerbates this issue:

> 'It's like a chicken-and-egg situation ,services can't decide whether to tackle mental health or substance use first. Patients are left without support because they don't fit neatly into either category.'

When asked about the impact of burnout, NHS7 described the overwhelming nature of their experiences:

> 'It feels like everything comes at once. You have clients who are shouting and demanding support, while services repeatedly decline assistance. You're left feeling completely isolated. I once asked my manager for support, and his response was simply to discharge the client. I know it sounds harsh, but clients with CEMS can be incredibly draining'.

Such challenges highlight the systemic gaps in care and support that need to be addressed to prevent burnout and improve outcomes for all involved. This perspective was further articulated by SP 2, who noted the delays and inefficiencies in accessing timely support:

> 'We'll have someone come to us motivated to change, but when we try to get them into services, they're told to wait weeks for an appointment. By then, that motivation is gone, and the cycle continues'.

These systemic failures not only erode professionals' empathy but also perpetuate cycles of unmet needs and poor outcomes. Anandan et al. (2024) observed that the constant demands and challenging behaviour exhibited by individuals with CEMS, coupled with staff stress, burnout, heavy workloads, and judgmental attitudes, may erode professionals' empathy towards these individuals. To counteract this erosion of empathy, Anandan and colleagues recommend that professionals working with people with CEMS adopt a holistic understanding of the biopsychosocial components of CEMS. They argue that this comprehensive approach will facilitate a deeper understanding and foster greater empathy towards individuals with CEMS, ultimately leading to more effective and compassionate care. By incorporating these lived experiences and professional perspectives, this section underscores the urgent need for systemic reforms to address burnout and enhance support for both clients and service providers.

8.5 Fear of judgment and stigma from society and healthcare professionals.

A further challenge faced by individuals with CEMS is navigating both judgment and stigma. Although these terms are often used interchangeably, they have distinct meanings. Judgment involves forming an opinion or conclusion about someone based on evaluating their attributes or actions against a set of criteria, which may be personal, moral, or social. In contrast, stigma refers to a mark of disgrace associated with a particular circumstance, quality, or person. It frequently involves stereotypes and discriminatory behaviour towards individuals based on an attribute perceived as different or undesirable within a societal context (Tyler, 2020).

People with CEMS frequently encounter systemic stigma and judgment from both the criminal justice and healthcare systems (Hartwell, 2004). This population is often primarily viewed through the lens of their criminal behaviour, namely their illicit substance use, rather than being recognised as individuals in need of comprehensive healthcare services (Hartwell, 2004). Such judgments can lead to harsher treatment within the criminal justice system, where policies commonly neglect their complex treatment needs in favour of punitive measures. Discussing her experience working in a prison with individuals with CEMS, P1 shared:

> ‘We had over 40 prisoners on our caseload, all with mental health and substance use issues , most were sentenced for minor offences like theft and given short sentences of a couple of months. We’d detox them, but that was it; we didn’t have enough time to address the addiction’.

P1 further highlighted the long-term consequences of this fragmented approach to care, especially for those with a custodial history:

> ‘I always found it interesting when it was someone’s first time in prison, and they had mental health and substance use needs. As soon as they were released, no one would touch them. It was hard enough dealing with the mental health and substance use, but as soon as you added a custodial sentence, that was it. I’d struggle with housing; mental health support was immediately off the table; they’d just say it was substance use.
>
> The substance use teams would say there’s nothing we can do; you’ve detoxed them.’

This experience demonstrates how the stigma surrounding substance use and mental health is further compounded by the stigma of incarceration, creating a vicious cycle of exclusion and inadequate support.

Building on this, NHS8 articulated their experience of being admitted to a mental health hospital, further underscoring the profound stigma faced by individuals with CEMS. They recounted:

> ‘I had been waiting for so long for help with my mental health ,things had become overwhelming, and I wanted to kill myself , so they sectioned me. I was sent to a mental health hospital and thought, finally, some help. But all I got was, 'You need to stop drinking;

it’s the alcohol.' One day, I overheard the nurses talking, saying I was just a raging alcoholic and that if I stopped drinking, I’d be fine.’

NHS8’s account underscores the pervasive stigma that often accompanies CEMS. Rather than receiving comprehensive care that addressed both their mental health and substance use needs, NHS8 was reduced to a single, stigmatising label. The dismissive attitudes of healthcare professionals not only invalidated their struggles but also perpetuated a narrative that framed their distress as self-inflicted and solvable by willpower alone. This type of stigma contributes to a cycle of inadequate care and reinforces the barriers to accessing the integrated support that individuals with cooccurring conditions desperately need.

Research and the experiences of professionals working with individuals with CEMS clearly indicate that this population is highly stigmatised. For instance, Livingston (2020) observed that people with CEMS are often devalued, rejected, shamed, and excluded due to their socially discredited health conditions. To better understand the stigma associated with people with CEMS, Livingston suggests examining it in three distinct forms: self-stigma, social stigma, and structural stigma.

Self-stigma involves understanding how people with CEMS perceive themselves in light of societal attitudes. When participants with lived experience were asked about their perceptions, many expressed a low opinion of themselves. For instance, LE1 shared:

‘I know people look at me like scum, I feel that most of the time.

LE3 echoed: similar sentiments*:*

Well, I’m the lowest of the low, aren’t I?

Adding to this, LE4 and LE5 described the social stigma they face daily: 'Being homeless and using drugs means you are the worst in society. 120 people walked past me yesterday, not one looked at me' *(LE4). 'You should see some of the looks people give you. I know I look a mess and I'm off my head, but that's the only way to cope ,all they see is a mess'.*

These experiences illustrate the pervasive nature of stigma at multiple levels, revealing how it shapes not only societal attitudes but also the self-perception of those living with CEMS. Such stigma, whether internalised or externally imposed, exacerbates the marginalisation of this population and underscores the urgent need for a more empathetic and integrated approach to care'

The comments from LE1, 3, 4, 5 and 8 powerfully illustrate self-stigma, shedding light on how individuals with CEMS internalise societal negativity and develop negative self-perceptions. Self-stigma occurs when these individuals absorb and accept negative attitudes and stereotypes projected by society, leading to feelings of unworthiness, and reduced self-capability. LE1's admission that he feels like 'scum' and perceives that others view him similarly reveals a deep internalisation of public perceptions, which makes him feel devalued and marginalised. This acknowledgment of being viewed as 'scum' signals a profound sense of unworthiness and low self-esteem, which are hallmarks of self-stigma.

Similarly, LE3's rhetorical question, 'Well, I'm the lowest of the low, aren't I?' underscores his resignation to negative societal perceptions. This acceptance reflects selfstigmatisation, where the individual not only agrees with but also reinforces the negative societal labels assigned to them. LE4's experience of being ignored by passers-by illustrates the social isolation that accompanies visible markers of stigma such as homelessness and drug use. His description of being 'the worst in society' indicates his acceptance of a marginalised identity, internalising society’s disdain, and exclusion. Finally, LE5 acknowledges the judgment he faces and describes his appearance and behaviour using negative terms likely echoed by others. His rationalisation of his state as a coping mechanism reveals an internal struggle between recognising his needs and contending with society’s harsh judgments.

Social stigma, as Livingston (2020) elucidates, arises when community members internalise and endorse negative stereotypes, leading to harmful and discriminatory actions towards those living with mental health and substance use issues. In the context of professional practice, approximately 30% of the professionals interviewed acknowledged the impact of social stigma. NHS11 reflected on personal growth, stating: ‘Growing up, I was always told that people with mental health difficulties were dangerous, and those that use drugs were the dregs of society. I know this isn't true now, but it's really hard at times to challenge these long-held beliefs’.

Similarly, NHS6 recounted direct experiences of stigma:

> ‘You hear the stigma straight away, especially in environments like A&E. I once overheard two nurses talking about my patient with CEMS, saying that it's all self-inflicted and they don’t deserve help. NSW 4 further added: I was working with two gents both homeless with CEMS, I was sitting with them and couple of blokes walked past shouting ‘loser, get a job’- it was disgusting. If only they knew the person, I’m sure they wouldn’t be so horrible’.

The prevalent endorsement of stereotypes does not just contribute to social stigma; it often informs regressive reforms and punitive policies within social institutions. This systemic issue manifests as reduced funding for substance use services, which is a critical issue that is further examined in Chapter 9. Beyond individual attitudes, structural stigma is embedded within the very fabric of societal rules, policies, and procedures that impose restrictions on the rights and opportunities of people with CEMS.

> NHS3's observations offer a stark illustration of this phenomenon: The law isn't set up to help people with CEMS; it uses terms like the Misuse of Drugs Act, so when anyone uses an illicit drug, they are automatically deemed criminals. Within my trust, we also have a policy that requires us to call the police if we find drugs on someone. Such legal frameworks and institutional policies perpetuate structural stigma by criminalising individuals for their health conditions and creating barriers to treatment. The implication of this is a systematic disadvantage for people with CEMS, where they are not only facing the challenges of their conditions but are also navigating an environment that is inherently unsupportive and, at times, punitive.
>
> This form of stigma is deeply ingrained in legislative and institutional practices and has far-reaching implications for accessibility to care and support. It reinforces a cycle where people with CEMS are treated less like patients in need of medical help and more like offenders. The policies that enforce such views fail to recognise the complex nature of CEMS and the necessity for a more compassionate and rehabilitative approach that aligns with modern health care ethics and practices.
>
> In conclusion, this chapter has provided a comprehensive examination of the multifaceted challenges faced by individuals with CEMS as they attempt to access essential services. The historical context established by early researchers such as Pepper et al. (1981) has revealed the enduring complexity of the relationship between mental health issues and substance use, as well as the systemic barriers that persist in providing effective care for this vulnerable population. Despite the advancements in understanding

and addressing these issues, contemporary challenges, as explored through both empirical data and theoretical insights, continue to underscore significant gaps in service provision.

The persistent misconceptions about the necessity of being substance-free before accessing mental health services, highlighted by first-hand accounts and critiques of abstinence-centric approaches, reflect a systemic flaw that complicates the treatment and recovery process for individuals with CEMS. The narratives of individuals like LE1 and LE7, who have been deterred from seeking help due to stringent abstinence requirements, illuminate the real-world implications of these policies and the urgent need for more inclusive treatment models.

Furthermore, the chapter has shed light on the considerable waiting times and the often-inadequate interactions with healthcare professionals, which exacerbate the difficulties faced by individuals with CEMS. The experiences shared by participants such as LE6 and NHS4 reveal the profound impact of delayed support and the disconnection between emergency advice and the immediate needs of those seeking help. These delays and interactions contribute to the disengagement and high rates of non-adherence to treatment protocols observed among this population.

The chapter also addresses the emotional toll and professional burnout experienced by healthcare providers working within these strained systems. The accounts of NHS4 and NHS3, alongside the broader literature on professional frustration and compassion fatigue, highlight the critical need for systemic changes to support both patients and healthcare workers. This burnout, coupled with negative attitudes toward individuals with CEMS, undermines the quality of care and further stigmatises an already marginalised group.

Finally, the pervasive fear of judgment and stigma, both from society and healthcare professionals, remains a significant barrier to accessing care for individuals with CEMS. The distinction between judgment and stigma, as well as the exploration of self-stigma, social stigma, and structural stigma, provides a nuanced understanding of the societal and systemic forces that perpetuate the marginalisation of this population. The insights from individuals with lived experiences, such as LE1 and LE3, poignantly illustrate the internalisation of negative societal perceptions and the resulting impact on self-worth and help-seeking behaviour.

By integrating these empirical findings with theoretical frameworks, this chapter has laid a critical foundation for discussing potential improvements in policy and practice. The next chapter will delve into the systemic challenges faced by people with CEMS. Building upon insights from previous chapters, it examines the pervasive fragmentation of services, highlighting how siloed treatment approaches and communication barriers between healthcare providers hinder integrated care. Through qualitative data and historical policy analysis, the chapter will explore the cultural and structural barriers to achieving holistic care, using Archer's morphogenetic framework. It will also offer policy recommendations to address these deficiencies, advocating for systemic reforms to create a more integrated and responsive healthcare system.

8.6 Summary

The interview material shows a consistent pattern. People are routed between parallel services that do not meet, told to be substance-free before they can be heard, and then asked to wait long enough for motivation to decay. In that space, substances often do the work services refuse to do, regulating sleep, fear, and intrusive memory, which then becomes the reason care is withdrawn. Stigma does not arrive as a slogan; it lands as a tone, a look, a discharge letter, a policy that treats a coping strategy as disqualifying. Practitioners are not indifferent; they are saturated. High demand, unclear responsibility, and thin training pull them toward defensive practice and away from curiosity, which service users read as judgement.

Where the pattern breaks, the ingredients are clear. Integrated teams hold both problems at once and stop the referral ping-pong. Abstinence is treated as a possible outcome, not a precondition. Time to first contact is short enough to catch resolve before it cools, and follow-up is steady enough to survive a lapse. Peer roles are resourced and supported rather than symbolic, and conversations are organised around what matters to the person, not around what the service can easily deliver. Taken together, these findings show how morphostasis is reproduced through everyday rules, and how small but specific changes create room for different action. The next chapter steps back to the systemic level to ask why these conditions are rare, and how to make them routine.

Chapter 8 advances the study's central aim by showing, in concrete detail, the challenges people with co-existing needs face and how those challenges deform treatment and recovery. It addresses stigma and discrimination by demonstrating how they are enacted at assessment, in eligibility language, and in clinical encounters, and how they are internalised as self-stigma that suppresses help-seeking. It clarifies the difficulties of seeking support by following the path from referral to refusal to relapse, and by showing how waiting and conditionality erode engagement. It contributes to identifying solutions by linking better experiences to integrated pathways, rapid and reliable first contact, supported peer involvement, and compassionate, trauma-literate practice. It also speaks to the objectives concerning co-existence, self-medication, and treatment availability by showing why people use substances to manage distress while services are paused, and how treatment availability is functionally curtailed when abstinence is made the entry fee.

9. Challenges of a Fragmented System

This chapter examines the persistence of systemic fragmentation in co-existing mental health and substance use services, showing how individuals and professionals are trapped in a system that has been promising integration since the early 2000s but rarely delivering it in practice. Where Chapter 8 focused on experiential accounts of exclusion and stigma, this chapter moves outward to analyse the structural and cultural logics that reproduce those experiences across organisations and decades. The empirical material demonstrates how siloed funding, split commissioning, abstinence thresholds, and professional hierarchies combine to prevent coherent pathways. Archer's morphogenetic framework is used to situate these findings within a cycle of conditioning, interaction, and elaboration, highlighting how morphostasis continues to dominate despite clear evidence of need for change.

The chapter therefore performs three linked tasks. First, it grounds the narratives of service users and practitioners in the wider structures that shape them, connecting individual frustration to systemic inertia. Second, it traces the cultural narratives—particularly stigma, criminalisation, and neoliberal responsibilisation—that sustain exclusionary practices even in the face of reform rhetoric. Third, it explores the constrained agency of both service users and practitioners, showing how tactical workarounds and everyday resistance illuminate possibilities for morphogenesis while also exposing the limits of action within rigid frameworks. By synthesising these layers, the chapter lays the groundwork for the introduction of a new care model in Chapter 10.

9.1 The Fragmentation of services

This section explores the pervasive fragmentation in service provision for individuals with CEMS. It details how siloed treatment approaches and poor communication between healthcare providers contribute to ineffective and disjointed care. By drawing on data from interviews, this section highlights the real-world implications of these systemic deficiencies and underscores the urgent need for integrated care models.

Having established the overarching challenges faced by people with CEMS in Chapter 7, the discussion now turns to empirical data to illustrate the most significant challenge: fragmented services. The findings reveal that fragmentation not only profoundly impacts the lives of individuals with CEMS but also affects the professionals who work with them. This issue, as discussed in Chapter 3 and Chapter 7, emerges as the most pressing factor, underscoring the critical need for cohesive and coordinated care systems. For instance, LE1 said:

> 'I've been drinking for 10 years, I've been in rehab three times, but as soon as you come out you are bounced between alcohol services and mental health services ,none actually work together.'

LE1’s comments focus on the fragmentation of care services, leaving people in LE1’s position to navigate a complex web of services. The impact of such fragmentation is profound, as LE1 further stated:

> ‘I’ve given up now, I don’t see the point ,you don’t ever get the help.’

Equally, professionals working with people with CEMS also emphasised the fragmentation of care as one of the main challenges. NHS2 said:

> ‘I’ve assessed so many people in crisis who use alcohol or drugs to cope with their mental distress, but trying to get them into treatment for their mental health is near impossible. You are constantly told the person needs to work with substance use services first. It’s so embarrassing; we are supposed to be helping, not hindering them.’

This experience further validates LE1’s feelings of hopelessness, ultimately underscoring that siloed services are ineffective.

The challenges faced due to siloed services continue outside of the NHS. For instance, LE7 said:

> ‘I knew I had a drinking problem when I was arrested for drunk driving ,the court and the police told me to get some help. I was initially sent to my GP, who then sent me to a local alcohol service, who then sent me to a mental health team, who then sent me back to the alcohol service ,it’s an absolute joke.’

LE7’s comments highlight that multiple entry points to different services can confuse and frustrate people trying to seek help. The impact is that, as LE7 said:

> ‘It’s been two months now, I’m still drinking, because they tell me not to stop, I’ve lost my job, the bills are piling up and I’m worried I’ll lose my house soon.’

Moreover, LE8 articulated her frustration at separate services by saying:

> ‘My family had been telling me to get support for months. I started drinking following the death of my son, drink was the only thing that stopped me thinking. But it had got out of hand; I was drinking three bottles of wine a day. I went to mental health services, who referred me for bereavement counselling. During my assessment with them, I was told that before I could start counselling, I needed to stop drinking. I tried to explain that it was the only thing that helped, but if I’m being honest, they didn’t care and discharged me.’

The impact of LE8’s discharge was further articulated when she said:

> ‘I tried to kill myself shortly after and was admitted to a mental health hospital. They were great, they got me off the drink. But, as soon as I was discharged, I was told that there is now a three-month wait for counselling. Luckily a friend took me to a charity and if I’m being honest, they have saved my life.’

LE8’s observations illuminate several critical issues regarding the separation of services for people with CEMS. LE8 underscores the detrimental effects of compartmentalised care, where services operate in silos rather than in a coordinated, holistic manner. Furthermore, LE8’s narrative reveals a process marked by barriers to accessing appropriate support, beginning with the challenges of being told to stop drinking ,a coping mechanism for her grief also discussed in Chapter 7.

Professionals also shared strategies they use to navigate such separate systems. NSW2 communicated:

> ‘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 will not get the support they need.’

NSW2's admission highlights a problematic workaround to bypass systemic exclusion. While strategic, this approach risks incomplete assessments and treatment plans, perpetuating stigma and undermining the therapeutic alliance.

This sentiment was echoed by LE4, who shared:

> 'I've been using heroin for over 5 years, I've been on a methadone script, but it didn't address the reason I first started using. I grew up in care and was sexually abused; it's something that I can't get out of my head. But trying to get any support is impossible. I've been referred to shit loads of different teams but, because I'm on gear [heroin] or homeless, no one will pick me up.'

Similarly, LE5 said:

> 'I've been referred to every community team in the city, but because I'm using dust, all I hear is that I need to stop using [monkey] dust before they will accept me. It's a complete joke ,tell them to live on the streets and not use drugs. Housing is the same; you've got to stop using dust.'

Professionals echoed these frustrations. NHS4 said:

> 'I've been working with a woman who is currently homeless. We applied for housing and were honest about her substance use, only for her application to be declined because she uses substances. As such, the most vulnerable people feel even more alienated in the face of the recovery process.'

LE11 and LE12 also shared the compounding challenges faced after incarceration, illustrating the cyclical nature of exclusion from services.

LE11 explained:

> 'Since I came out of prison, I've been placed [accommodated] in the worst place in the city; everyone in them uses drugs. I got clean in prison, but as soon as you come out, it's

> just the same. I need gear [heroin] to block it all out. My drugs worker referred me to mental health services because of my anxiety. But I was told there is a three-month waiting list. Then I was told I'm too complex. What's the fucking point?'

Similarly, LE12 described their experience:

> 'It's hard to get clean in prison because you can still get drugs, but you're told you need to be clean before mental health will help you. I was diagnosed with PTSD after seeing my mum hang herself. But I can't get into mental health services because I drink. But I drink because it's the only thing that blocks out the pain of seeing her hanging. Now I've been in prison for drink driving, and no one will touch me. I honestly don't see the point.'

The narratives of LE11 and LE12 expose the compounding barriers faced by individuals leaving prison, who not only deal with substance use and mental health issues but also encounter systemic barriers in accessing care. This reinforces the cycle of exclusion and despair experienced by many with CEMS.

The impact of these challenges is not limited to those seeking care but extends to professionals working within fragmented systems. NHS3 voiced their frustration:

> 'I've recently worked with a person who is alcohol dependent; she's had three rehabs now, but as soon as she gets home, she starts to drink. This is in part because I can't get her psychological support. She's got loads of trauma in her life that needs to be addressed, but because she drinks, psychology won't treat her. It honestly kills me. I have so much pressure from her family because they are afraid, she'll end up dead. I have no support from my manager. I've recently been off sick with anxiety and even considered suicide at one point because I felt such a failure.'

Such accounts underscore the emotional toll placed on professionals navigating these systems. NHS Participant 10 shared a similar sentiment, emphasising how the lack of integrated care models perpetuates cycles of crisis and relapse:

> 'If mental health services were involved immediately post-detox, we could prevent so many relapses. Instead, we see people discharged, unsupported, and returning to substance use within days.'

This reality leaves professionals feeling demoralised and unsupported, as noted by NHS4:

> 'It feels like you're constantly battling the system. You spend weeks trying to get someone into the right service, only to be told they're not eligible. It's exhausting, and it's no wonder so many of us burn out.'

The recurring theme of individuals being passed between services, coupled with situations of homelessness and the additional challenges of post-prison environments, amplifies the urgency for systemic reform. Equally, the insistence on abstinence as a precondition for mental health support, highlighted in interviews, is a testament to the counterproductive and exclusionary practices entrenched within the fragmented healthcare system.

LE8's earlier account highlights the potentially life-saving role of third-sector organisations, which often provide immediate, non-judgmental support absent in statutory services. Similarly, NHS Participant 12 pointed out the importance of integrated care:

> ‘If we had a model where substance use, mental health, and social support were all addressed together, we’d be far more effective. Right now, we’re just putting out fires.’

This reinforces the need for a multidisciplinary, person-centred approach that breaks down the silos currently hindering effective care.

9.2 Conclusion

The fragmentation of services for individuals with CEMS creates significant barriers to care, perpetuates cycles of exclusion, and exacerbates the challenges faced by both individuals and professionals. The insistence on addressing substance use or mental health issues in isolation fails to account for the complex interplay of these conditions, leaving service users and providers trapped in an ineffective system. The quotes and narratives presented in this section illustrate the urgent need for systemic reform, with integrated care models offering the most promising solution to these entrenched issues. By addressing the root causes of fragmentation, the healthcare system can move towards a more equitable, efficient, and compassionate model of care.

9.3 Archer’s Morphogenetic Framework and Service Fragmentation

Archer's (1995) Morphogenetic Approach, discussed at length in chapter 4, offers a robust theoretical lens to analyse the systemic fragmentation in services for individuals with CEMS. This framework emphasises the dynamic interplay between structure and agency, where social structures and human actions continuously influence each other in a cycle of morphogenesis. This approach is particularly useful for understanding the complex and evolving nature of service fragmentation and its profound impact on both individuals and professionals.

The historical context of policies aimed at integrating care for individuals with CEMS, as discussed in chapter 2, is crucial for understanding the current structural conditions. Despite longstanding policy recommendations for integrated care, the persistence of siloed services and fragmented funding structures continues to shape the landscape of care provision. These structural conditions are further reinforced by institutional norms and bureaucratic processes that prioritise separate treatment modalities for mental health and substance use disorders.

Qualitative data from interviews vividly reveals the lived experiences of individuals with CEMS and the professionals working with them. For instance, LE1 expressed frustration at being bounced between alcohol services and mental health services, illustrating the severe lack of coordination and continuity in care. This fragmentation not only undermines the efficacy of treatment but also exacerbates feelings of hopelessness among individuals seeking help.

Similarly, professionals like NHS2 face significant challenges in navigating the fragmented system. The insistence on prioritising substance use treatment before addressing mental health issues creates substantial barriers to comprehensive care. NHS2's experience of assessing individuals in crisis, only to be told that they need to work with substance use services first, underscores the systemic inefficiencies and the emotional toll on healthcare providers.

The potential for structural elaboration lies in recognising these systemic deficiencies and advocating for integrated care models. By analysing the data through Archer's framework, this research identified emergent properties and powers that contribute to the persistence of fragmentation. For example, the repeated emphasis on the need for an integrated approach, as highlighted in 182 instances across interviews, indicates a growing awareness and demand for systemic change.

The real-world implications of service fragmentation are profound, affecting both individuals with CEMS and the professionals who work with them. The narratives of LE1, LE7, LE8, LE4, and LE5, among others, illustrate the detrimental effects of being passed between services without a clear plan or continuity of care. These stories highlight the urgent need for cohesive and coordinated care systems that can address the complex needs of individuals with CEMS.

The experiences of professionals like NHS3, who face immense pressure and emotional strain due to the fragmented system, further validate the critical need for integrated care. The lack of support from management and the unrealistic preconditions for accessing mental health services exacerbate the challenges faced by both individuals and professionals.

The analysis of fragmented services using Archer's (1995) Morphogenetic Framework underscores the systemic nature of the challenges faced by individuals with CEMS. The historical and policy context, combined with the lived experiences of individuals and professionals, reveals the deep-rooted structural conditions that perpetuate fragmentation. However, the potential for structural elaboration and the growing demand for integrated care models offer a pathway for systemic change. The remaining section of this chapter delves deeper into the structural and cultural challenges using Archer’s framework, providing a comprehensive exploration of these critical issues and offering insights into potential solutions.

9.4 Structural Challenges

The persistent structural barriers within the UK's healthcare system significantly hinder the integration of care for individuals with CEMS. Utilising Archer's morphogenetic approach, it becomes evident that these barriers are deeply embedded in both historical and contemporary practices, requiring a nuanced understanding to address them effectively.

Historically, mental health and substance use services have developed along separate trajectories, creating a dichotomy that persists today. This historical separation has entrenched distinct funding streams, training protocols, and treatment philosophies, resulting in a fragmented system that fails to provide holistic care. Archer's concept of T1 structural conditioning elucidates how these entrenched patterns predate current efforts at integration, shaping the context within which agents , both service users and providers , must operate. Despite policy initiatives like the DOH, (2002) and DoH (2009) PIGs, which aimed to bridge these divides, the practical implementation has been fraught with challenges, leaving significant gaps in care.

One of the most critical challenges in the healthcare system for individuals with CEMS is the fragmentation of services. This issue, highlighted by Harris et al. (2023), is evident in the siloed treatment approaches, fragmented service provision, and significant communication barriers between healthcare providers. These factors contribute to a disjointed care landscape that severely hampers the effectiveness and continuity of care. For instance, the story of LE1, who has entered rehabilitation multiple times, underscores the implications of this fragmented system. Despite repeated interventions for alcohol dependency, LE1's necessary mental health support was never concurrently addressed, showcasing a system where services operate in isolation, devoid of necessary coordination. This results in a scenario where one aspect of the disorder is treated while the other is neglected, leading to incomplete recovery and eventual disillusionment with the system.

Similarly, the experiences of LE7 further illustrate the issues stemming from fragmented service provision. After an arrest for drunk driving, LE7 was caught in a frustrating loop of referrals among various services, each addressing only a fragment of his needs without any overarching coordination or clarity in the treatment pathway. This not only complicated his journey through the healthcare system but also significantly lessened the likelihood of a successful recovery, leaving him to continue struggling with his addiction.

Communication barriers within the healthcare system exacerbate these issues. The case of NSW 2 highlights an environment where professionals are aware of these barriers yet feel incapacitated to effectively address them. NSW 2 describes adopting a strategy of advising patients not to disclose their substance use to mental health services due to an anticipated lack of support. This approach, while strategic, underscores the communication failures across services, contributing to counterproductive care that forces patients to navigate a contradictory and complex treatment landscape.

Collectively, these individual stories reflect a broader systemic discontent that has long plagued the landscape of mental health and substance use care. The frequent documentation of integrated care deficiencies during research interviews emphasises the recognition and urgency of addressing these issues among healthcare professionals and individuals alike. This stark discrepancy between the envisioned holistic care models and the current siloed service structure necessitates a paradigm shift toward an integrated model of care.

The fragmentation of treatment approaches for individuals with CEMS is extensively critiqued by Peterson (2013), who characterises these approaches as often being disjointed. Therefore, such fragmentation frequently leads to suboptimal outcomes, including increased hospitalisations and considerable challenges in navigating services for those with CEMS. Peterson (2013) provides strong evidence that integrated treatment approaches are significantly more effective, offering improved continuity and coordination of care which holistically addresses the complexities of CEMS. Echoing Peterson's assertions, Yule and Kelly (2019) also advocate for an integrated approach to enhance the efficiency and effectiveness of therapeutic interventions, aligning with best practices to manage the intricacies of CEMS comprehensively.

However, achieving an integrated approach involves overcoming several structural barriers. Yule and Kelly (2019) identify funding as a primary structural challenge, noting that an integrated model demands extensive resources, including specialised staff training and enhanced coordination across various service systems. They point out that funding mechanisms in many healthcare systems are not ideally configured to support such integrative and multidisciplinary approaches, as they are often compartmentalised or designated specifically for either mental health or substance use services, but not both. This segmentation has been particularly evident since the enactment of the HSCA 2012, as discussed in Chapter 2, which restructured public health services by transferring commissioning responsibilities from the NHS to local councils and establishing PHE. This restructuring has led to increased fragmentation of services, further disrupting the continuity of care essential for individuals with CEMS (Gadsby et al., 2017). The split in commissioning responsibilities among various organisations has introduced complexity and confusion, undermining the holistic, integrated approach recommended by earlier guidelines.

Another significant barrier highlighted by Peterson (2013) is the lack of workforce training and expertise necessary for integrated care. Most healthcare professionals are trained in specific disciplines and may lack the cross-disciplinary skills required to effectively manage CEMS. This specialised focus results in a workforce that, while potentially skilled within their domains, is often ill-equipped for the interdisciplinary approach required for effective integrated care (Hamilton, 2014). Such a gap underscores the urgent need for comprehensive training programmes that foster a broader skill set among healthcare providers, enabling them to deliver care that adequately responds to the multifaceted needs of individuals with CEMS (Pinderup, 2017).

Implementing an integrated approach necessitates seamless interaction between services traditionally separated both institutionally and operationally. Yule and Kelly (2019) discuss how the lack of coordination can significantly impede the efficacy of treatment for individuals with co-occurring disorders. They highlight that without adequate coordination, patients may receive conflicting advice, undergo redundant treatments, or experience gaps in care that can lead to relapses or worsening conditions.

In their analysis, Yule and Kelly (2019) emphasise that continuity of care is essential for the long-term management of chronic conditions such as substance use disorders and mental health conditions, which often require ongoing intervention over extended periods. Continuity of care ensures that treatment is not disrupted as patients move between different services or levels of care. This aspect of treatment is challenging in a fragmented health system where mental health and substance use services often operate under different administrative structures, have separate funding streams, and follow distinct treatment protocols.

Moreover, Yule and Kelly (2019) note that successful coordination and continuity of care are not merely about co-locating services but involve integrating care pathways, treatment plans, and communication strategies among healthcare providers. The need for better coordination and continuity of care is further underlined by the systemic challenges faced in providing integrated treatment in all treatment settings. They argue for the importance of ongoing research to identify the best practices for improving access to integrated treatment, which includes addressing these coordination issues. They suggest that innovations in healthcare technology might offer new ways to enhance educational opportunities on co-occurring disorders and improve treatment delivery, potentially easing some of the challenges related to coordination and continuity of care.

Addressing these structural issues is fundamental to improving outcomes for individuals with co-occurring disorders. Without addressing these barriers, even well-designed integrated treatment programmes might fail to achieve their full potential in helping patients recover and maintain health over the long term.

In conclusion, the structural barriers to integrated care for individuals with CEMS in the UK are deeply rooted in historical separations, funding constraints, workforce training gaps, coordination challenges, and conflicting legislative frameworks. Utilising Archer’s morphogenetic approach highlights the complex interplay between these entrenched structures and the agency of individuals within the system. Addressing these barriers requires a multifaceted strategy that includes significant cultural and structural shifts, adequate funding, effective coordination, and a more inclusive approach to treatment.

Only by acknowledging and tackling these deep-seated issues can the healthcare system move towards providing truly integrated and effective care for individuals with CEMS.

9.5 Cultural Challenges

The intersection of mental health and substance use disorders presents complex challenges that are deeply embedded in societal, cultural, and institutional contexts. Building on the historical foundations explored in Chapter 2, this section focuses on the enduring issue of stigma ,its historical and contemporary manifestations ,and the ideological frameworks that shape responses to individuals with CEMS. Stigma remains a profound cultural challenge, arising from multiple sources including societal attitudes, institutional structures, media portrayals, and healthcare professionals themselves (Avery et al., 2016; El Hayek et al., 2024). Critically, this pervasive phenomenon affects not only individuals with CEMS but also their families, care providers, and wider service systems , undermining treatment outcomes and reinforcing marginalisation.

Goffman (1963) conceptualised stigma as an attribute that deeply discredits an individual, reducing them from a whole and usual person to a tainted, discounted one. He identified three types of stigma: that of character traits (e.g., mental illness or substance use), physical characteristics (e.g., disabilities), and group identity (e.g., race or religion). Stigma, in this sense, is not simply a label, but a powerful social process that enforces separation between ‘us’ and ‘them’. It is reproduced through everyday social interactions in which the stigmatised are discredited, leading to their exclusion from mainstream society and services.

In Chapter 3, Thomas De Quincey’s *Confessions of an English Opium-Eater* (1821) provided a vivid historical account of the cultural and personal stigma surrounding substance use ,an experience that resonates closely with Goffman's (1963) theory of managing a spoiled identity. De Quincey's use of narrative as both confession and self-justification reveals the dual existence many individuals with CEMS experience: navigating between societal condemnation and private survival. His efforts to rationalise his behaviour and elicit empathy illustrate an early form of 'stigma management' through selective self-presentation and disclosure. These strategies, while individualised, reflect broader social pressures and the persistent framing of addiction as morally deviant.

Despite being written over two centuries ago, De Quincey's reflections remain acutely relevant. El Hayek et al. (2024) revisit these dynamics within a global and contemporary framework, highlighting that stigma toward substance use is often more severe and entrenched than that associated with other mental health conditions. Their work echoes Goffman's insights by identifying the multifaceted origins of stigma ,ranging from public attitudes and media discourse to healthcare policy and practice ,and emphasising its entrenchment through punitive legal systems that criminalise addiction.

El Hayek et al. (2024) further identify key mechanisms sustaining this stigma. Chief among these are enduring moral narratives that frame addiction as a personal failure, the use of derogatory language in public discourse, and the continued criminalisation of substance use. In many contexts, individuals who use substances are portrayed as weak, dangerous, or morally corrupt ,labels that dehumanise and delegitimise their experiences. This dynamic directly aligns with Goffman's concept of a spoiled identity, wherein individuals are reduced to their most stigmatised behaviours, erasing the complexity of their lives and needs.

The consequences of this dehumanisation are far-reaching, particularly within healthcare settings. El Hayek et al. (2024) argue that stigma shapes clinical interactions, influencing professional attitudes and decision-making. Healthcare professionals who internalise stigmatising narratives may provide substandard care, avoid therapeutic engagement, or overtly label service users. These behaviours contribute to service disengagement, poor adherence, and increased relapse rates. The pattern is historically rooted, as evidenced by De Quincey's narrative, yet remains disturbingly prevalent. To address this, El Hayek et al. call for systemic reform: anti-stigma training, inclusive policy design, and a shift toward trauma-informed, person-centred care that frames substance use within the context of pain, trauma, and structural inequality.

The role of criminal justice systems in perpetuating stigma is also significant. El Hayek et al. (2024) argue that the continued criminalisation of substance use compounds marginalisation by framing addiction as a legal and moral infraction rather than a public health concern. This echoes the punitive responses of De Quincey's era and reinforces contemporary narratives of criminality and deviance. Hartwell (2004) illustrates how this structural stigma manifests in practice: individuals with CEMS are disproportionately represented in the criminal justice system, more likely to breach probation, reoffend, or experience homelessness. These outcomes are not merely behavioural but are embedded in systems that fail to provide coordinated, compassionate support.

Avery et al. (2016) further develop this analysis by examining how stigma operates within healthcare settings. Their research reveals that stigmatising attitudes among healthcare professionals ,including psychiatrists ,are both prevalent and harmful. These attitudes often result in under-treatment, poor communication, and the use of dismissive or moralistic language. Critically, they weaken the therapeutic alliance, lower engagement, and increase the likelihood of relapse. Importantly, Avery et al. note that professional stigma does not exist in a vacuum ,it interacts with and amplifies wider societal stigma, creating a feedback loop that perpetuates exclusion.

This interplay between professional and public stigma aligns with Goffman's (1963) concept of 'courtesy stigma', in which stigma extends to those associated with the stigmatised ,families, advocates, and even healthcare providers. Courtesy stigma can undermine support networks, reduce advocacy, and discourage professionals from working in addiction services, further weakening the system's capacity to respond effectively. Goffman's framework is thus not only descriptive but diagnostic ,it helps to illuminate the multiple layers of stigma that obstruct care, from interpersonal dynamics to institutional cultures.

By tracing these connections across time ,from De Quincey's self-stigmatised narrative to Goffman's sociological typology and through to contemporary research by Avery et al. and El Hayek et al. ,we gain a deeper understanding of the enduring and evolving nature of stigma in CEMS care. While its expression may vary across historical and cultural contexts, its function remains consistent: to mark certain individuals as 'other', reducing their access to care, community, and justice.

To understand why this stigma persists despite growing evidence and advocacy, it is useful to apply Archer's morphogenetic framework. The concept of *morphostasis* , which refers to the reproduction of existing structural and cultural patterns ,helps explain the durability of stigma across time. In the case of CEMS, stigma is maintained through institutional inertia, professional cultures, and cultural narratives that resist change. Legal systems, healthcare policies, and media discourse all act as morphostatic forces, reinforcing outdated perceptions and discouraging reform. This persistent cycle of stigma not only impedes service innovation but also undermines recovery-oriented, inclusive approaches.

However, recognising stigma's morphostatic nature also highlights the potential for *morphogenesis* ,for change driven by shifts in culture, structure, and agency. Understanding the roots and consequences of stigma is the first step in disrupting it. Addressing these challenges requires a dual strategy: systemic reform that dismantles exclusionary structures, and cultural transformation that rehumanises and legitimises the voices of those with lived experience. Only through such integrated efforts can we move toward a more compassionate, equitable model of care for individuals with CEMS.

9.6 Agency Challenges

This section examines how individuals with co-existing mental health and substance use difficulties (CEMS), alongside healthcare professionals, navigate and respond to the systemic constraints embedded within the current healthcare system. Drawing on Archer's (1995, 2004) concepts of agency and reflexivity, it foregrounds the active role individuals play ,often in the face of significant structural and cultural barriers. Despite various policy initiatives aiming to promote integration, institutional frameworks and service-level practices continue to reproduce fragmentation, resulting in disjointed treatment pathways, poor communication, and exclusionary access criteria.

Archer's insights into the dynamic interplay between structure, culture, and agency help illuminate the lived tensions within this context. The persistence of siloed services ,where mental health and substance use supports are divided by distinct funding streams, professional cultures, and eligibility thresholds ,was a recurring theme among participants in this study. These findings are echoed in existing literature, including Peterson (2013) and Yule and Kelly (2019), who call for greater investment in integrated care models, interdisciplinary training, and coordinated service delivery to improve continuity and health outcomes.

Beyond structural and institutional failings, the agency of those navigating the system emerges as a pivotal factor. Within Archer's morphogenetic framework, agency refers to the individual's capacity to reflect, make choices, and act upon them in the context of the structural and cultural conditions in which they are embedded. Reflexivity is the internal conversation through which people consider their circumstances and plan their actions. However, when structural fragmentation and cultural contradictions are present, agency may be constrained, co-opted, or forced into adaptation. For individuals with CEMS, agency becomes not just an act of choice, but one of negotiation ,of navigating services that are often poorly aligned with their needs.

The accounts of participants such as LE1, LE4, LE6, LE7, LE8, LE10, and LE12 (Chapter 8) highlight this complexity. These individuals demonstrated proactive engagement ,contacting multiple services, self-referring, advocating for themselves , despite encountering considerable bureaucratic and systemic resistance. Their reflexivity, as conceptualised by Archer (2016), involved ongoing assessment of available options and strategic adaptation to institutional expectations. Yet the options they could realistically pursue were severely limited. This reflects what Archer (2003) describes as the tension between internal deliberation and external constraints ,where individuals' efforts to shape their trajectories are persistently undermined by inflexible service structures and cultural inertia.

Culturally, the healthcare system imposes powerful norms that shape who is deemed "worthy" or "ready" for support. For example, the expectation that individuals must cease substance use before accessing mental health services reflects a procedural norm that privileges abstinence and compliance over person-centred, trauma-informed care. This expectation not only reproduces moralistic assumptions about recovery but also fails to recognise the role of substance use in coping with unaddressed psychological pain. The responses of participants to these norms ranged from disengagement and frustration to strategic adaptation. NSW2, a professional participant, described advising clients to withhold information about substance use in order to avoid exclusion ,a clear example of what Archer might describe as pragmatic reflexivity in response to institutional incoherence. While ethically fraught, this form of “gaming the system” reflects the lived reality of negotiating help within a rigid framework.

Agency in this context has a dual meaning. On one hand, it reveals the resilience and resourcefulness of individuals attempting to make sense of and survive within a fragmented system. On the other, it exposes the limits imposed on that agency by systemic inefficiencies, conflicting service philosophies, and exclusionary thresholds. These constraints often lead to cyclical patterns of engagement and withdrawal: initial attempts to seek help are blocked by inaccessible services, resulting in demoralisation and disengagement, followed by renewed efforts when crises re-emerge. This cycle of approach–rejection–withdrawal reflects what Archer would describe as a disjuncture between reflexive intent and structural possibility ,a mismatch that stifles potential for sustained engagement or transformation.

Importantly, agency is not solely exercised by service users. Professionals also operate within ,and against ,these constraints. The example of NSW2 illustrates how practitioners themselves adapt to systemic shortcomings by bending rules, advising workarounds, and attempting to fill service gaps. While distinct from the lived experiences of individuals with CEMS, this form of professional agency is equally shaped by structural pressures, performance metrics, and risk-averse cultures. The capacity for both users and practitioners to influence their environments, however limited, suggests that morphogenesis is possible, even if incremental.

Indeed, while individual agency is often circumscribed, it can still function as a catalyst for broader cultural and structural change. Participants such as LE11 and LE12, in sharing their stories in research and public forums, engage in what could be understood as transformative reflexivity. By making visible the harms of fragmentation and exclusion, they contribute to shifting dominant narratives and potentially influencing policy, practice, and public perception. In this sense, constrained agency can still seed the conditions for morphogenetic change.

In summary, the analysis of agency in the context of CEMS highlights a complex and often contradictory dynamic. Individuals are not passive recipients of a broken system ,they reflect, act, adapt, and resist. Yet their capacity to shape outcomes is frequently limited by structural rigidity and cultural norms that delegitimise complexity and prioritise conformity. Understanding this interplay is vital for informing more responsive, integrated models of care. As the next section will demonstrate, applying Archer's full morphogenetic cycle (T1–T4) provides a deeper understanding of how these dynamics unfold over time, and where opportunities for meaningful systemic transformation may arise.

9.7 Application of Archer's Morphogenetic Framework

This section will now analyse the challenges faced by individuals with CEMS through the lens of Archer's (1995) morphogenetic framework. It will draw on data from across the thesis, both current and historical, to critically examine structural and cultural issues such as service fragmentation, financial constraints, stigma, discrimination, and the impact of neoliberal ideologies. This analysis builds upon the foundational discussion in Section 4.3, providing a deeper understanding of how these factors shape the experiences and outcomes of individuals with CEMS.

9.8 T1: Structural and Cultural Conditioning

The historical development of mental health and substance use treatment systems has laid the groundwork for structural and cultural conditions that continue to constrain the experiences and outcomes of individuals with CEMS. From the perspective of T1 in Archer's (1995) morphogenetic framework ,where pre-existing structures and cultural systems shape the conditions within which agents operate ,it is evident that contemporary services, policies, and discourses are still shaped by long-standing legacies of fragmentation, stigma, and reductionism. Despite successive policy reforms and theoretical advancements, the present landscape often replicates past inadequacies, signalling not meaningful transformation but the reproduction of deep-seated systemic flaws.

A key structural barrier at T1 is the persistent fragmentation of services, intensified by the Health and Social Care Act (HSCA) 2012. By transferring commissioning responsibilities for substance use services from the NHS to local authorities, the Act embedded a patchwork approach that has resulted in significant geographical variability in access and quality of care. The disaggregation of commissioning structures has undermined the principles of integration enshrined in earlier guidance, such as the 2002 and 2009 Dual Diagnosis Policy Implementation Guides (PIGs), and the 2017 refresh (Christie, 2017). These documents advocated for a 'no wrong door' approach, yet the implementation has been hindered by fragmented governance, siloed funding streams, and inconsistent accountability across local systems.

Financial constraints further exacerbate this fragmentation. Sustained austerity era cuts to mental health and substance use services have reduced not only the availability of support but also the capacity for innovation, cross-training, and collaborative working. Despite rhetorical commitments to parity of esteem, frontline services remain overstretched and underfunded, with staff unable to meet complex needs within disjointed systems (Pinderup, 2018). The gap between policy aspiration and practice on the ground reflects a failure of operational coherence, often leaving individuals with CEMS excluded from both services ,perpetuating the very disconnection that integration policies sought to resolve.

Culturally, stigma and discrimination remain powerful conditioning forces. They manifest in public discourse, clinical practice, and institutional culture, reinforcing harmful assumptions that individuals must achieve abstinence before accessing mental health support (Van Hagen *et al.*, 2019). This gatekeeping logic, shaped by moralising narratives, undermines the ethos of person-centred care and deters individuals from seeking help. For many, fear of judgment ,by professionals, family, or society ,acts as a deterrent to service engagement, especially where services are perceived to be punitive or dismissive.

These experiences disproportionately affect individuals from already marginalised groups, including those facing poverty, racialised disadvantage, or gendered forms of exclusion, adding an intersectional dimension to the structural inequalities embedded in the system.

Neoliberal ideology has further entrenched these cultural conditions by promoting discourses of personal responsibility, individual blame, and marketised service provision (Holland, 2020). Within this framework, mental distress and substance use are framed not as social or structural issues, but as failures of individual resilience or moral character. This logic locates responsibility for recovery within the individual while deflecting scrutiny from the social determinants of health ,such as homelessness, unemployment, or trauma. Consequently, individuals with CEMS are expected to self-manage complex conditions across fragmented systems, despite being among the most structurally disadvantaged. The result is a model of care that is reactive, exclusionary, and increasingly punitive.

The criminalisation of substance use under neoliberal governance exemplifies this punitive logic. The Misuse of Drugs Act 1971, despite being widely discredited, remains a cornerstone of UK drug policy. As Crome et al. (2022) argue, it represents one of the most harmful pieces of social legislation still in force, codifying a legal framework that prioritises punishment over harm reduction or support. This policy orientation reinforces stigma, deters help-seeking, and ensures that many individuals with substance use difficulties remain entangled in the criminal justice system rather than receiving appropriate health and social care. The law thus acts not as a protective measure but as a structural mechanism of exclusion.

The dominance of the medical model also forms part of the structural conditioning at T1. Rooted in biomedical reductionism, this model continues to shape how both mental health and addiction are understood, often to the exclusion of psychological, social, and cultural dimensions. While biological interventions have their place, the overreliance on psychiatric diagnosis and pharmacological treatment obscures the complexity of lived experience. In CEMS contexts, this has led to a binary logic where services focus exclusively on either the ‘mental illness’ or the ‘addiction’, rather than the person as a whole. Such reductionism is not only clinically inadequate ,but it also reproduces the institutional separation that has historically marginalised individuals with CEMS.

When viewed historically, these enduring structural and cultural conditions echo past patterns of exclusion and medical neglect. The autobiographical work of De Quincey, (1821) vividly illustrates how stigmatising attitudes and reductive responses to addiction were already present in the early 19th century. De Quincey’s experience reflects a society that failed to recognise the interwoven nature of pain, trauma, and substance use ,much like today. While scientific understanding and clinical language have evolved, the fundamental challenge of how society positions and supports individuals with cooccurring difficulties has remained largely static.

From a T1 perspective, it is clear that individuals with CEMS enter a landscape heavily conditioned by institutional fragmentation, cultural stigma, punitive legislation, and ideological frameworks that delegitimise complexity. These enduring structural and cultural arrangements set the parameters within which both individuals and professionals must act. They shape the possibilities for agency, constrain service innovation, and entrench systemic inequalities. Without a fundamental shift in these conditioning forces, meaningful progress toward integrated, person-centred care will remain elusive.

In summary, the T1 phase highlights the powerful legacy of structural and cultural conditioning in shaping the landscape of CEMS care. It reveals how policy, ideology, and institutional culture continue to reproduce fragmentation, exclusion, and inequality.

Recognising these conditions is essential if we are to understand why so many well-intentioned reforms have failed ,and what must change to enable morphogenetic transformation. The subsequent sections will examine how agents (both individuals with CEMS and professionals) respond to these constraints during T2–T3 and what potential exists at T4 for structural and cultural elaboration.

9.9 T2-T3: Social Interaction

In examining the period of T2–T3 within Archer's (1995) morphogenetic framework, we focus on the stage in which social interactions are shaped by, and in turn shape, the structural and cultural conditions established during T1. It is at this phase that agents ,both service users and professionals ,interact with the realities of service fragmentation, financial austerity, stigma, and neoliberal ideology. These interactions either reinforce morphostasis or begin to create conditions for morphogenesis. The experiences of individuals with CEMS during this phase illustrate how historical legacies and contemporary systemic arrangements manifest in everyday practice, often with harmful consequences.

During T2, the tangible effects of structural and cultural conditioning become evident in the daily lives of individuals with CEMS. The fragmentation of services , produced in part by policy reforms such as the HSCA 2012 ,forces individuals to navigate multiple, often contradictory, systems of care. One service may provide mental health support, another may offer substance use treatment, but rarely do these services communicate effectively or operate with shared goals. Service users are bounced between disconnected providers, with each agency addressing only a fragment of their needs. This lack of continuity results in incomplete or contradictory interventions, leaving individuals vulnerable to disengagement and worsening health outcomes. These fragmented interactions not only diminish care quality but erode trust in services, reinforcing a cycle of unmet need and chronic crisis.

Stigma and discrimination, also conditioned by the T1 context, further complicate these interactions. Many healthcare professionals ,socialised within a risk-averse, medicalised culture ,internalise deficit-based understandings of individuals with CEMS. The reductive influence of the medical model encourages a narrow focus on diagnostic categories and personal compliance, often at the expense of relational and trauma-informed approaches. In practice, this can manifest as judgemental attitudes, exclusionary criteria, or therapeutic nihilism. For example, a participant may be told to address their substance use before being eligible for mental health support ,a message that implicitly blames the individual and fails to recognise the self-medication dynamic underpinning many co-occurring conditions. Such interactions compound feelings of shame, reduce help-seeking behaviours, and deepen cycles of marginalisation.

Neoliberal ideology reinforces these cultural dynamics by promoting an ethic of personal responsibility, individualism, and market-based logic. In healthcare settings, this results in a system that demands service users become their own case managers ,self-navigating referrals, advocating for eligibility, and meeting procedural thresholds. For individuals with CEMS ,many of whom experience poverty, trauma, and fluctuating mental health ,this expectation is both unrealistic and harmful. The system's refusal to account for broader social determinants such as housing instability, unemployment, and social exclusion entrenches structural disadvantage while rhetorically locating failure at the individual level. This moralisation of need is not simply a discursive issue ,it has material consequences, as support is withheld from those who cannot demonstrate

“readiness” or “recovery capital” in line with narrow commissioning frameworks.

The agency of professionals within this context must also be considered. Healthcare workers face significant systemic pressures ,high caseloads, chronic underfunding, and competing organisational priorities ,that limit their capacity to provide holistic, compassionate care. Burnout among professionals is common, particularly in under-resourced services dealing with complex presentations. This leads to high staff turnover, reduced continuity of care, and an erosion of professional morale. In some cases, practitioners attempt to subvert or bypass harmful system logics ,such as advising clients to underreport substance use to secure access to mental health services ,but these acts of resistance are constrained by institutional risk management cultures and fear of regulatory sanction. Thus, the agency of professionals is also shaped and limited by the same morphostatic structures that constrain service users.

Intersectional factors exacerbate these challenges. People of colour, women, LGBTQ+ individuals, and those from lower socioeconomic backgrounds often face compounded barriers due to systemic biases and lack of culturally appropriate services. For instance, the stigma faced by a young Black man with a dual diagnosis may intersect with racialised narratives of criminality, making engagement with services even more fraught. These experiences further highlight how structural and cultural forces differentially shape agency, often intensifying disadvantage and producing inequitable outcomes across groups.

The cumulative result of these social interactions is a service environment characterised by mistrust, disengagement, and cyclical crisis. Individuals with CEMS often move between periods of contact and avoidance, with support sought only at points of acute need. This reactive model fails to support recovery in any meaningful sense. Moreover, the emphasis on individual change, disconnected from social and structural realities, renders lasting transformation elusive. Without system-level responsiveness to the complexities of co-existing conditions, the T2–T3 stage becomes one of frustrated reflexivity ,where agents are aware of their constraints but unable to meaningfully alter them.

In summary, the T2–T3 phase reveals how the structural and cultural conditioning of T1 is reproduced through everyday interactions between service users, professionals, and institutions. Fragmented services, austerity, stigma, and neoliberal policy combine to produce a constrained field of action where both service users and providers must operate tactically, rather than transformatively. These interactions serve to maintain morphostasis, unless new logics ,grounded in empathy, integration, and structural reform ,are introduced. The next phase, T4, will consider the conditions under which such reform might emerge and how structural and cultural elaboration can begin to disrupt cycles of exclusion and fragmentation.

9.10 T4: Structural and Cultural Elaboration

The T4 phase, in Archer's morphogenetic framework, marks the point at which the cumulative effects of structural conditioning (T1) and the social interactions that unfold during T2–T3 result in either the reproduction of existing norms (morphostasis) or the elaboration of new ones (morphogenesis). For individuals with CEMS, this phase represents a critical juncture: the possibility of genuine transformation, or the entrenchment of long-standing systemic failures.

The persistent fragmentation of services and ongoing financial constraints exemplify the morphostatic tendencies that dominate the current healthcare landscape. Despite decades of policy rhetoric promoting integration, the structural disarticulation caused by reforms such as the Health and Social Care Act 2012 continues to manifest as inconsistent service provision, geographical disparities, and administrative confusion. These conditions reinforce siloed care and limit the potential for coordinated interventions. For morphogenesis to occur, policymakers and commissioners must move beyond surface-level reforms and invest in truly integrated, trauma-informed care pathways that are not only theoretically sound but operationally resourced and equitably accessible.

The need for structural realignment is inseparable from the requirement for cultural transformation. As demonstrated in T2–T3, stigma ,both societal and institutional ,continues to influence how individuals with CEMS are perceived and treated. The pervasive belief that individuals must be ‘clean’ before accessing mental health services, or that substance use is solely a matter of personal choice, must be actively dismantled. Tackling these entrenched narratives requires multi-level action: comprehensive public education campaigns to challenge misconceptions; clinical training programmes that promote compassion over compliance; and the inclusion of lived experience voices in service design and policy development. Unless the cultural infrastructure of care is reoriented toward dignity and inclusion, structural reforms alone will be insufficient.

Equally important is the challenge posed by the enduring dominance of the medical model. As discussed in earlier sections, the reduction of CEMS to biological pathologies obscures the social, psychological, and relational dimensions of distress. At T4, structural elaboration must include the development and legitimisation of alternative paradigms ,holistic models that integrate biopsychosocial approaches and embrace complexity rather than pathologise it. Treatment planning should account for the impact of trauma, poverty, housing instability, and discrimination ,not as peripheral issues but as central determinants of recovery. This shift requires institutional willingness to cede power, reallocate funding, and embrace cross-sectoral collaboration.

Furthermore, a serious reckoning with the effects of neoliberal ideology is essential to any transformative project. As shown in T1 and T2–T3, neoliberalism has embedded a culture of responsibilisation within mental health and substance use services ,an ethos that frames distress as an individual failing and recovery as a matter of personal motivation (Brown *et al.*, 2022). This has enabled the withdrawal of state support, encouraged punitive policy responses (e.g. the Misuse of Drugs Act 1971), and normalised service criteria that exclude those deemed non-compliant or high risk. Structural elaboration at T4 must therefore include a broader political and economic shift ,one that reasserts the role of the state in protecting health equity and recognises the social determinants of health as central to effective intervention. Policies must move beyond individual-level fixes to address systemic causes of harm, including poverty, racism, gender-based violence, and structural inequality.

Importantly, this phase must also be shaped by reflexive agency ,both from service users and professionals. The public sharing of lived experience (as exemplified by participants in this study) offers a mechanism through which dominant narratives can be contested and new cultural logics introduced. When these voices are elevated in research, service design, and policy consultation, they provide powerful counternarratives that reframe addiction and mental health as responses to social pain rather than symptoms of pathology. Similarly, professionals who resist exclusionary practices, advocate for systemic change, or engage in collaborative, person-centred care contribute to a cultural shift that may precipitate broader institutional transformation. Though incremental and often constrained, these expressions of agency are essential drivers of morphogenesis.

The historical resonance with figures like Thomas De Quincey remains instructive. Despite advances in pharmacology, diagnostic sophistication, and service architecture, the underlying issues that plagued De Quincey ,stigma, neglect, and the absence of integrated care ,persist in modern form. This continuity underscores the importance of rejecting superficial change in favour of deep, structural and cultural reform. De Quincey's narrative, positioned as both confession and critique, mirrors the experiences of many contemporary service users who must navigate systems that continue to misunderstand or reject them.

Ultimately, the T4 phase encapsulates both the risks of inertia and the promise of transformation. If the lessons of history and the insights of those with lived experience are acted upon, there exists the potential to reshape the healthcare landscape into one that is more inclusive, responsive, and humane. However, without a deliberate and coordinated effort to dismantle structural silos, challenge cultural stigma, and reframe the ideological underpinnings of care, the system is likely to reproduce itself ,failing yet another generation of individuals with CEMS.

In conclusion, structural and cultural elaboration is not merely about service redesign or improved funding mechanisms. It is about fundamentally reimagining the values, priorities, and power structures that govern how society responds to co-existing mental health and substance use challenges. True morphogenesis will require courage, collaboration, and sustained commitment across all levels of the system.

9.11 Diagnosing the Persistence of Morphostasis in CEMS Care

The previous analysis of T1 to T4 has illustrated how co-existing mental health and substance use (CEMS) care remains embedded in a structurally and culturally static system. Despite decades of policy documents, research insights, and increasing public discourse on integration, the lived reality for individuals with CEMS remains one of systemic fragmentation, cultural marginalisation, and inadequate support. This section draws these threads together to argue that the field has become locked in a state of *morphostasis* ,a condition of apparent change that leaves underlying structures, ideologies, and practices intact.

This persistent morphostasis is not simply the result of policy neglect, but the outcome of a self-reinforcing system in which structural inertia, professional silos, and cultural narratives mutually reinforce one another. Policy documents from the 2000s onwards, including the Dual Diagnosis Policy Implementation Guide (PIGs), have repeatedly called for integrated care pathways and “no wrong door” approaches. However, implementation has been inconsistent, underfunded, and undermined by structural contradictions ,particularly those introduced by the Health and Social Care Act 2012, which fragmented commissioning across mental health and substance use services. Localised interpretations of national policy, coupled with variable political will and chronic underinvestment, have ensured that even the most well-intentioned initiatives have failed to gain meaningful traction.

Moreover, reform efforts have been stymied by a mismatch between the scale of the problem and the nature of the solutions offered. Many integration policies have adopted a technical or procedural focus ,calling for better communication, co-location of teams, or streamlined referrals ,without addressing the deeper cultural, epistemological, and ideological divisions that underpin service silos. The dominance of the medical model, for example, has privileged a biological framing of distress, which remains largely incompatible with the social, trauma-informed paradigms emerging within substance use practice. These paradigmatic tensions inhibit collaborative working, reinforce professional hierarchies, and lead to services that are ill-suited to meet the complexity of CEMS presentations.

Culturally, the persistence of stigma and the influence of neoliberal ideology have further entrenched morphostasis. Public and professional narratives continue to frame substance use and mental distress as matters of personal responsibility, reinforcing punitive attitudes and undermining efforts to adopt person-centred, non-judgemental approaches. Neoliberal rationalities have reframed structural deficits ,such as housing instability, poverty, or adverse childhood experiences ,as individual failings to be managed through behavioural compliance. Within this ideological context, the very notion of “complex needs” becomes problematic, viewed not as a call for more nuanced care, but as a reason for exclusion.

Critically, even where examples of innovation exist, they remain isolated and precarious ,dependent on local champions, short-term funding, or pilot status. There is little evidence that such efforts have led to systemic transformation or wider adoption.

Instead, services continue to operate within the same constrained logics and institutional frameworks. This reflects a broader phenomenon in public service reform, where change is often rhetorical rather than material ,policies evolve on paper, but practice remains shaped by historical legacies and institutional risk aversion.

This enduring disconnect between policy ambition and practice reality reflects what this research terms the 'morphostasis trap': a cyclical pattern in which partial reforms fail to disrupt the deeper mechanisms that sustain fragmentation and marginalisation. Within this trap, reflexive agents ,whether service users, professionals, or policymakers ,may be aware of the system's failings but lack the structural capacity or cultural mandate to enact change. Their agency is constrained by organisational pressures, risk-driven cultures, and the lack of shared frameworks for understanding and addressing co-occurring conditions.

To move beyond this trap, a fundamentally different approach is needed ,one that aligns with the principles of *morphogenesis*. Such an approach must not only reconfigure structural arrangements but also transform the cultural logics and institutional assumptions that shape care delivery. It must foster collaboration across professional domains, empower service users as active participants in their own care, and respond meaningfully to the social and relational dimensions of CEMS. In short, it must create the conditions under which integrated, holistic, and humane care can flourish ,not just in isolated projects, but across the system as a whole.

This thesis therefore concludes that the limitations of past reforms cannot be addressed by incremental adjustments or rhetorical commitments to integration. What is required is a new model of care ,one that is grounded in the lived realities of those with CEMS, supported by structural and cultural reform, and designed to promote long-term, relationally oriented recovery. The next chapter introduces the Integrated Morphogenetic Care Model (IMCM)**,** a framework developed in direct response to the failures outlined in this thesis. Drawing on the morphogenetic approach, it offers a practical and theoretical roadmap for achieving structural flexibility, cultural transformation, and enhanced agency within CEMS care.

9.12 Summary

The analysis in this chapter has shown that the fragmentation of CEMS care is not an accidental by-product but the predictable result of entrenched structures and enduring cultural logics. Despite successive policy documents advocating integration, the disaggregation of commissioning, the dominance of abstinence as a gatekeeping criterion, and chronic underinvestment have preserved a system that delivers piecemeal responses to complex needs. Archer's framework makes visible how these conditions are set at T1 by policy and ideology, enacted and reinforced at T2–T3 in daily encounters, and rarely disrupted at T4, where elaboration is consistently blocked by morphostatic pressures.

Stigma remains a powerful cultural force, shaping not only how individuals with CEMS are perceived but also how services justify exclusion. Neoliberal narratives of personal responsibility, amplified by punitive legislation such as the Misuse of Drugs Act 1971, further displace attention from the structural determinants of health and entrench moralising approaches. Professionals, meanwhile, navigate heavy caseloads and institutional contradictions, sometimes subverting rules to secure access for service users, but more often succumbing to burnout in a system that punishes complexity. Service users respond with persistence, avoidance, or resignation, their agency circumscribed by structures that demand tidiness before offering help.

What emerges is a picture of morphostasis: a system in which the surface of reform shifts but the core logic remains untouched. Pilot projects and local innovations show that alternatives are possible, but they remain fragile, dependent on champions and short-term funding. Without structural realignment, cultural transformation, and ideological challenge, the cycle of exclusion will continue. The chapter therefore concludes that meaningful change requires a deliberate break with morphostatic repetition, creating conditions in which integration is not rhetorical but lived. Chapter 10 responds to this challenge by introducing the Integrated Morphogenetic Care Model (IMCM), a framework designed to provide both the theoretical and practical basis for systemic transformation.

This chapter advances the study's central aim by making visible the systemic barriers that explain why individuals with CEMS experience exclusion, relapse, and disengagement when seeking support. It deepens the exploration of stigma and discrimination by showing how these are embedded in institutional cultures, legal frameworks, and commissioning structures, rather than confined to individual prejudice. It clarifies the difficulties encountered by people with lived experience by linking their narratives of being bounced between services, denied access for using substances, or refused housing after prison, to the broader morphogenetic forces that structure those outcomes. It also addresses the objective of generating evidence of systemic limitations in provision by demonstrating, through interview data and theoretical analysis, how siloed funding, inadequate workforce training, and fragmented commissioning lock services into cycles of inefficiency. Finally, by situating both user and practitioner agency within a morphogenetic analysis, the chapter points towards possible solutions integrated models, trauma-informed practice, and structural flexibility that will be developed in Chapter 10. In this way, Chapter 9 translates the personal costs of fragmentation into a systemic diagnosis, preparing the ground for the model of reform proposed in the final substantive chapter.

10. An Integrated Morphogenetic Care Model

This chapter introduces the Integrated Morphogenetic Care Model (IMCM), the thesis's original contribution to knowledge and practice. It arises directly from the systemic failings mapped in Chapter 6, the lived experiences detailed in Chapters 7 and 8, and the structural and cultural analysis of Chapter 9. Where previous chapters showed fragmentation as entrenched morphostasis, the IMCM offers a pathway to morphogenesis: structural flexibility, cultural change, and enhanced agency.

The IMCM is designed not as an abstract blueprint but as a framework that bridges theory and practice. Grounded in Archer's morphogenetic approach, it recognises that services do not exist in a vacuum; they are embedded in structural legacies, cultural narratives, and lived realities. By aligning health care, social determinants, and service-user agency, the IMCM aims to reconfigure service delivery into an integrated ecosystem that adapts to context while remaining faithful to core principles of dignity, continuity, and justice.

This chapter outlines the theoretical underpinnings of the IMCM, details its core components, and demonstrates its feasibility through practical pathways, cost-consequence analysis, and a case study. It also addresses the likely points of resistance, situating them not as signs of failure but as the very conditions that must be confronted if systemic transformation is to occur. In doing so, the chapter sets out the IMCM not just as a model, but as a moral and structural claim: that those with CEMS deserve care systems capable of recognising complexity, sustaining connection, and enabling recovery.

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10.1 Structural Flexibility and Evolution

At the heart of the Integrated Morphogenetic Care Model (IMCM) lies the principle of structural flexibility and evolution ,the capacity of health and social care systems to adapt meaningfully and responsively to the changing needs of individuals with CEMS and broader societal transformations. Rooted in Archer's (1995) morphogenetic framework, this approach acknowledges that both individual experiences and the sociopolitical context in which care is delivered are dynamic. Therefore, the system must possess the ability to undergo morphogenesis ,a process of structural and cultural elaboration ,rather than remaining trapped in morphostasis.

The foundation of this model is built on values of inclusivity, holistic care, and user-centred design, ensuring that individuals can access appropriate support regardless of their point of entry into the system. It advocates for the dismantling of institutional silos through the creation of formal partnerships across multiple sectors: healthcare, mental health, substance use treatment, housing, employment, social services, the criminal justice system, and voluntary and community organisations. Such cross-sector integration is essential to delivering a seamless continuum of care that reflects the complex and interconnected realities of people's lives.

To translate this theoretical foundation into practice, the IMCM proposes the establishment of Integrated Care Networks (ICNs) **,**flexible, localised structures designed to respond rapidly to shifting needs. These networks would operate on a modular basis, allowing services and teams to be reconfigured without undermining the integrity or continuity of care. This design enables services to be expanded, contracted, or adjusted in response to emergent challenges or new evidence, without the need for costly or destabilising system overhauls.

A key feature of structural flexibility is the decentralisation of decision-making to local units, empowering frontline professionals to act on real-time knowledge of service user needs and local contexts. This approach promotes quicker, more tailored responses, avoiding the bottlenecks and delays often associated with top-down bureaucratic governance. It is supported by the development of an integrated data system that captures service-level information across domains, enabling continuous feedback, outcome monitoring, and informed resource allocation.

To ensure cohesion across a decentralised system, a cross-sectoral coordination body is proposed. This body would facilitate strategic alignment, ensuring that all sectors operate toward shared objectives, standards, and performance measures. Its remit would include overseeing data integration, promoting shared care pathways, and supporting professional development across sectors.

Equally essential is the introduction of flexible funding models that allow for pooled budgets and dynamic resource allocation. Rigid, siloed funding streams frequently inhibit collaborative working and reinforce service fragmentation. In contrast, a more agile funding structure ,responsive to changing priorities and local needs ,can support the adaptability and responsiveness central to the IMCM’s design.

Underpinning this entire system is a commitment to policy and organisational adaptability. Policies governing CEMS care must be subject to regular review and coproduced with a broad range of stakeholders, including people with lived experience. This not only ensures relevance and legitimacy but fosters a policy environment that supports innovation and responsiveness. Likewise, the model promotes a culture of professional development and interdisciplinary learning, enabling staff to reflect on practice, share learning across disciplines, and respond effectively to evolving challenges.

In line with Laker's (2006) critique of legal and ethical inconsistencies in mental health and substance use services, the IMCM also addresses disparities in consent**,** participation rights, and legal frameworks. These inconsistencies can obstruct access to integrated care and result in contradictory practices across services. The IMCM advocates for harmonised legal and ethical standards that respect the distinct nature of each domain while recognising their deep interconnection. Reforming these frameworks is essential for delivering coherent, ethically sound care that honours both autonomy and need.

In sum, structural flexibility within the IMCM is not simply about allowing the system to bend ,it is about enabling purposeful, intelligent evolution. By designing care infrastructures that are modular, decentralised, integrated, and responsive, the IMCM lays the foundation for a service system that can learn, adapt, and transform ,facilitating sustained improvement rather than temporary reform.

10.2 Deep Integration of Social Determinants

A central pillar of the Integrated Morphogenetic Care Model (IMCM) is the deep integration of social determinants of health into all aspects of service delivery. The model recognises that the well-being of individuals with co-existing mental health and substance use challenges (CEMS) is shaped not only by clinical factors but also by the broader socioeconomic, environmental, and cultural conditions in which people live. Health behaviours and outcomes are inextricably linked to these social determinants ,such as housing security, income stability, educational access, employment opportunities, social support, and exposure to violence or discrimination ,none of which can be meaningfully addressed in isolation.

Despite growing policy recognition of the importance of social determinants, implementation across health systems remains uneven. Buzelli et al. (2022) highlight that while the NHS increasingly acknowledges these wider influences on health, there remains a lack of clear, actionable strategies to embed them within everyday care. Social prescribing, for example, has gained traction in recent years, but without the structural reform necessary to support broader interventions and intersectoral partnerships, its impact is limited. The IMCM addresses this policy-practice gap by embedding the social determinants of health as a structural and operational component of care, rather than an adjunct or referral pathway.

The model begins with a comprehensive and holistic assessment process that actively considers the full context of a person's life. Practitioners are trained not only to diagnose and treat mental health and substance use conditions, but also to identify social risk factors and protective assets that influence recovery. These include housing instability, unemployment, social isolation, experiences of trauma or discrimination, and other intersecting structural inequalities. Assessments are used to develop personalised care plans that integrate clinical support with targeted interventions aimed at mitigating these social challenges. The intention is to ensure that care addresses both symptoms and systems, allowing individuals to recover within environments that support rather than undermine their well-being.

Community-based interventions are a central feature of this approach. Initiatives such as supported housing programmes provide the stability necessary for individuals to engage with services and sustain recovery. Similarly, employment-focused interventions, including job training and placement support, enhance financial independence and social inclusion ,two crucial elements in reducing reliance on substances and improving psychological health. These interventions are not ancillary to treatment but integral to addressing the conditions that drive and sustain co-occurring difficulties.

In addition to service-based responses, the IMCM places significant emphasis on community engagement. Building socially cohesive, inclusive, and responsive communities is critical in mitigating the isolation and stigma frequently experienced by individuals with CEMS. This is achieved through the creation of peer support networks, community centres, and opportunities for civic participation that not only enhance service engagement but promote belonging and dignity. Engaging local stakeholders in the design and delivery of these initiatives ensures cultural relevance and enhances sustainability, making interventions more effective and contextually attuned.

However, deep integration of social determinants also requires structural change at the policy level. The IMCM positions healthcare providers not only as service deliverers but as advocates for systemic reform. This includes collaboration with policymakers to shape policies that reduce health inequalities ,such as those promoting affordable housing, quality education, fair employment practices, and anti-discrimination legislation. By working across sectors, health and social care systems can help shift the conditions that give rise to CEMS, rather than simply responding to their consequences.

Operationally, this requires a reconfiguration of service delivery structures. The IMCM envisions a coordinated system in which mental health services, substance use treatment, housing agencies, employment services, and community organisations work together within Integrated Care Networks. These networks facilitate seamless communication, coordinated care planning, and shared accountability for outcomes, enabling individuals to move between services without falling through the gaps. Such collaboration is not optional ;it is fundamental to the model’s design and necessary for ensuring continuity of care across the full spectrum of an individual’s needs.

To achieve this level of integration, workforce development is essential. Practitioners must be supported to develop the competencies needed to operate within an interdisciplinary, context-sensitive care model. This includes training in cultural humility, trauma-informed care, and structural awareness ,ensuring that professionals understand the social dimensions of health and are equipped to address them in practice. Organisational cultures must value this learning, promote reflective practice, and embed opportunities for collaboration across disciplinary and sectoral boundaries.

In conclusion, the deep integration of social determinants within the IMCM represents a fundamental shift in how health and social care for individuals with CEMS is conceptualised and delivered. Rather than treating social factors as external to clinical care, the model recognises them as central to both the origins of distress and the possibilities for recovery. By embedding these determinants into assessment, intervention, and advocacy, the IMCM offers a robust and socially responsive framework ,one that seeks not only to improve individual outcomes but to foster broader social change. In doing so, it advances a vision of care that is equitable, holistic, and capable of addressing the layered realities of co-existing mental health and substance use challenges.

10.3 Enhancing Agency within Structural Constraints

A critical function of the Integrated Morphogenetic Care Model (IMCM) is to enhance the agency of individuals with CEMS within the structural and cultural constraints that shape their lives. Drawing on Archer's (2003) concept of agency as a temporally situated, reflexive process, this stage of the model seeks to empower individuals not by denying the existence of constraints, but by enabling meaningful action within them. Enhancing agency is not simply about individual empowerment ,it is about creating the conditions under which individuals can participate actively and autonomously in decisions about their care and thereby exercise influence over their trajectories.

Central to this approach is the development of personalised care pathways that reflect the unique circumstances, histories, and aspirations of each individual. Personalisation moves beyond standardised service templates by recognising that each person engages with systems of care through their own reflexive lens, informed by prior experiences, cultural identity, and practical concerns. Collaboratively developed care plans, co-produced by service users and professionals, help establish realistic, meaningful goals and foster a sense of ownership over the recovery process. This collaborative dynamic enhances motivation, strengthens the therapeutic alliance, and supports continuity of care.

Education also plays a vital role in strengthening agency. Access to accurate, comprehensible, and relevant information about diagnoses, treatment options, potential outcomes, and available services allows individuals to make informed decisions and navigate care systems more confidently. Educational interventions should be responsive to different levels of health literacy and delivered through multiple formats ,including one-to-one sessions, group workshops, and peer-led discussions ,to ensure accessibility. Informed decision-making is a cornerstone of autonomy, and the IMCM positions education not as an add-on but as an integral component of care delivery.

An additional and highly effective strategy for enhancing agency is the integration of peer support networks**.** Peer supporters ,individuals with lived experience of CEMS , offer practical guidance, emotional reassurance, and relational credibility that traditional service providers often struggle to provide. Their presence not only validates the experiences of service users but actively counters stigma, offering visible evidence that recovery is possible. As noted by Tracy and Wallace (2016), peer support has been linked to increased treatment engagement, improved self-efficacy, and stronger social connectedness. By fostering a sense of solidarity and mutual understanding, peer networks contribute to the reconstitution of identity, particularly for individuals whose experiences of services have been marked by exclusion or trauma.

The IMCM also incorporates service-user feedback mechanisms to ensure that individuals are not merely recipients of care, but active contributors to its development. Regular opportunities to provide feedback ,through structured interviews, focus groups, or anonymous surveys ,are vital to service responsiveness and quality improvement. These mechanisms support a culture of mutual respect, signalling to service users that their insights are valued and their experiences taken seriously. More than a procedural gesture, this feedback loop is embedded in the model’s reflexive ethos, reinforcing the idea that system learning must be informed by lived experience.

Yet the ability to act with agency is contingent on more than individual disposition ,it is also shaped by broader structural barriers. Therefore, enhancing agency also necessitates policy and advocacy efforts aimed at removing systemic obstacles to care.

These may include reforming eligibility criteria that exclude individuals who are actively using substances, increasing investment in community-based services, or reducing the stigma that surrounds both mental illness and substance use. Providers working within the IMCM are encouraged to advocate for equitable access to services and to challenge discriminatory practices at both organisational and policy levels.

Special attention must also be given to marginalised populations who face compounded layers of structural oppression. Individuals experiencing homelessness, those from racially minoritised communities, people with disabilities, and those living in poverty often encounter multiple and intersecting barriers to accessing care. Tailored interventions are essential to reaching these populations. For example, mobile outreach teams may be needed to engage rough sleepers, while culturally competent care pathways should be designed in collaboration with local communities to ensure relevance and trust. Without these targeted approaches, efforts to enhance agency risk reproducing inequalities by privileging those already more able to engage.

Within the prison system, the IMCM envisions a distinctive application of agency enhancement. In this setting, where autonomy is profoundly constrained, promoting agency means creating structured opportunities for incarcerated individuals to engage in education, therapeutic programmes, and vocational training that support reintegration post-release. By enabling individuals to make decisions, set goals, and envision a life beyond incarceration, such interventions help mitigate the disempowering effects of institutionalisation and reduce recidivism.

Delivering these interventions effectively requires a multidisciplinary approach. No single profession can adequately address the multifaceted needs of individuals with

CEMS. Collaboration between mental health professionals, substance use specialists, social workers, legal advisors, housing officers, and educators is essential. Interdisciplinary teams facilitate more coherent and holistic responses, supporting service users not only with their immediate clinical needs but with the broader challenges that affect their capacity to exercise agency in the long term.

In conclusion, enhancing agency within the IMCM is not a standalone task, nor is it reducible to individual resilience or motivation. It is a deliberate, system-wide strategy that operates across care planning, education, peer support, advocacy, and service design. By embedding agency enhancement into its core, the IMCM acknowledges that meaningful change requires both personal engagement and structural support. In doing so, it aligns recovery with dignity, autonomy, and empowerment ,moving away from models that position service users as passive recipients and towards a future in which they are recognised as active participants in their own recovery journeys.

10.4 Contextualised Care for Special Environments

While the previous section of the IMCM outlined strategies for enhancing agency within structural constraints, this stage focuses specifically on how these strategies must be adapted for special environments ,settings where individuals with co-existing mental health and substance use difficulties (CEMS) face heightened barriers to care. These include, but are not limited to, prisons, homeless hubs, and rural or remote areas. Such contexts demand not only responsive, integrated service models, but also nuanced understandings of how systemic exclusion and environmental conditions shape both care needs and the possibility of recovery.

The IMCM acknowledges that structural constraints in these environments are often more acute and entrenched than in standard community settings. Consequently, while the principles of personalised, trauma-informed, and interdisciplinary care outlined in Section 10.3 remain foundational, they must be contextualised and operationalised differently to ensure meaningful impact in these settings.

Prisons and Post-Release Transitions

Within prison systems, individuals with CEMS are subject to extreme constraints on autonomy and access. Incarceration often exacerbates both mental health and substance use issues, while institutional conditions ,including rigid routines, social isolation, and limited specialist services ,undermine therapeutic engagement. The IMCM addresses this by advocating for comprehensive, in-prison care programmes that are fully integrated with general healthcare and involve multidisciplinary teams composed of mental health practitioners, substance use specialists, and medical personnel. In addition, prison officers should receive specific training to identify and respond appropriately to CEMS presentations.

Critical to the model is the development of individualised care plans within the prison setting, with a strong emphasis on continuity beyond incarceration. Transition planning should begin well in advance of release and be conducted collaboratively with community-based providers to secure housing, employment support, and ongoing health and peer-based services. Strengthening the bridge between prison-based care and post release systems can reduce the risk of relapse, re-offending, and homelessness, and promote long-term stability.

Homelessness and Transitional Housing

Individuals experiencing homelessness encounter intersecting disadvantages, including chronic poverty, unstable housing, unmet healthcare needs, and high exposure to trauma. These structural inequalities are not just background conditions ;they are central to the development and persistence of co-occurring conditions. (Adams *et al.*, 2022). Within homeless shelters and transitional accommodation, the IMCM advocates for an immediate focus on basic needs ,safe housing, food, and access to urgent healthcare ,followed by a gradual extension into mental health and substance use interventions.

To overcome accessibility barriers, outreach-based models of care are essential. Multidisciplinary teams ,comprised of mental health professionals, substance use professionals, social workers, and general medical staff ,should deliver services within hubs or via mobile clinics, ensuring proximity and responsiveness. Trauma-informed practice is especially crucial in these settings, as is the inclusion of peer supporters with lived experience of homelessness and dual diagnosis. These peer roles offer a relational depth that can foster trust, reduce stigma, and increase engagement in ways traditional models often cannot. Empowering peer supporters through training and employment not only enhances individual recovery but also contributes to the overall ecology of care, promoting a sense of community and purpose within transitional housing environments.

Rural and Remote Areas

The delivery of care in rural or remote regions presents distinct logistical and infrastructural challenges. Geographic isolation, limited-service availability, provider shortages, and transportation barriers all impede timely and effective support. For individuals with CEMS in these areas, the consequences can be particularly acute, resulting in untreated conditions, preventable crises, and deepened marginalisation.

To mitigate these issues, the IMCM recommends a twofold strategy. First, investment in telehealth services is essential for expanding access to mental health and substance use care. These platforms allow individuals to connect with providers remotely, reducing the dependency on travel and increasing the frequency of contact. Second, local capacity-building must accompany technological expansion. Primary care practitioners in rural areas should receive training in CEMS management, enabling them to provide effective, immediate support even in the absence of specialist services.

Mobile healthcare units can supplement these efforts by offering regular, on-site multidisciplinary support in more isolated communities. Meanwhile, community engagement plays a vital role in shaping culturally appropriate and sustainable interventions. Collaborating with local leaders, voluntary organisations, and service users ensures that care pathways reflect the values and realities of rural life, fostering a sense of ownership and legitimacy.

Effective implementation of the IMCM in special environments depends on both system responsiveness and workforce readiness. System responsiveness refers to the capacity of services to adapt dynamically ,through ongoing assessment, feedback, and real-time data monitoring ,to the evolving needs of individuals and communities. This flexibility allows for rapid modifications to care strategies in response to emerging challenges or insights. Equally important is the readiness of the workforce. Care providers operating in prisons, shelters, or rural areas must be specifically trained to deliver services under constrained or complex conditions. This includes proficiency in trauma-informed practice, cultural competence, and interdisciplinary collaboration. Without this targeted preparation, even well-intentioned interventions risk failure due to poor implementation or lack of contextual fit.

Conclusion

Contextualised care for special environments is not a departure from the principles of the IMCM ,it is their application under conditions of intensified structural constraint. These environments underscore the importance of adaptation, local relevance, and systemic support, reminding us that integrated care must not only be theoretically sound but practically feasible in diverse real-world contexts. While Section 10.3 outlines the broad strategies for enhancing agency and personalised care, this section reinforces the importance of embedding those strategies within tailored responses to distinct environmental challenges. By acknowledging and addressing the specific barriers present in prisons, homelessness, and rural areas, the IMCM strengthens its commitment to delivering comprehensive, equitable, and contextually grounded care for individuals with CEMS.

10.5 Operationalisation of the IMCM

The operationalisation of the Integrated Morphogenetic Care Model (IMCM) requires a detailed and context-sensitive strategy to ensure successful implementation within the current policy, regulatory, and funding frameworks of the UK health and social care system. This section outlines a practical roadmap for turning the IMCM into a viable, scalable, and sustainable model of care. It focuses on breaking down the model into implementable components, aligning it with relevant policies and commissioning structures, piloting in high-need regions, embedding service-user involvement throughout, and ensuring mechanisms for policy advocacy, evaluation, and continuous improvement.

The first step is to translate the IMCM's core principles ,structural flexibility, the integration of social determinants of health, and the enhancement of individual agency , into specific interventions with defined responsibilities, resources, and operational processes. For instance, structural flexibility may be achieved by introducing adaptive appointment systems and community-based outreach teams that meet service users in accessible, non-stigmatising environments. These interventions would require cross agency collaboration between local NHS trusts, Integrated Care Boards, voluntary sector organisations, and community health teams. Similarly, integrating social determinants of health into practice might involve co-locating housing officers or employment advisors within clinical teams, enabling holistic assessments and responses to socio-economic drivers of distress. Realising such changes will depend on new role development, interprofessional training, and revised funding mechanisms, potentially drawn from existing ICS transformation budgets or targeted NHS block contracts.

To move from conceptual development to real-world application, a phased implementation strategy is essential. This should begin with a regional assessment of need, capacity, and existing infrastructure, followed by pilot programmes, iterative scaling, and embedded evaluation. Each phase must be grounded in clear objectives, timelines, stakeholder roles, and outcome indicators to ensure accountability and strategic alignment. In early phases, stakeholder mapping and local engagement workshops will be essential to tailor implementation plans to specific community contexts. Later phases should focus on replicating successful pilots, sharing learning, and refining tools for wider adoption.

Importantly, service-user involvement must be embedded at every stage of the operational process ,not only in the design of care pathways but in governance structures, feedback systems, and model evaluation. Individuals with lived experience should participate in the co-production of services, the development of assessment tools, and the interpretation of outcome data. Evaluation frameworks should incorporate not only quantitative metrics ,such as reduced hospital admissions or improved treatment adherence ,but also qualitative insights gathered through focus groups, reflective interviews, and user-led evaluations. Regular six-monthly reviews should be structured to include service users as co-evaluators, recognising their unique expertise in identifying gaps, suggesting innovations, and ensuring care remains relevant and humane.

To ensure alignment with current national strategy and commissioning priorities, the IMCM must be mapped against existing frameworks, such as the NHS Long Term Plan, and the 2017 Policy Implementation Guide for CEMS. Where alignment is clear ,for example, with goals around integrated, person-centred care ,the model can leverage funding through ICS transformation plans or pooled commissioning budgets. Where misalignments exist, advocacy will be necessary to secure the legislative and financial flexibility required to support the IMCM's cross-sector model. Potential barriers such as siloed budgets, short-term commissioning cycles, or entrenched professional hierarchies must be anticipated, with mitigation strategies that include coalition-building, policy engagement, and the development of shared metrics for success.

Pilot sites ,such as Stoke-on-Trent, given its demographic diversity and high levels of need ,will be central to demonstrating feasibility. Pilot programmes should be carefully scoped, include well-defined aims and delivery components, and be grounded in interprofessional collaboration. For example, a pilot might trial the integration of mental health, substance use, and housing support through a shared team operating from a single care hub. A theoretical case scenario ,such as ‘John,’ introduced in Section 10.11 , can help illustrate how such integration might function in practice, showing how a fragmented journey through care can be transformed into a streamlined, coordinated process.

Robust evaluation must accompany these pilots. This includes the development of mixed-methods outcome frameworks that combine service data (e.g., appointment attendance, crisis presentations) with stakeholder feedback, including service users, families, and front-line staff. Evaluation should be iterative and formative ,providing insights that inform real-time adjustments rather than waiting for end-of-cycle review. Creating opportunities for service-user panels to help interpret findings and shape responses ensures that evaluation is not extractive but participatory, consistent with the model’s ethos of agency enhancement.

Alongside this, the building of collaborative infrastructure is essential. Local Health and Wellbeing Boards or Integrated Care Partnerships can be mobilised to coordinate model delivery, set priorities, and pool resources. These bodies must include service-user representatives as equal partners. Digital infrastructure ,including shared electronic health records and cross-sector data dashboards ,can facilitate communication, enable care continuity, and support coordinated planning. Technology also offers a platform for real-time feedback and for users to track their own care pathways.

To ensure that the IMCM is embedded over time, policy advocacy and political will are crucial. This includes identifying champions ,whether senior NHS figures, public health leaders, or peer advocates ,who can communicate the model’s value, both economically and ethically. Advocacy should be supported by a clear communication plan, detailing core messages, timelines, evidence summaries, and stakeholder engagement strategies. This helps make the case for necessary reforms in commissioning, workforce development, and legal frameworks that currently reinforce fragmentation.

Sustainability and scale-up will require long-term infrastructure planning, including the development of professional training curricula, dedicated funding lines, and policy frameworks that mandate integrated working. Strategies must be tailored to the needs of different regions and adaptable to evolving health and care priorities. Mechanisms for long-term stakeholder engagement ,such as regular co-production forums, joint commissioning reviews, and public reporting of outcomes ,should be built into the operational architecture to support transparency and shared accountability.

In conclusion, operationalising the IMCM requires more than implementation logistics ,it demands a new culture of care grounded in structural responsiveness, intersectoral collaboration, and continuous learning. Crucially, it requires that service users are not only involved in shaping services at the design stage, but actively embedded in systems of governance, evaluation, and refinement. By centering lived experience throughout the model's operational life, the IMCM ensures that integration is not just a structural or procedural reform but a moral and relational one ,rooted in respect, responsiveness, and the collective construction of meaningful, effective care.

10.6 Limitations

While the Integrated Morphogenetic Care Model (IMCM) offers a comprehensive and adaptive framework for responding to the complex needs of individuals with CEMS, its successful implementation will require careful planning and sustained strategic coordination. As with any systemic reform initiative, the operationalisation of the IMCM must account for a range of interdependent challenges ,each of which has the potential to influence feasibility, fidelity, and long-term sustainability if not addressed in advance.

One of the key considerations is the management of expectations. The IMCM is an ambitious model, and there is a risk that stakeholders may underestimate the time, resources, and structural change required to achieve meaningful integration (Hudson, Hunter and Peckham, 2022). Overly optimistic expectations, particularly in the early phases, can lead to disillusionment, reduced stakeholder confidence, and the erosion of political or financial support. To safeguard credibility, implementation timelines must be realistic and underpinned by clear communication about the incremental nature of systemic transformation.

A second challenge relates to the fragmented governance landscape of UK health and social care. The decentralisation of commissioning responsibilities ,particularly following the Health and Social Care Act 2012 ,has produced a patchwork of organisational structures, funding mechanisms, and local priorities. This variation creates difficulties in ensuring consistent implementation across regions, especially where political will or commissioning capacity may be uneven (Kozlowska et al., 2018). While the model allows for local adaptation, some level of standardisation and oversight will be necessary to ensure fidelity to core principles.

Achieving the interdisciplinary collaboration that the IMCM requires may also be constrained by existing **policy silos** and professional boundaries. Integrated working is often hindered by institutional legacies, sectoral mistrust, and distinct regulatory or clinical cultures. These divisions are reinforced by short-term political cycles that incentivise demonstrable, near-term outcomes over long-term structural reform (Hudson, Hunter and Peckham, 2022). Such pressures may threaten the continuity of funding and leadership necessary to realise integrated care on a sustainable basis.

The complexity of the IMCM is, by design, reflective of the complexity of the population it seeks to serve. However, that same complexity poses operational demands: the need for multi-level coordination, local tailoring, and real-time responsiveness increases the resource intensity of implementation. This includes the need for sustained investment in training, infrastructure (including digital systems), and workforce development. Competing healthcare priorities, particularly during periods of economic restraint, may limit the availability of these resources and challenge the model's scalability.

Evaluating the impact of the IMCM presents another important planning consideration. Integrated care outcomes are inherently difficult to measure using traditional, reductionist metrics. The development of comprehensive, meaningful, and standardised evaluation tools ,incorporating both clinical and social indicators ,is critical. Equally, data collection systems must be designed to track long-term outcomes and inform continuous learning, which will require coordination across agencies and sustained resourcing.

Cultural and structural barriers, particularly stigma and professional identity, remain deeply embedded in health and social care systems. These factors can limit uptake of new models, particularly where there is resistance to cross-disciplinary collaboration or where integrated care is seen as a threat to professional autonomy. Similarly, individuals with lived experience of fragmented, exclusionary systems may be justifiably cautious about new interventions. Rebuilding trust and promoting patient engagement will require not only relational sensitivity but sustained demonstration that the IMCM can deliver meaningful, respectful, and consistent support.

Finally, current policy frameworks and legislative structures may not fully support the level of integration proposed by the IMCM. Misalignments between national mandates, funding mechanisms, and local accountability structures can hinder progress. Legislative and regulatory reforms may be needed to provide a more enabling environment for integrated commissioning, pooled budgets, and cross-sector accountability.

Mitigation Strategies and Forward Planning

Acknowledging these system-level challenges does not undermine the IMCM's viability ,it strengthens it. Anticipating potential points of friction allows for strategic planning that is proactive rather than reactive. Several mitigation strategies are critical to supporting successful implementation.

First, expectation management should be embedded into the communication and governance strategy from the outset. Clear timelines, transparent benchmarks, and staged objectives can help sustain engagement while avoiding early burnout or disillusionment. Leadership teams should regularly update stakeholders, including service users, on progress and challenges to maintain credibility and trust.

Second, the model's flexibility should be balanced with a strong central framework. Regional adaptations must occur within agreed parameters, guided by a shared set of core principles, common language, and outcome metrics. This can be facilitated through a national steering group and the use of implementation toolkits that provide structured guidance for local teams.

Cross-sector collaboration should be actively nurtured through interprofessional training programmes, joint commissioning agreements, and co-located services. Shared decision-making frameworks and team charters can help establish common purpose and clarify roles within integrated teams. Additionally, structural incentives ,such as joint outcomes targets or pooled performance metrics ,can help align institutional priorities.

To address data and evaluation challenges, the IMCM should incorporate codesigned outcome frameworks developed in partnership with service users, practitioners, and commissioners. These should include both short-term indicators (e.g., service utilisation, satisfaction) and long-term markers of recovery, stability, and quality of life.

Data infrastructure must be capable of tracking these outcomes over time, ideally through shared electronic systems accessible to all partners.

Stigma and cultural resistance can be mitigated through strategic use of lived experience narratives, leadership from trusted clinical and community figures, and the integration of peer support roles. These roles are not only critical for service delivery but also for cultural transformation, demonstrating the value of relational, person-centred care.

Policy and legal reform may take time, but targeted advocacy ,supported by a robust evidence base and pilot data ,can build the case for change. Collaboration with national policy bodies, regulators, and legal scholars can help ensure that the IMCM is not only operationally sound, but legally and politically feasible.

Conclusion

Implementing the IMCM at scale is undoubtedly complex, but complexity should not be equated with impossibility. Rather than framing these challenges as reasons for caution, they should be treated as factors to be strategically planned for and addressed through thoughtful, inclusive, and evidence-informed approaches. By embedding robust governance structures, building cross-sector alliances, securing sustained investment, and centring service users in evaluation and refinement, the IMCM can move from theoretical model to real-world impact. Addressing these implementation considerations is not a secondary concern ,it is central to the success and sustainability of the model.

10.7 Practical Application of IMCM

The Integrated Morphogenetic Care Model (IMCM) represents a significant departure from traditional care models that are typically fragmented, reactive, and siloed. In contrast to the prevailing system ,where mental health, substance use, housing, and social services often operate in isolation with minimal communication or coordination , the IMCM proposes an integrated, multidisciplinary framework designed to provide seamless, person-centred care across all domains of need. This section outlines how the IMCM would function in daily practice, with a particular focus on the coordinating mechanisms that ensure continuity, responsiveness, and sustained engagement.

Daily Operation and Team Structure

At the heart of the IMCM is a multidisciplinary team embedded within a central care hub (see figure 10.1) This team collaboratively addresses the full range of needs experienced by individuals with CEMS, including psychological support, substance use treatment, housing assistance, and social support. The structure replaces traditional referral-based models, where individuals are passed between agencies and often lost to follow-up, with a unified care system that is actively co-managed across disciplines.

Mental health practitioners, including nurses and social workers, take responsibility for the psychological well-being of service users. They conduct assessments, manage therapeutic interventions and medication, and work with the broader team to tailor support plans. Substance use workers address dependency-related issues through harm reduction strategies, counselling, and access to detoxification or rehabilitation, ensuring that addiction is not treated in isolation but in direct connection with other life circumstances.

Housing officers form a vital part of the team by attending to one of the most pressing social determinants of health ,stable accommodation. Their work involves coordinating placements in shelters, transitional housing, or permanent homes, and liaising with local housing services to secure long-term solutions (Adams *et al.*, 2022). Support staff, including administrative personnel and peer support workers, underpin daily operations. Peer workers, who bring lived experience, offer invaluable relational insight and build trust with service users navigating complex systems.

What differentiates this structure from fragmented systems is its shared accountability and continuous coordination. Rather than operating in parallel or through sequential referrals, the team functions as a unified entity with a collective responsibility for outcomes. This collaborative ethos ensures that no single need is treated in isolation and that services adapt in real time to changes in individual circumstances.

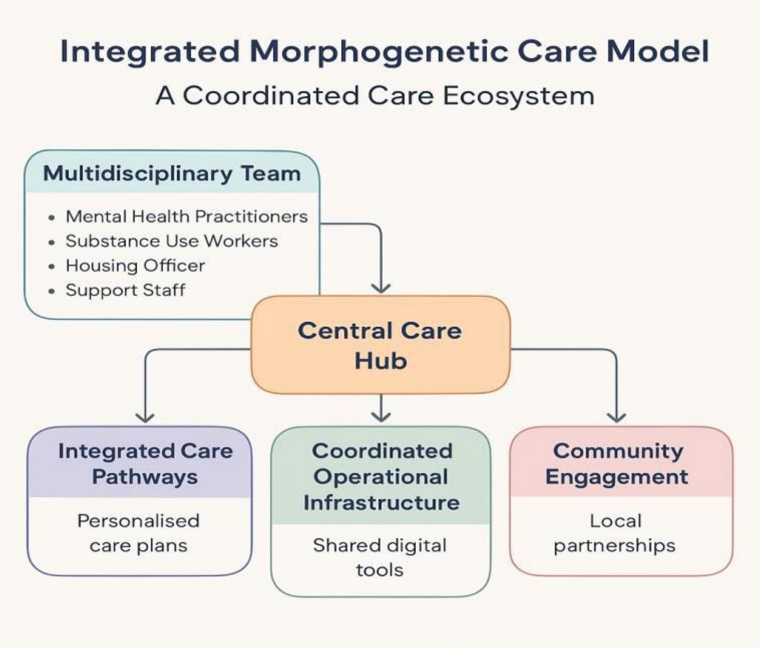

Figure 10.1: *Conceptual overview of the Integrated Morphogenetic Care Model (IMCM) as a coordinated care ecosystem.* This diagram illustrates the central role of the **Care Hub** as the operational and coordinating core of the model, linking the multidisciplinary team with care pathways, operational infrastructure, and community engagement. It visually underscores the model's departure from traditional fragmented systems by highlighting its structural integration and collaborative focus.

Integrated Care Pathways

The care journey within the IMCM is organised through integrated care pathways, which guide individuals from initial assessment through to long-term recovery. These pathways are dynamic and adaptive ,designed to evolve in response to individual progress, challenges, and preferences.

The process begins with a comprehensive, multidisciplinary assessment, which not only evaluates mental health and substance use issues, but also identifies barriers such as housing instability, employment status, social isolation, and exposure to violence or trauma. Based on this assessment, a personalised care plan is co-developed with the individual. This plan is not static; it is revised regularly in response to formal reviews and informal feedback, ensuring responsiveness to change.

Integrated service delivery means that all interventions ,therapeutic, social, and practical ,are implemented concurrently, rather than fragmented across different agencies with disparate priorities. The care plan acts as a single, guiding document that is accessed and updated by all members of the team through shared electronic systems, enabling real-time coordination.

Ongoing monitoring and adaptation is central to the model's success. Regular check-ins and outcome assessments enable the team to adjust the intensity and focus of interventions as needed. For instance, if substance use stabilises but housing insecurity remains, the focus of the plan shifts accordingly ,ensuring that care remains relevant and targeted.

Crucially, the IMCM is equipped for crisis intervention. If an individual experiences a mental health crisis or relapse, the team is prepared to respond immediately, reallocating resources and intensifying support. The capacity for rapid reorganisation , enabled by flexible team roles and shared infrastructure ,reduces the likelihood of disengagement or deterioration during periods of acute need.

As individuals move toward stability, the focus transitions to long-term planning and reintegration. Support for employment, education, and community engagement is introduced alongside ongoing therapeutic work. Peer support becomes increasingly central at this stage, helping individuals build confidence and maintain continuity as they exit formal care.

Coordinated Operational Infrastructure

A key innovation of the IMCM lies in its coordinating infrastructure. Unlike existing models that rely on ad hoc communication or episodic case conferences, the IMCM is organised around a central care hub that facilitates day-to-day coordination. This hub provides the physical and digital infrastructure for team meetings, shared record-keeping, care planning, and data monitoring.

Technology is fully embedded into the model to support real-time data integration and care synchronisation**.** All care processes ,from assessments to interventions ,are documented using shared Electronic Health Records (EHRs), accessible to all team members. Telehealth capabilities expand access for individuals in rural or under-served areas, and digital dashboards allow managers to track outcomes and trends across service domains.

The IMCM also ensures collaborative governance with external agencies, including hospitals, legal services, and community organisations. When individuals require inpatient admission, legal advocacy, or specialist services, the IMCM team maintains active oversight and ensures that these external interventions are coordinated with the wider care plan.

Community Engagement and Continuity

Community engagement is not peripheral but integral to the IMCM's practical implementation. The model actively involves local partners ,such as businesses, peer-run organisations, and community leaders ,in the delivery of care. This includes codeveloping opportunities for employment, social participation, and local advocacy efforts aimed at reducing stigma.

Moreover, the continuity of care provided by the IMCM ensures that support does not end at the point of clinical discharge. Ongoing engagement with individuals, including regular peer support and follow-up check-ins, maintains stability and responsiveness over time. This longitudinal commitment addresses one of the most harmful features of the current system ,abrupt transitions and gaps in care that often result in relapse, homelessness, or disengagement.

Conclusion

In practice, the IMCM offers more than a service delivery model ,it represents a coordinated care ecosystem that replaces the fragmented, siloed, and crisis-oriented systems currently in place. The multidisciplinary team, integrated care pathways, central coordination hub, and commitment to shared accountability distinguish it from existing structures. The coordinating function ,enabled through infrastructure, shared digital tools, and collaborative governance ,is the linchpin of the model's success. It ensures that care is not only comprehensive and responsive, but also truly integrated ,centred around the individual, rather than the boundaries of institutions. In doing so, the IMCM provides a practical, scalable, and person-centred response to the complex and interconnected needs of individuals with CEMS

10.8 Economic Justification and Cost-Consequence Analysis of the IMCM

Transitioning from a fragmented, crisis-led system of care to an integrated, person-centred model such as the IMCM requires not only ethical and clinical justification, but a robust economic and systemic rationale. However, conventional economic evaluation methodologies ,particularly cost-effectiveness analysis (CEA) and cost-utility analysis (CUA) ,are ill-suited to capturing the complex, cross-sectoral consequences of whole-system transformation (Kim et al., 2023). These methods reduce diverse and long-term outcomes to singular indices, limiting their capacity to account for structural and cultural reform, workforce dynamics, and shifts in service-user experience (Drummond et al., 2015).

In contrast, Cost-Consequence Analysis (CCA) offers a more appropriate evaluative framework for systemic reforms such as the IMCM. CCA disaggregates economic and noneconomic impacts, allowing decision-makers to assess multiple outcome domains side by side. This includes cost savings, improved quality of care, workforce stability, enhanced service-user engagement, and reductions in health inequalities. Crucially, CCA resists the reductive logic of monetisation that underpins cost-benefit analysis (CBA), which often fails to capture non-market and moral consequences, particularly those relating to trauma, social exclusion, and relational trust (Brent, 2023).

Methodologically, CCA aligns with the critical realist epistemology underpinning this thesis. It accommodates the layered, generative nature of social systems, acknowledging that observable outcomes (e.g. relapse rates, emergency admissions) are shaped by deeper structural mechanisms (e.g. service design, funding logic, cultural stigma). Unlike CEA or CBA, CCA does not require these layers to be collapsed into a single causal chain. Instead, it recognises that outcomes are produced through interacting structural, cultural, and agential domains ,mirroring the morphogenetic logic of the IMCM itself.

Policy-wise, CCA also provides greater transparency and flexibility for commissioners and system leaders. It allows for scenario modelling that includes different timelines, funding routes, and local governance configurations ,each of which may produce different combinations of consequences. This makes it uniquely suited for assessing reforms such as the IMCM, where interventions occur across time, space, and system levels**,** and where both intended and emergent effects are significant to long-term sustainability.

By adopting a CCA framework, this thesis does not simply calculate the financial cost of integration. It critically evaluates how investment in IMCM redistributes systemic value ,not only reducing financial waste, but generating relational, organisational, and ethical dividends across the system. In doing so, it provides a strategic and theoretically coherent foundation for understanding the economic case for integrated care.

The Economic Burden of CEMS

The necessity of systemic reform is underscored by the scale and inefficiency of the current economic burden associated with coexisting mental health and substance use needs. Estimates place the annual cost of mental ill health in England at £300 billion (Centre for Mental Health, 2024), while substance use-related harms account for an additional £32.2 billion (Public Health England, 2018). These figures reflect direct healthcare expenditure, lost productivity, and informal care burdens ,but they do not fully account for the compounded costs associated with CEMS.

Christie (2017) found that 70% of people in drug treatment and 86% of those in alcohol treatment have coexisting mental health conditions. Applying a conservative 78% overlap rate across expenditure categories reveals that approximately £210 billion of mental health-related costs and £25.98 billion of substance use-related costs are attributable to CEMS ,resulting in an annual economic burden of around £234 billion. This figure, while already substantial, likely underestimates the hidden costs of fragmented systems: disjointed assessments, duplicated referrals, administrative inefficiencies, and loss of trust that reduces service re-engagement and increases relapse.

Crucially, this financial burden is not a product of unmet need alone, but of structural design. The bifurcation of services leads to inefficiencies that multiply over time: hospital readmissions due to lack of integrated discharge planning, emergency interventions resulting from inaccessible early support, and staff burnout due to poorly coordinated care environments. These are not isolated events, but systemic consequences of morphostatic service design ,a direct reflection of the logic critiqued throughout this thesis.

The IMCM, by contrast, aims to reconfigure the causal architecture of service delivery**.** It seeks not only to treat conditions more efficiently but to interrupt the mechanisms ,organisational, financial, and relational ,that reproduce high-cost, low yield outcomes. From a CCA perspective, this is not just a fiscal challenge but a design failure. The goal of economic analysis in this context, therefore, is not to prove marginal savings per intervention, but to map how investment in integrated care alters the long-term cost trajectory by reshaping the system's internal logic.

Strategic Investment and Local Implementation

To operationalise this shift, a phased investment strategy is proposed ,beginning with localised implementation in a high-need area such as Stoke-on-Trent. This region, selected for its high CEMS prevalence and structural disadvantage, serves as a live context in which to model the effects of integration. The approach begins not with top-down restructuring, but with locally embedded pilots that test configuration, coordination, and community responsiveness.

Projected start-up costs for a local site include £350,000–£1 million in staffing (multidisciplinary professionals including nurses, social workers, psychiatrists), £200,000–£500,000 in physical infrastructure upgrades, and £150,000–£300,000 for interoperable IT systems and shared electronic records (HMG Treasury, 2023; NHS Digital, 2024). These figures represent more than capital investment ,they are the preconditions for systemic coherence**,** enabling data flow, team alignment, and cross-sector governance.

Crucially, these investments are not framed as new expenditures but as **strategic reallocations**. Current spending patterns prioritise high-cost reactive care: emergency admissions, short-term housing, and acute detox beds. IMCM reallocates those resources into relational continuity, prevention, and long-term stability. This is the core logic of CCA: not to reduce complex reform to a marginal gain ratio, but to evaluate whether the pattern of consequences is more socially and economically desirable than the status quo.

Scaling and Sustainability: National-Level Considerations

National scaling requires both additional resources and regulatory reform. Based on pilot extrapolation, the national setup cost of IMCM is estimated at £430 million to £1.07 billion, with annual operational costs between £710 million and £1.46 billion. These figures, while significant, represent a fraction of the £234 billion annual cost attributed to CEMS-related fragmentation.

Under a CCA framework, these figures are not to be interpreted as a break-even calculation, but as part of a structural reinvestment strategy. Cost-consequence analysis allows for an evaluative comparison of two system states: one in which spending continues along a path of reactive fragmentation, and another in which spending is restructured to generate lower long-term burdens through integrated support. The latter offers not only financial sustainability, but moral and workforce viability.

However, realising this potential requires policy-level alignment. The current disjunction between NHS-funded mental health care and local authority-funded substance use and housing services undermines pooled budgeting and shared accountability. This structural misalignment contributes to care discontinuity, financial duplication, and workforce demoralisation. Embedding the IMCM nationally would require legislative reform to enable joint commissioning models, aligned outcomes frameworks, and shared funding incentives.

Economic Consequences of Systemic Reform: A CCA Perspective

Through the lens of CCA, the implementation of the Integrated Morphogenetic IMCM presents a multidimensional matrix of outcomes ,each tied to distinct structural, cultural, and experiential domains. Unlike singular cost-efficiency models that reduce value to monetary units, the CCA approach enables an explicit articulation of what is gained, not just what is spent. The following consequences illustrate the breadth and interdependency of IMCM's systemic impacts, as evidenced throughout Chapters 6 and Chapter 10.

System-Level Efficiency: Reconfiguring Care Logic and Resource Flow

Fragmentation, as mapped through FOI data in Chapter 6, leads to overlapping assessments, duplicated interventions, and delayed responses. Individuals with CEMS often bounce between multiple disconnected services, increasing reliance on high-cost crisis responses such as A&E admissions and emergency housing. As noted, one emergency admission related to mental health or substance use costs the NHS an estimated £500, compared to just £50–£100 for a single session of community-based, preventive care.

The IMCM addresses this by consolidating care into multidisciplinary teams operating from a central coordination hub (see 10.7). This design eliminates duplication, improves clinical handovers, and enables adaptive care planning in real-time. By displacing reactive care with planned, integrated interventions, IMCM reduces inefficiencies embedded in current practice and realigns resource use with long-term sustainability.

Workforce Retention: Shifting from Exhaustion to Stability

Workforce depletion and burnout ,highlighted in Chapter 7 as endemic to current CEMS services ,have cascading consequences: recruitment costs, loss of institutional memory, and degraded service quality. As evidenced in Chapter 10, burnout-driven attrition increases recruitment and retraining costs by up to 30% per lost employee.

The IMCM mitigates this by embedding co-located, trauma-informed teams with manageable caseloads and shared responsibilities. This structural shift not only improves professional morale but also reduces duplication of effort across silos. Within chapter the emphasis on modular service design allows staff to operate in more flexible, responsive environments ,thereby promoting retention and minimising the systemic churn that perpetuates staffing crises. These effects are cumulative: lower turnover begets greater stability, which enhances service consistency and ultimately improves outcomes.

Service-User Engagement: From Conditional Access to Relational Continuity

Qualitative findings in Chapters 7 and chapter 8 consistently highlight that service users often experience care as conditional, stigmatising, and inaccessible ,particularly when services demand abstinence before engagement. These barriers, as detailed in chapter 8, foster disengagement, recurrence of crisis, and long-term distrust of health systems.

By contrast, the IMCM proposes user-led care planning, peer support integration, and the recognition of agency within constraint (10.3 and 10.6). CCA highlights that the economic consequences of engagement ,improved adherence, fewer crises, reduced relapses ,are not abstract but measurable. As shown in this chapter, integrating peer support workers has been empirically linked to lower rates of disengagement and higher treatment retention From Fragmentation to I…. These outcomes directly reduce the financial burden of repeat admissions and foster relational trust ,a key indicator of system legitimacy.

Equity and Access: Addressing Structural Exclusion and Contextual Complexity

Access to care is not evenly distributed. As demonstrated in Chapter 6, trusts with limited commissioning flexibility or geographic constraints often provide no dedicated CEMS pathways, forcing individuals to self-navigate fragmented services. For marginalised groups ,e.g. homeless populations, rural communities, or people with multiple exclusions ,this often results in total service detachment.

The IMCM's commitment to contextualised care (10.4) means adapting service design to diverse settings. For example, mobile teams and telehealth services in rural areas, peer-run drop-ins for urban homelessness, and in-prison care continuity pathways all form part of a structurally responsive strategy. By embedding flexibility at the systemic level, IMCM improves equity ,not only in theoretical access, but in realised, sustained engagement. CCA, in this instance, allows equity to be treated as both a moral imperative and a system outcome with direct impacts on service utilisation, crisis frequency, and community resilience.

Policy Legitimacy: Aligning With National Priorities and Public Confidence

The IMCM is not proposed in a policy vacuum. As discussed in Chapter 10.9, it aligns explicitly with the NHS Long-Term Plan (2019), which mandates integrated, place-based care. Yet implementation of such policy has been uneven, largely due to funding misalignment and structural inertia (Chapter 9).

Through CCA, we can assess how the IMCM not only delivers service-user outcomes but restores faith in public institutions by making policies operational. When service users and frontline professionals experience genuine integration ,as in the Stoke on-Trent pilot discussed in this chapter ,this builds political legitimacy and public trust. These are not intangible goods. Trust correlates with early help-seeking, workforce morale, and community compliance ,all factors that reduce long-term expenditure and increase system resilience.

Conclusion: Reframing Consequences as Value Domains

Cost-Consequence Analysis, when applied to the IMCM, reveals an ecology of value: systemic, professional, social, and cultural. These are not secondary effects ;they are the essential justification for reform. The IMCM's contribution is not only in service reconfiguration but in restoring coherence to a system riven by contradiction, exclusion, and inefficiency.

To evaluate the IMCM solely in terms of financial cost would be to miss the broader horizon: it is an investment in structural transformation, with consequences that span trust, engagement, justice, and sustainability. This aligns directly with the core objectives of this thesis ,grounded in Archer's morphogenetic framework ,which insists that structural change must be understood through its capacity to enable new forms of agency, interaction, and social elaboration.

10.9 Practical implementation of the IMCM

The practical implementation of the Integrated Morphogenetic Care Model (IMCM) must be strategically staged and contextually sensitive. Drawing on Archer's morphogenetic framework, which views structural transformation as emerging through the interplay of pre-existing conditions, social interaction, and cultural elaboration, implementation must be treated as a phased process of systemic alignment. The IMCM does not propose a one-size-fits-all programme but a principled architecture that can be adapted across diverse settings while maintaining fidelity to core values. This section outlines how the IMCM can be operationalised at both micro (local) and macro (regional and national) levels, ensuring coherence, sustainability, and contextual relevance.

Local-Level Implementation: Foundations for Systemic Change

Implementation at the local level is the crucible in which the IMCM must prove its utility. As highlighted in Chapter 8, services currently operate in fragmented silos, with individuals navigating disjointed care pathways and inconsistent eligibility criteria. The IMCM seeks to counter this by establishing locally responsive infrastructures that are coproduced, data-informed, and relationally grounded.

Foundational Phase (First 6 Months)

The initial phase focuses on stakeholder mobilisation and diagnostic assessment. Trust-building is essential ,particularly with marginalised populations whose previous encounters with services have often been exclusionary or stigmatising (see Chapter 7). Community forums, focus groups, and individual consultations should be facilitated with representatives from health services, housing, employment, social care, third-sector organisations, and most critically, individuals with lived experience of CEMS.

A local steering committee, comprising professionals and community representatives, should be established to oversee governance. This committee must set clear implementation goals, timelines, and feedback loops. Drawing on findings in Chapter 6 regarding regional disparities in service configuration, local adaptation is key. For instance, in areas with high unemployment, the model may integrate vocational rehabilitation more prominently within care plans.

A needs assessment will map service gaps, social determinants of health, and structural bottlenecks. This assessment is not just an information-gathering tool but a strategic diagnostic, informing the customisation of IMCM components to the area's socio-economic context.

Pilot Implementation (Months 6–24)

The second phase involves piloting IMCM in selected neighbourhoods, rural areas, or high-impact environments such as prisons or supported housing units (see Section 10.4). These pilots serve both as proof of concept and as vehicles for model refinement. Services should be delivered through integrated care hubs using shared assessment protocols, real-time electronic records, and team-based case management.

Capacity building is critical. Multidisciplinary training programmes must equip staff with core IMCM competencies: trauma-informed practice, cultural humility, shared decision-making, and systems navigation. These programmes should be iterative and codeveloped with practitioners and service users to ensure relevance.

Data systems must be embedded to support continuous monitoring and adaptive learning. Key performance indicators (KPIs) might include hospital admission rates, service engagement duration, housing stability, and user-reported outcomes. More importantly, the data should be disaggregated by demographic and structural variables to monitor equity.

Critically, service-user feedback mechanisms must be embedded. This is not just about gathering satisfaction scores but integrating experiential knowledge into iterative service redesign. As explored in Chapter 7, service users' insights into system gaps, procedural contradictions, and relational breakdowns offer some of the most potent levers for service improvement.

Local Scale-Up and Sustainability (Months 24–60)

Based on the outcomes of pilot programmes, the IMCM should be scaled across the local system. This will involve expanding care hubs, strengthening inter-agency protocols, and establishing integrated governance bodies. Community partnerships ,with housing associations, local businesses, education providers, and peer-led organisations , must be cultivated to embed the model beyond statutory services.

Sustainability depends on institutionalising continuous quality improvement. The local steering committee should evolve into a long-term oversight board, ensuring ongoing evaluation, professional development, and adaptation. Embedding IMCM principles into local authority policy and commissioning frameworks will also secure the model's political and fiscal future.

National-Level Implementation: Enabling Macro-Structural Alignment

While local implementation provides the foundation for proof and iteration, national support is essential to achieve scalability and structural transformation. A top down enabling environment must be created to remove systemic barriers and provide the infrastructure for regional diffusion.

Strategic Planning and National Governance (Year 1)

A national steering committee should be established comprising government departments, NHS England, local authority representatives, advocacy groups, and experts in coexisting conditions. This committee's task is not to centralise delivery, but to standardise principles, policies, and funding mechanisms to support local adaptation.

A national implementation framework should be published within the first year. This document must outline:

- Core IMCM principles (e.g., integration, contextualisation, agency enhancement).
- Minimum delivery standards.
- Data and evaluation requirements.
- Resource allocation formulas that ensure equitable access and regional parity.

Resourcing and Regional Adaptation (Years 2–5)

Sustainable national implementation depends on a combination of state investment, third-sector partnerships, and international funding opportunities (e.g., innovation grants from the WHO or OECD). Funding should be structured through block grants or pooled budgets accessible to Integrated Care Systems (ICSs), conditioned on demonstration of co-production, inter-agency collaboration, and outcome tracking.

Each region should establish regional implementation hubs and training centres to localise workforce development, oversee fidelity to the model, and promote horizontal learning between sites. For example, rural regions may prioritise telehealth and mobile outreach, while urban sites may integrate homelessness prevention and criminal justice liaison into the care pathway.

Technology and Infrastructure

National rollout must be underpinned by a robust technology infrastructure. This includes:

- Interoperable electronic health records (EHRs) accessible across mental health, substance use, housing, and social care domains.
- Telehealth platforms to reach geographically isolated populations.
- AI-assisted triage and data analytics to support proactive, needs-led service allocation.

The role of technology is not simply administrative ;it is structurally transformative. It enables real-time coordination, reduces duplication, and builds institutional memory across traditionally siloed services.

Monitoring, Legislative Embedding, and Public Communication

A national evaluation framework must accompany implementation. This framework should combine standardised metrics (e.g., reductions in emergency admissions, improved workforce retention) with region-specific outcomes (e.g., housing access in deprived areas, engagement in rural communities). Evaluation should be mixed methods, incorporating both service-user and staff perspectives (see Chapter 8).

To ensure long-term viability, IMCM principles must be embedded in legislation. For example, amendments to the Health and Social Care Act could mandate cross-sector care planning and pooled funding for CEMS populations. Legislative clarity would not only secure political commitment but also shield the model from being diluted by changes in leadership or fiscal priorities.

Public awareness campaigns are also essential. These should be co-developed with lived experience advocates to build understanding, reduce stigma, and enhance uptake. Messaging should be regionally adapted and disseminated through multiple channels, including social media, community radio, and primary care providers.

In conclusion. The IMCM's success depends on vertical integration between local experimentation and national scaffolding. Local innovation without national support risks inconsistency and eventual collapse. National policy without grounded delivery risks abstraction and irrelevance. The strength of the IMCM lies in its ability to harmonise both ,anchoring change in local realities while enabling structural transformation through macro-policy alignment.

As argued throughout this thesis, systemic reform requires more than model design. It requires attention to conditions of emergence, interaction, and elaboration , precisely the logic that underpins both morphogenetic theory and the IMCM itself. By embedding this logic into its implementation strategy, the IMCM offers not just a framework for improved care, but a blueprint for sustainable system change.

10.10 Theoretical Case Study: John's Journey Through the IMCM

Background**:** John is a 35-year-old male living in an urban area with a long history of mental health issues and substance use. He was diagnosed with bipolar disorder in his early twenties and has struggled with alcohol and opioid dependence for the past decade. John has been in and out of various treatment programmes but has never received fully integrated care that addresses both his mental health and substance use issues simultaneously. He is currently homeless, cycling between shelters, and has recently lost his job due to his condition.

Initial Contact and Assessment: John is referred to the IMCM by a local community outreach programme after being found sleeping rough and in poor health. Upon his referral, John is quickly connected with the IMCM team, who schedule an initial assessment at a central care hub. The assessment is conducted by a mental health practitioner, and a substance use worker, who work together to understand John's full range of needs.

During the assessment, the team identifies that John's bipolar disorder is poorly managed, leading to frequent mood swings and depressive episodes, which he has been self-medicating with alcohol and opioids. They also learn that John's housing situation is unstable, which exacerbates his mental health issues and makes it difficult for him to maintain employment. Recognising the interconnected nature of his challenges, the team collaborates with John to develop a personalised care plan.

Developing the Care Plan: The care plan for John includes several key components:

Mental Health Treatment: John's bipolar disorder will be managed with a combination of medication and therapy. The nurse coordinates with a psychiatrist to adjust John's medication regimen, ensuring that it is effective and manageable given his current health status. Weekly therapy sessions are scheduled with the nurse, focusing on mood management and coping strategies.

Substance Use Treatment: The substance use worker arranges for John to begin a medically supervised detoxification process, followed by participation in a harm reduction programme. This includes counselling sessions aimed at addressing the root causes of his substance use, as well as group therapy with others facing similar challenges.

Housing Support: Recognising that stable housing is critical for John's recovery, the housing officer on the team immediately begins working to secure transitional housing. They liaise with local shelters and housing programmes to find a suitable place where John can stay while he stabilises. The goal is to eventually transition him into more permanent housing as his condition improves.

Support Services: To address John's unemployment and help him regain stability, the support staff, including a peer support worker with similar lived experiences, connect John with job training programmes and help him apply for disability benefits to provide financial support during his recovery.

Integrated Service Delivery: John's care plan is implemented with the full coordination of the IMCM team. The mental health practitioner and substance use worker meet regularly to discuss John's progress and adjust his care as needed. The housing officer ensures that John's living situation is stable, checking in with him regularly to address any issues that arise. The peer support worker provides ongoing emotional support, helping John stay engaged with his treatment and encouraging him during difficult times.

The use of technology, such as EHRs, allows all team members to stay updated on John's status. If, for example, John misses a therapy session, the substance use worker is immediately informed and can follow up to ensure he is safe and address any barriers preventing him from attending.

Ongoing Monitoring and Adaptation: As John progresses through his care plan, regular assessments are conducted to monitor his mental health, substance use, and overall well-being. These assessments reveal that while John's mood has stabilised with the new medication, he continues to struggle with cravings for opioids. In response, the substance use worker introduces a new therapeutic approach, including more intensive counselling and the possibility of medication-assisted treatment.

John's housing situation also improves, and after several months in transitional housing, the housing officer helps him secure a more permanent residence. This stability significantly contributes to John's overall sense of security and well-being, allowing him to focus more effectively on his recovery.

*Crisis Intervention***:** During one particularly challenging period, John experiences a significant depressive episode and relapses into alcohol use. The IMCM team responds quickly: the mental health practitioner adjusts his medication and increases the frequency of therapy sessions, while the substance use worker provides additional support to help him manage the relapse. The housing officer ensures that John's living situation remains secure during this time, preventing a return to homelessness. The peer support worker plays a crucial role in keeping John engaged with his treatment, reminding him of the progress he has made and helping him navigate this setback.

Transition and Long-Term Support: After a year of intensive treatment and support, John's condition stabilises. His bipolar disorder is well-managed, he has maintained sobriety for several months, and he is living in stable housing. The IMCM team begins to focus on transitioning John to long-term support services. They help him secure part-time employment through a job training programme, which boosts his confidence and provides him with a steady income. The team also connects John with a community mental health programme that offers ongoing therapy and support groups, ensuring that he continues to have access to the resources he needs.

John's care plan is gradually scaled down as he becomes more self-sufficient, but the IMCM team remains available for support during this transition period. The peer support worker continues to check in with John, offering encouragement and reminding him of the resources available if he encounters difficulties in the future.

Outcome: John's experience with the IMCM highlights the effectiveness of an integrated, multidisciplinary approach to care. Over the course of his treatment, John not only stabilised his mental health and overcame his substance use but also regained his independence, securing stable housing and employment. The comprehensive support provided by the IMCM addressed the full spectrum of John's needs, from medical treatment to social support, demonstrating how the model can facilitate recovery and improve quality of life for individuals with CEMS.

This theoretical case study of John illustrates the IMCM in action, showing how the model brings together diverse services and professionals to provide coordinated, person-centered care. Through the collaborative efforts of mental health practitioners, substance use workers, housing officers, and support staff, the IMCM addresses the complex, interrelated challenges faced by individuals with CEMS. The model's flexibility and responsiveness allow it to adapt to the evolving needs of each individual, ensuring that care remains relevant and effective throughout their journey. This example underscores the potential of the IMCM to transform the lives of individuals with CEMS by providing them with the comprehensive, integrated support they need to achieve long-term stability and well-being.

10.11 Potential Resistance to Implementing the Integrated Morphogenetic Care Model (IMCM)

While the Integrated Morphogenetic Care Model (IMCM) offers a coherent, evidence-based response to the fragmented and exclusionary nature of CEMS care, its implementation will inevitably face resistance. As this thesis has demonstrated (particularly in Chapters 4 and chapter 9), systemic reform in healthcare is not simply a matter of rolling out new procedures or protocols; it involves challenging embedded structures, institutional logics, and professional cultures. This resistance is not peripheral ,it is constitutive of what this thesis has termed the morphostasis trap: a self-reinforcing dynamic in which systems remain nominally in motion, but substantively unchanged.

The morphostasis trap is sustained by institutional, cultural, and structural mechanisms that resist disruption. Implementing the IMCM entails dislodging entrenched service silos, shifting power dynamics between professional groups, and redistributing resources toward integrated, person-centred models of care. These transformations threaten the coherence and legitimacy of current arrangements and thus provoke defensive reactions ,even when reform is visibly needed.

Institutional Resistance and Inertia

Institutional resistance often begins with inertia ,the preference for continuity over change. As Rosenbaum (2021) notes, institutions develop internal structures and routines that become self-reinforcing over time, insulating them from external critique or reform. This is especially true in mental health and substance use services, where decades of parallel development have resulted in separate funding streams, governance arrangements, and clinical pathways.

From this perspective, the IMCM is not merely proposing service innovation but institutional reconfiguration. It undermines legacy systems built on compartmentalised expertise, often aligned to funding incentives that reward throughput rather than outcomes. This reconfiguration is unsettling because it requires a redistribution of control, including the devolution of decision-making to integrated teams and community stakeholders.

Financial constraints exacerbate this resistance. As Gadsby (2017) outlines in relation to the Health and Social Care Act 2012, commissioning systems are already under pressure to prioritise cost-efficiency over long-term transformation. The IMCM's demand for upfront investment ,especially in workforce training and digital integration ,may be seen as unaffordable, even if it offers savings over time. Thus, short-termism becomes a defensive strategy that reinforces morphostasis.

Cultural Resistance and Professional Identity

The cultural dimensions of resistance are equally significant. As Laker (2006) and Fleetwood (2019) argue, mental health and substance use services are underpinned by divergent epistemologies and professional norms. The former often adheres to the medical model, while the latter may lean toward social, relational, or harm-reduction frameworks. These paradigms are not simply technical ,they are identity-defining. Integrated models like the IMCM, which seek to reconcile these paradigms, may be perceived as diluting professional boundaries or devaluing disciplinary expertise.

Such cultural resistance is often manifested in cross-disciplinary mistrust, turf protection, and scepticism toward shared planning or co-located teams. Moreover, the stigma surrounding both mental illness and substance use continues to shape clinical perceptions and can inhibit the willingness of professionals to collaborate across domains. As shown in Chapter 7 and chapter 8, this stigma is not limited to the public ,it is embedded in referral thresholds, risk frameworks, and treatment eligibility criteria that perpetuate exclusion.

Structural Resistance and Co-option

Even where institutional and cultural resistance is overcome, there remains a more insidious risk: co-option. This occurs when new models are formally adopted by existing systems but stripped of their transformative intent. In such cases, the IMCM might be implemented in name but absorbed into existing bureaucratic routines, leaving structural logics unchanged. For example, an integrated care pathway may be created, but without pooled funding, shared metrics, or relational continuity, it functions as a superficial rebranding of fragmented services.

Co-option is particularly dangerous because it allows systems to appear responsive without enacting meaningful change. As highlighted in Chapter 9, this is a central mechanism through which morphostasis is preserved. The logic of co-option is not outright opposition but strategic absorption ,the domestication of reform through procedural compliance. Addressing this requires fidelity frameworks and robust governance mechanisms that evaluate implementation not only for adherence but for impact.

Strategies for Navigating Resistance

Resistance is not simply an obstacle to be overcome ,it is a systemic signal that reform is encountering power, values, and embedded routines. Therefore, strategies must be contextual, iterative, and reflexive.

Leadership and Change Management: Effective implementation requires leadership that can articulate a shared vision, frame reform as aligned with professional values and distribute ownership across stakeholder groups. Kotter’s eight-step model offers a useful roadmap, particularly in building coalitions, generating short-term wins, and institutionalising new practices.

Cross-Disciplinary Training and Dialogue: Breaking down silos requires more than co-location; it demands epistemological translation. Interdisciplinary training should be grounded in joint case reviews, reflective practice, and values clarification, allowing professionals to engage with difference without defensiveness.

Policy Alignment and Structural Reform: As outlined in Chapter 10.8, structural barriers ,such as disjointed commissioning frameworks ,must be addressed through national legislation, pooled budgeting, and performance incentives that reward collaboration and user-defined outcomes.

Guarding Against Co-option: Fidelity frameworks should track not only procedural implementation but systemic consequences. For instance, has integration reduced service duplication? Has user experience improved? Are professionals working collaboratively, or merely reporting compliance?

Conclusion: Resistance as a Site of Meaningful Change

The implementation of the IMCM will encounter resistance ,not as a failing of the model, but as a reflection of the deeply entrenched logics it seeks to displace. As argued throughout this thesis, systemic transformation cannot proceed without confronting the conditions that sustain fragmentation. Institutional inertia, cultural divergence, and structural rigidity are not incidental ,they are constitutive of the current state.

By naming and planning for these dynamics, the IMCM does not fall into the trap of utopian design. Instead, it aligns with the morphogenetic view that change is contingent, emergent, and often hard-won. Resistance, in this sense, is not merely an obstacle ,it is a site of transformation. If engaged with reflexively, it can surface the hidden assumptions, power asymmetries, and discursive contradictions that must be addressed for integration to succeed.

In this way, the IMCM does not merely propose a new model of care. It proposes a new way of relating ,to systems, to knowledge, and to one another. It is in the encounter with resistance that its most profound work may begin.

10.12 Summary

The IMCM represents a deliberate departure from the procedural fixes and rhetorical reforms that have defined the past two decades of CEMS policy. Instead of reinforcing silos or demanding conformity from service users, it reframes care around flexibility, deep integration of social determinants, and the active enhancement of agency. It shows how integrated care can be operationalised through shared hubs, pooled budgets, peer-led structures, and cross-sectoral governance, and why these reforms are both economically viable and ethically urgent.

The model anticipates resistance—financial, institutional, cultural—and incorporates strategies to address it. Rather than treating inertia as accidental, it views resistance as evidence of entrenched morphostasis and therefore as the key site for transformation. By providing both a theoretical justification and a practical roadmap, the IMCM positions itself as more than a model: it is a structural and cultural intervention designed to rewire the logics that currently produce exclusion.

As the case study of John’s journey illustrates, the IMCM has the capacity to turn a fragmented, crisis-led trajectory into a coherent and sustainable path to recovery. By addressing structural determinants, aligning care teams, and embedding lived experience in governance, it provides a framework for services that are responsive, relational, and resilient. In doing so, it demonstrates how morphogenetic theory can inform not just analysis, but reform, and how empirical findings can be translated into a model with real-world application.

The IMCM thus constitutes the thesis's original contribution: a theoretically grounded, practically feasible, and ethically compelling alternative to fragmented care. The final chapter will synthesise this contribution with the wider findings of the study, consider its limitations, and outline future directions for research and policy.

Chapter 10 advances the overarching aim of the study by offering a concrete model that addresses the challenges faced by people with CEMS and the systemic failings that exacerbate them. It directly engages with the aim of exploring stigma and discrimination by embedding agency, peer roles, and trauma-informed practice into the heart of the IMCM, countering exclusionary logics. It fulfils the aim of identifying systemic issues and possible solutions by translating the findings of earlier chapters into a structured, scalable model.

The objectives of gathering service-user and professional insight are carried forward into the model's design, ensuring that the IMCM is not a top-down reform but a co-produced, context-sensitive framework. The objectives of exploring whether co-existence, self-medication, and treatment availability are recognised are addressed by embedding holistic assessments, concurrent pathways, and integrated social support as standard features of care. In short, Chapter 10 is where the research moves from diagnosis to prescription, providing a theoretically robust and operationally credible answer to the systemic problems documented throughout the thesis.

11. Conclusion: Integrating Care and Insights for CEMS

This chapter draws together the threads of the thesis, synthesising historical analysis, empirical findings, theoretical application, and model development into a coherent whole. It reflects on how the research objectives have been met, what new insights have been generated, and how these contributions extend beyond description into prescription. Where earlier chapters diagnosed fragmentation and traced its reproduction through policy, culture, and lived experience, this chapter clarifies how those insights culminate in the Integrated Morphogenetic Care Model (IMCM).

The chapter begins with a summary of key findings, situating them within the broader literature and the morphogenetic framework. It then turns to the IMCM as the thesis's original contribution, outlining how its principles, structural flexibility, deep integration of social determinants, enhancement of agency, and contextualised care, offer a practical and theoretically robust response to systemic inertia. Practical implications for policy and practice are highlighted, followed by an honest reflection on the limitations of the study and suggestions for future research. The chapter concludes with personal reflections on the intellectual and ethical journey that shaped the thesis, reaffirming the urgency of reform in CEMS care.

11.1 Summary of Key Findings

This thesis set out to explore the structural, cultural, and experiential dimensions of Co-Existing Mental Health and Substance Use (CEMS), with the aim of understanding how persistent fragmentation in care is reproduced and how systemic transformation might be achieved. Drawing on Archer's morphogenetic framework, the findings of this study demonstrate that fragmentation in CEMS services is not merely the result of operational inefficiencies or policy oversight, but the product of entrenched structural inequalities, historically embedded divisions, and the persistence of morphostasis , where dominant systems resist change despite increasing evidence of failure.

The historical and policy analysis reveals that the bifurcation of mental health and substance use services is deeply rooted in centuries-old moral and punitive frameworks. Mental illness was historically medicalised or pathologised within institutional settings, while substance use was criminalised and treated as evidence of moral failing. These dual trajectories led to the development of distinct service pathways, which over time have become embedded in separate funding streams, regulatory frameworks, and professional identities. Despite multiple efforts to address this legacy ,such as the Department of Health's Policy Implementation Guides in 2002 and 2009 ,service silos remain resilient. The thesis finds that this is not due to a lack of policy intent, but rather the inability of policy to penetrate the structural and cultural boundaries that continue to shape care delivery.

The Freedom of Information (FOI) analysis provides concrete evidence of this fragmentation in contemporary practice. Many NHS trusts retain mental health services in-house while outsourcing substance use provision to third-sector organisations. This structural division produces disjointed care pathways in which service users are frequently passed between agencies operating under incompatible frameworks. These separations are further reinforced by resource disparities. The Health and Social Care Act 2012, which decentralised public health commissioning, has resulted in substantial regional variation. FOI data reveals striking disparities in budget allocation:

Nottinghamshire’s Coexisting Mental Health and Substance Use Pathway receives £788,303 annually, allowing for a more comprehensive and responsive service, whereas Leicestershire’s pathway is funded at just £245,000, severely limiting its scope and reach. These inconsistencies reflect a broader failure to prioritise CEMS care as a national health equity issue.

The 2017 PIG (Christie, 2017) renewed calls for integrated service delivery and a ‘no wrong door’ approach. However, the implementation of these policy ambitions has been inconsistent and undermined by practical realities. FOI data shows that average waiting times for initial assessments range between 2.4 and 3 weeks, followed by additional delays of up to four weeks before treatment begins. In urgent and crisis-laden contexts, such timelines can significantly reduce the effectiveness of intervention and increase disengagement. Moreover, restrictive eligibility criteria continue to exclude those deemed too complex, high-risk, or treatment-resistant ,individuals who often need integrated care the most. These procedural barriers serve as gatekeeping mechanisms, reifying fragmentation under the guise of clinical appropriateness.

The analysis further highlights how financial austerity has shaped the CEMS landscape. Budget cuts have compelled many services to prioritise short-term, symptom focused interventions over holistic, long-term care. This shift has accelerated reliance on third-sector organisations to fill the widening gaps in provision. While these organisations play a vital role, their inclusion within a fragmented system, without consistent oversight or integration, has contributed to further inconsistency in service delivery and accountability. This fragmentation is not accidental; it is the result of structural conditions and governance failures that continue to reinforce morphostasis ,a dynamic in which reform is symbolically endorsed but substantively resisted.

In response to these persistent barriers, this thesis introduces the Integrated Morphogenetic Care Model (IMCM) as a theoretically grounded and empirically informed response to the systemic inertia that defines current CEMS care. The IMCM is designed not simply to improve care coordination but to challenge and reconfigure the very logics that sustain fragmentation. Its core features ,structural flexibility, cultural sensitivity, and the enhancement of agency ,are not added components but foundational principles intended to disrupt the morphostatic cycle and facilitate systemic transformation.

The theoretical contributions of this thesis lie in its original application of Archer's morphogenetic framework to the CEMS context. This framework enabled a layered analysis that disentangles how structural conditions (e.g., policy design, funding arrangements), cultural norms (e.g., stigma, professional identities), and agential responses (e.g., resistance, disengagement, adaptation) interact to shape service fragmentation and reform potential. Central to this analysis is the concept of morphostasis, which explains the persistence of service silos and organisational inertia despite decades of reform rhetoric. The FOI data substantiates this dynamic by illustrating how entrenched systems continue to prioritise internal stability over integration, even when evidence of dysfunction is clear. For example, while programmes like

Gloucestershire’s COMHAD demonstrate that collaborative, integrated models are both possible and effective, they remain exceptions rather than evidence of system-wide transformation.

In parallel, the thesis uses phenomenological insights to explore how these structural and cultural failures are lived. Qualitative data reveals that individuals with CEMS often experience care systems as fragmented, alienating, and conditional. They are frequently required to fit service eligibility criteria that do not reflect the complexity of their lives, leading to disengagement, repeated crisis, and deteriorating health. Participants in the study described feeling caught in endless loops of referral and rejection, where responsibility for coordination was shifted onto them, despite their limited access to stable housing, employment, or community support. These experiences are not only personally devastating but structurally patterned, reinforcing the broader claim that fragmentation is a systemic ,not incidental ,feature of CEMS care.

Yet the thesis also documents moments of agency, resilience, and innovation. Participants found ways to navigate systems, re-establish connections with trusted providers, or advocate for themselves when faced with exclusion. The FOI data also shows that transformation is possible when structural support aligns with local leadership and cultural openness. Nottinghamshire’s coexisting pathway, for instance, expanded its reach from 32 individuals in 2022 to 288 in 2024, illustrating that systemic change is not only necessary but achievable when funding, governance, and workforce capacity are aligned.

These findings culminate in the development of the IMCM as a concrete response to systemic fragmentation. The IMCM draws directly from the multi-level analysis provided by the morphogenetic framework, integrating structural, cultural, and agential considerations into a coherent model of reform. Unlike previous attempts that added integration as a supplementary goal, the IMCM is structured around the principle that integration must be designed in, not retrofitted. By offering a framework that can be adapted to local contexts while maintaining fidelity to core values, the IMCM provides a pathway toward a genuinely integrated, person-centred model of care.

In sum, this thesis shows that addressing the needs of individuals with CEMS requires more than operational adjustments. It demands a systemic realignment grounded in an understanding of how structures resist change, how cultures sustain division, and how individuals continue to seek care within and despite these constraints. The IMCM emerges as a blueprint for systemic morphogenesis ,a model capable of shifting the underlying dynamics of care to better reflect the lived realities of those it is intended to serve.

11.2 Structural Flexibility and Evolution

A central principle of the IMCM is its commitment to structural flexibility ,a deliberate counterpoint to the rigidity that has characterised traditional models of care for individuals with CEMS. As this thesis has shown, current systems remain defined by inflexible organisational structures, static eligibility criteria, and siloed service pathways. These rigidities not only impede effective intervention but actively reproduce systemic fragmentation and exclusion. Structural flexibility within the IMCM is therefore not an operational convenience, but a strategic mechanism for disrupting morphostasis and enabling conditions for sustainable reform.

Conventional models of care have failed to accommodate the complexity and fluidity of coexisting needs. As highlighted in the FOI data (Chapter 6) and lived experience narratives (Chapter 7), service users are often forced to navigate multiple, poorly coordinated services that do not communicate, share records, or operate with a shared understanding of recovery. These fragmented infrastructures are sustained by institutional inertia and compounded by professional silos that demarcate roles, restrict collaboration, and reinforce division. The IMCM responds to this by proposing a modular and adaptive care infrastructure ,a design that prioritises responsiveness over rigidity and coordination over compartmentalisation.

At the heart of this framework is the formation of integrated, cross-trained care teams capable of working across diagnostic and disciplinary boundaries. These teams are composed of professionals who are jointly trained in mental health and substance use interventions and who operate with a shared philosophy of care. Their mandate is not only to treat clinical symptoms but to engage with the broader socio-economic and relational conditions that shape a person's well-being. By dismantling the epistemological and operational walls between service domains, these teams facilitate truly person-centered care that aligns with the lived realities of individuals navigating multiple intersecting challenges.

Importantly, structural flexibility is not solely about team composition. It also refers to the architecture of service delivery, including care coordination, referral mechanisms, and governance structures. Within the IMCM, care planning is iterative and co-produced with service users, allowing interventions to evolve over time in response to changing needs. Rather than relying on fixed pathways or rigid thresholds, the model enables continuous adjustment based on real-time feedback and outcome monitoring. This approach challenges the dominant logic of standardised interventions and instead embraces complexity, uncertainty, and contextual variation as integral to effective care.

This dynamic design is supported by built-in feedback loops that function at multiple levels. At the individual level, service users participate in ongoing reviews of their care plans, ensuring that support remains relevant and empowering. At the system level, data analytics and outcome tracking inform organisational learning and resource allocation. Unlike conventional models where evaluation is retrospective and external, the IMCM embeds reflexivity into its operational fabric ,transforming service delivery into a process of continuous morphogenesis.

The emphasis on flexibility also acknowledges that structural change must be contextually sensitive. As demonstrated in Chapter 10 local areas vary significantly in terms of population needs, workforce capacity, and available resources. The IMCM does not impose a singular model across all contexts but provides a principled framework within which local adaptations can occur. This capacity for localisation is essential to both feasibility and sustainability, ensuring that the model can operate effectively in rural, urban, custodial, or community-based settings.

Through its focus on structural flexibility, the IMCM disrupts the binary between stability and chaos. It offers a third path ,structured adaptability ,where coherence is maintained not through control, but through coordination, feedback, and shared purpose. This shift is central to moving from a system governed by morphostatic inertia to one capable of genuine transformation. In this sense, structural flexibility is not merely a feature of the IMCM; it is its operational theory of change.

In embedding this principle at the core of service design, the IMCM moves beyond symbolic reform and towards a model capable of responding dynamically to complexity. It resists the allure of static solutions and instead proposes a care infrastructure that evolves with need, learns from experience, and remains accountable to those it serves. In doing so, it transforms integration from an abstract goal into a practical, relational, and structural reality ,one that reflects the lived conditions of individuals with CEMS and the institutional conditions necessary to support them.

11.3 Deep Integration of Social Determinants

While structural flexibility is essential for dismantling rigid service boundaries, it is insufficient on its own to address the layered complexities of CEMS. The IMCM therefore positions the integration of social determinants of health not as a secondary enhancement, but as a foundational element of effective care. In doing so, it challenges the enduring dominance of biomedical frameworks that isolate mental health and substance use symptoms from the broader socio-economic and cultural conditions in which they are embedded.

CEMS cannot be adequately understood ,let alone addressed ,without attending to the structural inequalities that shape people's lives. Poverty, insecure housing, unemployment, food insecurity, exposure to violence, and social exclusion are not peripheral stressors, but core drivers of mental health distress and substance use dependency. As demonstrated in Chapters 6 and Chapter 8, participants in this study frequently linked their substance use to chronic instability, trauma, and marginalisation, revealing how symptoms are often survival responses to unaddressed material realities. FOI data further reinforced this relationship, highlighting how service users were often excluded from care due to factors that were in fact the result of systemic neglect ,such as homelessness, risk profiles, or lack of adherence.

Despite these well-documented dynamics, mainstream service models continue to prioritise symptom management and individual behavioural change, often at the expense of contextually informed support. The logic underpinning such models is one of clinical containment, where care is defined by diagnostic thresholds, risk assessment tools, and standardised treatment plans. This approach not only reproduces medicalisation but actively displaces responsibility for recovery onto individuals, obscuring the social origins of their distress. The IMCM directly challenges this paradigm by embedding social determinants into the core of care planning and delivery.

Operationally, this involves the development of interdisciplinary teams that extend beyond clinical professionals to include social workers, housing officers, employment advisors, and community connectors. These teams are not peripheral additions but central actors in supporting recovery. Their inclusion ensures that care plans do not begin and end with medication adherence or therapeutic compliance, but instead encompass meaningful engagement with housing stability, financial security, and relational support. In doing so, the IMCM reframes recovery not as a linear clinical outcome but as a social process embedded in the material conditions of people's lives.

This holistic approach is not only ethically sound but pragmatically necessary. Chapter 10 demonstrates that failing to address social determinants leads to treatment disengagement, crisis relapse, and repeated service contact ,outcomes that increase individual suffering and drive-up public expenditure. Conversely, addressing these determinants can reduce hospitalisation, improve mental health, and enhance long-term resilience. As the FOI data revealed, more comprehensively funded pathways ,such as Nottinghamshire's ,were able to incorporate these supports, resulting in expanded reach and greater engagement. This is not coincidental; it is structural.

The IMCM also repositions care planning as a co-produced process, where service users are not merely assessed but engaged in the identification of their needs and priorities. By embedding social determinants into these conversations, the model acknowledges that service users often hold a deeper understanding of the structural barriers they face than the professionals tasked with supporting them. This approach strengthens engagement, aligns interventions with lived realities, and redistributes power within the care relationship.

Moreover, the integration of social determinants is critical to challenging systemic inequity. As noted in the theoretical chapters, structural injustice is not only reproduced through funding models and institutional policy but also through the omissions of care systems that fail to recognise social determinants as central to health. The IMCM therefore operates as a corrective model: one that surfaces the political and economic dimensions of distress and incorporates them into the practical and therapeutic dimensions of support. It does so not by replacing clinical intervention but by contextualising it ,recognising that mental health and substance use cannot be treated in isolation from the environments in which they occur.

This commitment to socio-structural integration also enhances the model’s adaptability. By embedding these dimensions into care, the IMCM becomes more responsive to specific community contexts. In areas marked by high unemployment, partnerships with local employers or training providers can be developed; in areas of high housing need, close collaboration with supported accommodation services can be prioritised. This local responsiveness reinforces the model’s practical viability and its alignment with place-based care strategies outlined in national policy documents such as the NHS Long-Term Plan (2019).

Ultimately, the IMCM's integration of social determinants affirms that recovery is not simply a clinical task but a collective one ,requiring coordinated, systemic support that attends to the full ecology of a person's life. By operationalising this principle, the IMCM not only addresses unmet social needs but enacts a more socially just and structurally aware model of care**.** It repositions service users as individuals embedded within systems, and care as a relational, collaborative response to complexity ,not a unidirectional delivery of interventions. In doing so, it marks a decisive move away from fragmented, biomedical models and toward a more equitable, holistic, and sustainable approach to CEMS.

11.4 Enhancing Agency within Structural Constraints

A defining principle of the IMCM is its commitment to enhancing the agency of individuals with CEMS, not as a rhetorical gesture but as a structural and epistemological necessity. As this thesis has shown, conventional service models frequently position service users as passive recipients of care, subject to standardised assessments, rigid eligibility criteria, and top-down decision-making processes. This passivity is not accidental ,it is structurally produced, shaped by institutional cultures that prioritise risk management and compliance over collaboration and self-determination.

The IMCM offers a different vision. It is grounded in the understanding ,derived from Archer's morphogenetic framework ,that agency is never exercised in a vacuum. Rather, it is conditioned by pre-existing structures and cultural norms that enable or constrain the possibilities for action. In the context of CEMS, these constraints are acute. As detailed in Chapters 7 and Chapter 8, individuals often face intersecting barriers of stigma, institutional rejection, and economic precarity, which limit their ability to access support and participate meaningfully in care decisions. These are not simply personal challenges, but manifestations of systemic failures that suppress agency while rhetorically celebrating “service-user involvement.”

The IMCM challenges this dynamic by embedding agency at the core of care planning, not as an outcome of successful intervention but as a precondition for meaningful engagement. This is operationalised through the co-creation of personalised care plans, in which service users are not merely consulted but act as equal partners in shaping their treatment pathways. These plans are iterative, negotiated, and responsive to both clinical need and individual aspiration. They do not assume a linear progression through predefined steps but accommodate uncertainty, change, and complexity , hallmarks of CEMS lived experience.

The inclusion of peer support workers ,individuals with lived experience of mental health and substance use challenges ,is another vital mechanism through which the IMCM enhances agency. These roles serve multiple functions: they provide practical guidance, relational support, and symbolic recognition that lived experience is a form of expertise. Peer workers are not “adjuncts” to clinical teams but integrated members whose presence challenges hierarchical knowledge systems and rehumanises care relationships. As evidenced in Chapter 10, their involvement has been shown to improve trust, reduce disengagement, and foster greater commitment to treatment ,all outcomes with tangible personal and systemic benefits.

Importantly, the model does not assume that agency can be “activated” in isolation from structure. Instead, it recognises that meaningful participation depends on relational trust, procedural fairness, and structural responsiveness. These conditions are rare in the current system, where service users often experience exclusion, conditional access, or tokenistic involvement. For agency to flourish, services must be designed to accommodate disruption, dissent, and difference ,not just compliance. This is where structural flexibility and the integration of social determinants (as outlined in Sections 11.2 and 11.3) become essential preconditions for agential participation.

Moreover, agency must be understood as political as well as personal. To empower individuals with CEMS is also to challenge the systems that have historically silenced, excluded, or pathologised them. As this thesis has shown, many participants exercised agency not by complying with services, but by resisting or circumventing them ,seeking care outside of institutional channels, advocating for themselves in the face of exclusion, or withdrawing from systems that failed to support them. These actions, often framed as disengagement, are more accurately understood as expressions of constrained reflexivity ,what Archer would term "fractured" or "contested" agency in contexts of structural contradiction.

By acknowledging these dynamics, the IMCM reframes agency not as an individual trait, but as a relational practice situated within broader socio-structural conditions. Enhancing agency thus requires changes at every level: professional cultures must be trained to listen and co-produce; policies must be rewritten to remove conditional access barriers; data systems must include user-defined metrics of success; and evaluation frameworks must prioritise user experience as much as service efficiency.

In contrast to traditional care models that define success through throughput, risk containment, or adherence, the IMCM foregrounds agency as both means and end. It asserts that person-centred care is not achieved through occasional consultation or service-user panels, but through a redistribution of power and recognition ,both at the point of care and in the governance of care systems. This is not only an ethical imperative but a strategic one: as shown throughout this thesis, services that fail to engage individuals as agents inevitably reproduce disengagement, relapse, and cyclical crisis.

In advancing a model that enhances agency within and against structural constraints, the IMCM moves from treating individuals to working with them. It affirms that transformation in CEMS care is not possible without the active involvement of those most affected by systemic failure. By building care pathways that are co-created, contextually informed, and structurally supported, the IMCM represents a shift from service delivery to relational partnership ,and from institutional control to shared authorship of recovery.

11.5 Contextualised Care for Special Environments

The IMCM recognises that the needs of individuals with CEMS cannot be met through a universal template. While policy frameworks often call for consistency, this thesis has demonstrated that care must also be *contextually attuned* ,responsive to the specific environments in which support is sought and delivered. Traditional service models, anchored in clinic- or hospital-based infrastructures, frequently fail to adapt to non-clinical settings such as prisons, homeless shelters, and outreach services. As a result, the individuals most in need of flexible, integrated care are often those most likely to be excluded from it.

This exclusion is not incidental. As shown in Chapter 7 and Chapter 10, individuals engaging with services in carceral, temporary housing, or street-based settings often encounter heightened forms of stigma, procedural rigidity, and institutional neglect. These environments are not merely backdrops to exclusion ,they are structurally produced and maintained through a lack of investment, fragmented oversight, and policies that deprioritise care for those deemed 'complex' or 'non-compliant.' In these spaces, trust in services is often low, and the risks of disengagement are high.

The IMCM directly addresses these challenges through its commitment to contextualised care. This is not a superficial commitment to “meeting people where they are,” but a structural reorientation of how care is conceptualised, organised, and delivered. Rather than forcing individuals to adapt to the service environment, the IMCM proposes that services must adapt to the *realities of people’s lives*. This involves designing care that is both relationally safe and structurally accessible ,qualities that are especially critical in high-stigma settings.

In prisons, for example, mental health and substance use are often treated through parallel, reactive pathways, with little communication between service teams. Carceral environments frequently prioritise control and discipline over therapeutic engagement, making integrated care difficult to deliver and even harder to sustain post release. The IMCM responds to this by proposing in-reach, cross-disciplinary teams that can operate within prisons while maintaining links to community-based services. As explored in Chapter 10, continuity of care ,particularly around housing, medication, and relapse prevention ,is essential in reducing recidivism and supporting re-entry.

Similarly, in homeless shelters or outreach programmes, service users face numerous logistical and relational barriers to care, including lack of identification, digital exclusion, and histories of traumatic service encounters. The IMCM’s emphasis on nonjudgemental, trauma-informed engagement, paired with peer support and harm reduction strategies, allows it to be both accessible and acceptable in these contexts. As seen in the Nottinghamshire case (Chapter 6), expanding services into transitional housing and community spaces dramatically improved engagement and extended service reach. Such expansion was not merely a matter of location, but of structural redesign , embedding relational continuity and multidisciplinary collaboration within environments that are typically peripheral to mainstream care systems.

The model's contextualisation also has implications for rural and under-resourced regions, where access to specialised services may be severely limited. In these settings, the IMCM supports the development of hybrid approaches, combining telehealth infrastructure with locally based, cross-trained generalists. This ensures that care is not delayed or denied due to geography, and that engagement is not contingent upon navigating distant or disconnected bureaucracies. As with urban pilot sites, care plans are co-produced, continuously adapted, and designed to evolve with local feedback and resource availability.

What distinguishes the IMCM's approach to contextualisation is its integration of environment-specific dynamics *into the structural logic of the model itself*. It does not treat outreach, in-reach, or place-based adaptation as add-ons to a centralised system. Rather, it builds structural adaptability into the very architecture of care ,allowing services to flex without losing coherence. This is consistent with the morphogenetic logic that underpins the model more broadly: sustained transformation requires not only structural disruption, but a redesign of the relational and cultural conditions through which care is delivered.

By embedding this adaptability into its core design, the IMCM addresses a key gap in current integration efforts: the failure to account for how place, stigma, and exclusion shape both access and outcomes. It moves integrated care beyond rhetorical commitments to flexibility and into the realm of practically enacted responsiveness , ensuring that care remains not only evidence-based, but also environmentally intelligent. In doing so, it expands the reach and relevance of CEMS care, bringing services into alignment with the realities of the people and places they are meant to serve.

11.6 Operationalisation and Implementation

The IMCM offers more than a theoretical vision for integrated care ,it provides a structured and pragmatic roadmap for operationalising systemic transformation. As this thesis has shown, individuals with CEMS face fragmented and often exclusionary service pathways that perpetuate cycles of disengagement, crisis, and institutional mistrust. The IMCM responds to this by detailing how integration can move from policy rhetoric to material reality, embedding change at the level of infrastructure, workforce, governance, and everyday practice.

Central to the model's implementation is the design of clear, co-ordinated care pathways that facilitate seamless transitions between services. These pathways are not linear templates but dynamic frameworks that support flexible entry points, promote relational continuity, and reduce the procedural friction that currently characterises the CEMS care experience. As discussed in Chapter 10, individuals are often passed between services with incompatible eligibility criteria and assessment protocols, leading to delayed interventions and fractured therapeutic relationships. The IMCM addresses this by ensuring that each service is embedded within a wider care ecosystem ,one that shares information, communicates in real-time, and operates under common governance principles.

To maintain fidelity and accountability, the model incorporates robust clinical governance structures. These include mechanisms for routine outcome monitoring, multiagency review processes, and service-user feedback systems that operate not as appendices but as integral components of care. Governance in this model is not merely administrative; it is transformational, designed to promote system learning, responsiveness, and continuous refinement. In keeping with Archer's morphogenetic framework, governance functions not as a static control system, but as an adaptive reflexive structure ,a site where emergent tensions are recognised and addressed in real-time, rather than deferred or ignored.

A critical enabler of implementation is workforce development. As detailed in Chapter 9 and Chapter 10, the current workforce operates within siloed training paradigms that reflect the structural divisions between mental health and substance use care. The IMCM proposes a shift toward cross-disciplinary professional education, embedding knowledge of coexisting conditions, trauma-informed approaches, and relational engagement into the core curricula for health and social care practitioners. This training is not an isolated event but a process of ongoing professional development that enables practitioners to collaborate effectively across traditionally divided domains. Equally, peer support roles are integrated into teams as standard practice, not exceptions, reinforcing the value of lived experience and diversifying the knowledge base within care teams.

The model also acknowledges the financial and logistical complexity of transitioning from a fragmented system to an integrated one. Integration requires not only clinical alignment but also structural reorganisation, digital infrastructure upgrades, and time-limited dual-running of old and new systems. To address this, the IMCM is supported by a phased implementation strategy, outlined in detail in Chapter 10, which balances urgency with realism. It begins with localised pilots, followed by iterative scaleup informed by real-time data and service-user input. Cost-consequence analysis, as discussed in Chapter 10, further reinforces that while initial investments are significant, the long-term economic and social returns ,through reduced crisis care, improved engagement, and workforce retention ,are equally substantial.

Importantly, the model's implementation strategy is not linear or technocratic. It is rooted in a recognition that change occurs through interaction ,between structures, cultural logics, and agential responses. As such, implementation requires more than technical solutions; it demands cultural negotiation, organisational trust, and political commitment. Resistance is expected, as mapped in Chapter 10, and must be anticipated and navigated through inclusive leadership, strategic alignment, and clear communication of the model's purpose and benefits. This includes safeguarding against co-option , where the language of integration is adopted without its structural or philosophical underpinnings ,by embedding fidelity checks and user-defined success metrics into the implementation process.

Ultimately, the IMCM does not offer a formulaic rollout. It provides a principled architecture ,a flexible, evidence-informed structure that can be adapted to local contexts without compromising its core commitments to integration, equity, and agency. It recognises that systems change is not imposed from above but cultivated through coproduction, reflexivity, and an ongoing commitment to aligning care with the complex lives of those it is intended to serve.

In operationalising the IMCM, healthcare systems are not simply reorganising services ,they are participating in a deeper structural transformation that aligns service delivery with social justice, relational ethics, and the lived realities of CEMS. Through its staged, locally adaptable, and systemically grounded approach, the IMCM offers a practical framework for making integrated care not only possible, but durable, scalable, and person-centred.

11.7 Summary of Key Contributions

The IMCM developed in this thesis represents a significant contribution to both the theory and practice of care for individuals with CEMS challenges. Through its integration of structural, cultural, and agential dimensions, the IMCM provides a comprehensive, context-sensitive response to the long-standing problem of service fragmentation. Grounded in the empirical findings of this study and the application of Archer's morphogenetic framework, the model offers not only a critique of current systems but a practical, adaptable blueprint for systemic reform.

The thesis demonstrates that fragmentation is not simply a failure of operational design or policy implementation. Rather, it is the outcome of historically embedded structures ,such as distinct funding streams, regulatory frameworks, and workforce cultures ,that continue to reinforce the separation of mental health and substance use services. These structures are sustained through what Archer conceptualises as **morphostasis** ,a self-reinforcing cycle in which existing systems resist change, even in the face of persistent inadequacy. As shown throughout the historical and policy analysis (Chapter 2 and Chapter 3), past attempts at integration have often failed not due to lack of intention, but due to their inability to penetrate these deeply embedded structural logics.

At the same time, the thesis highlights the powerful role of cultural systems , including stigma, professional hierarchies, and societal perceptions of mental illness and substance use ,in shaping how individuals access and experience care. Cultural dynamics are not simply reflections of structure; they are active in their own right, shaping expectations, institutional behaviours, and clinical decision-making. This was especially evident in the FOI findings, which illustrated how service access is often conditioned by assumptions about 'risk,' 'readiness,' or 'compliance' ,terms that frequently function as exclusionary mechanisms rather than neutral descriptors.

Despite these constraints, this thesis also foregrounds the role of individual agency in navigating, resisting, and occasionally transforming these systems. As the qualitative data reveals, individuals with CEMS are not passive recipients of care. They actively seek alternatives when conventional pathways fail, advocate for themselves in exclusionary contexts, and form alliances with practitioners and peers to access support. However, agency is always situated ,conditioned by the relational and structural context in which it is exercised. The thesis illustrates how agency, while resilient, is often constrained by systemic barriers that limit choice, undermine trust, and fragment care continuity.

By tracing the interplay between structure, culture, and agency, the thesis advances a more nuanced understanding of the complexity of CEMS and the conditions necessary for genuine integration. It argues that effective interventions cannot focus on one domain in isolation. Structural reform without cultural change will replicate existing inequalities under a different name. Cultural shifts without structural support will be fragile and unsustainable. And efforts to enhance agency will falter unless individuals are embedded within systems that validate their choices, honour their experiences, and respond to their realities.

This integrated perspective is synthesised in the development of the IMCM. The model draws directly on the empirical insights of this study, embedding them within a framework that is both theoretically coherent and practically grounded. It proposes structural flexibility to replace rigid, siloed systems; the deep integration of social determinants to ensure care is responsive to lived conditions; the enhancement of agency through co-created care and peer support; and the contextualisation of services to diverse environments such as prisons, rural communities, and homeless shelters. These principles are not independent components but interdependent functions, designed to work collectively to transform how care is delivered, governed, and experienced.

The IMCM does not offer a prescriptive solution but a relational and adaptive framework, capable of being tailored to local contexts while maintaining fidelity to core principles. It is informed by the morphogenetic understanding that lasting transformation requires both structural redesign and cultural elaboration, and that this change emerges through iterative engagement with the complexities of the system. As such, the IMCM is not a static model, but a dynamic, reflexive architecture ,intended to evolve alongside the needs of those it serves.

In offering this framework, the thesis contributes to the academic field in several important ways. First, it brings Archer's morphogenetic framework into empirical dialogue with the field of mental health and substance use for the first time in a sustained way. Second, it demonstrates how a dual-method approach ,combining FOI data with phenomenological inquiry ,can uncover the multi-layered dynamics of system fragmentation and reform potential. Third, it proposes a concrete, theory-informed model that addresses a well-documented but persistently unresolved issue in health and social care.

Finally, the IMCM provides a foundation for transformational practice, demonstrating how integrated care can move from abstract aspiration to material implementation. It challenges policymakers, practitioners, and commissioners to go beyond incremental adjustments and instead reimagine integration as a structural, cultural, and ethical reconfiguration of the system itself.

By bridging critique and innovation, the IMCM makes visible the conditions under which true integration becomes possible ,not as a rhetorical promise, but as a lived, systemic reality.

11.8 Practical Implications

The findings of this thesis carry significant practical implications for policymakers, commissioners, healthcare providers, social workers, and other stakeholders involved in the design and delivery of care for individuals with CEMS. By diagnosing the persistent failures of existing models and proposing the IMCM as a theoretically grounded and operationally viable alternative, this research offers a strategic blueprint for systemic transformation.

A central challenge identified across the thesis is the entrenched fragmentation of mental health and substance use services ,a fragmentation rooted in historical separations, sustained by distinct funding streams, and reinforced by cultural silos. Addressing this requires more than piecemeal adjustments or isolated pilot schemes. As Chapter 6 and Chapter 10 have shown, integration must be embedded at both the policy and operational levels. This involves rethinking commissioning models to ensure unified funding streams, establishing national service standards that mandate collaboration, and introducing regulatory frameworks that hold systems accountable for integrated delivery.

The decentralisation of public health commissioning under the Health and Social Care Act 2012 has exacerbated regional disparities in provision and must be critically reassessed. National guidelines that provide both clarity and consistency across localities are essential to ensuring that individuals with CEMS are not subjected to postcode-dependent care.

Securing adequate and sustained funding is equally critical. While much policy rhetoric supports the idea of integration, this thesis has shown that genuine reform is impossible without strategic investment. The IMCM highlights the need for funding to be directed not only toward expanding service capacity, but toward training, infrastructure development, and continuous evaluation mechanisms. Workforce development is a particularly urgent priority. As noted in Chapter 9 and Chapter 10, practitioners across mental health and substance use sectors must be equipped to work collaboratively, drawing on shared knowledge bases and operating from a position of mutual respect. Investment in professional development, particularly in cross-disciplinary and trauma-informed training, is essential to fostering the kind of collaborative practice that integration demands.

Alongside structural and financial reform, this thesis emphasises the necessity of cultural change within healthcare systems. Stigma ,both institutional and interpersonal , continues to distort service delivery and shape user experiences in ways that perpetuate exclusion. As evidenced in Chapter 7, service users frequently internalise messages that they are ‘too complex’ or ‘undeserving’ of support, leading to disengagement and mistrust. Addressing this requires national anti-stigma campaigns, but also local initiatives embedded in organisational culture. Anti-stigma training, reflexive supervision, and peerled education should be mainstreamed within healthcare and social services to ensure that equity and dignity are not aspirational values but everyday practices.

At the level of service delivery, the IMCM presents a clear, person-centred model capable of guiding clinical and community-based interventions. Integrated, multidisciplinary teams ,comprising professionals with cross-sectoral training and lived experience ,are better positioned to respond to the complex, layered realities of individuals with CEMS. These teams co-create personalised care plans that reflect the unique needs, strengths, and aspirations of each service user, shifting the paradigm from compliance to collaboration. As explored in Chapter 10, this relational and iterative approach enhances therapeutic engagement and increases the likelihood of sustained recovery.

The IMCM also supports a more adaptive and flexible approach to care pathways, allowing for the evolving nature of service users' needs. Continuous assessment and feedback mechanisms ensure that care remains relevant and responsive, avoiding the common trap of static, standardised interventions that fail to account for change. This responsiveness is particularly crucial for addressing social determinants of health, which are often overlooked in narrowly biomedical models. As discussed in Chapter 10, interventions that support housing stability, financial security, employment access, and social inclusion are critical to long-term recovery. Embedding these supports within care plans and ensuring they are delivered in coordination with clinical interventions ,is vital to preventing relapse and fostering resilience.

Finally, the thesis underscores the importance of promoting cultural humility and advocacy within professional environments. Practitioners must not only provide compassionate, non-judgemental care but also actively challenge discriminatory norms within their teams, organisations, and systems. Change cannot be delegated to service users alone; it must be modelled, enacted, and upheld by the systems that claim to support them.

In sum, the IMCM offers a pragmatic and theoretically grounded framework for responding to the deeply interconnected challenges of CEMS. It calls for the simultaneous transformation of structures, cultures, and practices ,recognising that integration cannot occur in isolation from equity, trust, and power redistribution. Policymakers, commissioners, and practitioners who adopt the IMCM have an opportunity not only to improve service outcomes, but to realign care systems with the principles of social justice and relational accountability. In doing so, they move closer to realising integrated, person-centred care as a structural norm, rather than a rhetorical aspiration.

11.9 Limitations of the Study

While this thesis provides meaningful insights into the systemic and lived challenges faced by individuals with CEMS, it is important to acknowledge the methodological and contextual limitations that shape the scope and interpretation of its findings. These limitations do not undermine the value of the research but offer important boundaries within which its contributions should be understood.

One of the primary limitations concerns the scope and scale of the qualitative sample. The study drew on in-depth interviews with a relatively small group of participants, selected for their capacity to speak directly to the experience of navigating fragmented services. While these narratives offered rich, textured accounts of how structural and cultural forces shape individual experiences, the small sample size limits the generalisability of the findings. The depth and nuance of qualitative inquiry are well suited to uncovering patterns, meanings, and contradictions in lived experience, but they cannot provide statistical representation or predict prevalence across broader populations.

The study's geographic specificity further limits its generalisability. All participants were based in Stoke-on-Trent, a region with a notably high prevalence of both mental health and substance use challenges. While this made it a highly relevant and revealing case study, the particular socio-economic and institutional characteristics of the region , such as deprivation levels, commissioning structures, and community resources ,may not reflect those of other localities. Findings drawn from this context must therefore be cautiously applied to regions with different healthcare infrastructures, demographic profiles, or cultural conditions. The extent to which the IMCM can be directly replicated in other settings depends on local context, though its core principles remain adaptable.

The COVID-19 pandemic also shaped the research process in important ways. The need to transition from face-to-face to remote interviews introduced practical and relational constraints. While telephone and video calls enabled continued engagement with participants, these modes of interaction may have limited the spontaneity, depth, or emotional immediacy of responses. Furthermore, the pandemic itself altered service delivery, increased social isolation, and exacerbated anxiety ,factors that may have influenced how participants experienced care and reflected on their situations. These conditions became part of the data but also introduced variables that were not uniformly present across all participants or transferable to post-pandemic contexts.

The study's exclusive reliance on qualitative methods, while essential for capturing the complexity of experience and the interplay of structure, culture, and agency, means that the findings should be read as illustrative rather than statistically generalisable. Qualitative approaches provide a powerful means of accessing individual perspectives and uncovering hidden dynamics, but they are inherently context-dependent and not designed to generate universally applicable conclusions. That said, the insights produced here offer a vital foundation for hypothesis generation, policy critique, and the development of more robust, mixed-method evaluations of integrated care models in future research.

In addition to these methodological considerations, the application of Archer’s morphogenetic framework introduced its own challenges. While the framework proved valuable in disentangling the layered interactions between structural conditioning, cultural systems, and agential responses, its operationalisation within empirical research required significant interpretive work. Concepts such as morphostasis, morphogenesis, and reflexivity ,though analytically powerful ,are abstract and multifaceted, demanding careful adaptation to empirical data without reducing their theoretical richness. This complexity may have influenced the way in which data was coded, synthesised, and presented, particularly in framing the relationship between institutional logics and individual experiences.

Despite these limitations, the theoretical contributions of this thesis ,and particularly the development of the IMCM ,retain broader applicability. While the empirical insights are shaped by the particular conditions of Stoke-on-Trent, the underlying propositions advanced in this research ,namely, that structural and cultural transformation is necessary for meaningful integration, and that agency must be both recognised and supported ,are not context-specific. These principles offer a durable foundation upon which models of integrated care can be designed, tested, and adapted across a range of socio-cultural and institutional settings.

In summary, while the findings of this study are best understood as contextually grounded and theoretically informed, rather than universally generalisable, the broader insights offer valuable contributions to the design and implementation of more integrated, equitable, and person-centred models of care. By acknowledging the limits of its methodology and the specificity of its context, this thesis remains committed to the principles of epistemological transparency and conceptual rigour ,offering not definitive answers, but a framework for continued inquiry, adaptation, and transformation.

11.10 Future Research Directions

While this thesis has made substantial contributions to the understanding of CEMS and has introduced the IMCM as an innovative response to system fragmentation, several important avenues for future research remain. These areas of inquiry are critical for refining the model, evaluating its impact, and ensuring its relevance across diverse contexts.

One of the most immediate priorities is the practical implementation and empirical testing of the IMCM in real-world service environments. Although the model has been conceptually and theoretically developed in this thesis, its practical effectiveness across various health and social care settings requires sustained evaluation. Pilot studies and case-based research are necessary to assess how the IMCM performs when translated from theory into practice. Such research should explore its application in community mental health teams, acute hospital settings, primary care services, and social support systems, identifying the operational enablers and barriers that shape implementation. These studies will be critical in understanding how the model can be scaled, adapted, and refined for different organisational and clinical landscapes.

In addition to operational feasibility, future research should explore how the IMCM can be adapted to different socio-cultural and geographic contexts. The model, as developed here, is grounded in the specific realities of Stoke-on-Trent ,a locality with high levels of deprivation and a unique service ecology. While many of the challenges identified are mirrored elsewhere, further investigation is needed into how the IMCM might be contextualised for settings with different population demographics, healthcare infrastructures, and cultural attitudes toward mental health and substance use. For instance, in rural regions with limited access to specialist services, telehealth-supported integration may be critical, whereas in multicultural urban environments, culturally competent adaptations will be essential to address varied help-seeking behaviours and community expectations.

A further research imperative is the longitudinal evaluation of the IMCM's impact on individual and systemic outcomes. While the model is designed to support recovery, improve care coordination, and reduce fragmentation, its actual effects on health trajectories, relapse rates, and quality of life remain to be empirically tested over time. Longitudinal studies tracking individuals receiving care within the IMCM could offer valuable insights into its capacity to generate sustained benefits, not only for service users but also for systems ,through reduced emergency presentations, improved staff retention, and cost efficiencies.

Broader sociocultural influences on CEMS care also merit deeper exploration. In some communities, stigma and cultural perceptions of mental illness and addiction significantly shape engagement with services. Future research should investigate how these attitudes interact with service design and delivery, and how models like the IMCM can be adapted to address stigma-related disengagement. This includes exploring how peer support, community-led interventions, and culturally grounded messaging can support integration efforts and build trust with historically marginalised groups.

Relatedly, further research is needed into the intersectionality of identity and structural vulnerability**.** Race, gender, sexuality, class, disability, and immigration status intersect in ways that influence both service access and health outcomes. Individuals from marginalised backgrounds often encounter compounding barriers within systems designed around normative assumptions of identity, behaviour, and compliance. Future research could examine how intersectional experiences shape the effectiveness of integrated care and what specific adaptations are needed to ensure equity within the IMCM. This work is crucial not only for enhancing inclusivity but also for ensuring that integration does not inadvertently reinforce existing inequalities under the guise of reform.

The role of social determinants of health in shaping CEMS trajectories also remains a rich area for further inquiry. While this thesis has foregrounded factors such as poverty, housing instability, and employment precarity, future research could examine the mechanisms through which these determinants interact with cultural and institutional systems to shape service engagement, retention, and outcomes. Comparative studies across regions or nations could offer insight into how different welfare and healthcare infrastructures either mitigate or amplify these effects.

Finally, as healthcare systems continue to evolve in response to globalisation, migration, and cross-national policy exchange, future research should explore the transnational applicability of the IMCM. Models of integrated care differ widely across countries due to variations in governance, funding, and cultural norms. Understanding how the IMCM aligns ,or must be adapted ,to international frameworks will be essential for its broader uptake and relevance. Cross-cultural collaborations and global implementation studies could test the model's flexibility and identify universal principles versus context-specific components.

In summary, while this thesis lays a strong conceptual and empirical foundation, the development and refinement of the IMCM must be an ongoing, iterative process. Future research should prioritise its implementation across settings, explore adaptations for diverse populations, and examine long-term impacts on individuals, systems, and communities. By doing so, the field can continue to move beyond fragmented, siloed interventions and toward care models that are not only structurally integrated, but culturally responsive, agentially inclusive, and socially just.

11.11 Final Reflections

Personal Insights

This research journey has been eye-opening, both academically and personally. When I started, my focus was on using theoretical frameworks to understand the complexities of CEMS. But as I went deeper, I found my assumptions being challenged, and my understanding of the interplay between structural, cultural, and individual factors became far more nuanced than I had anticipated.

One of the biggest surprises was realising that the conversation about service fragmentation and the need for integration has been happening for decades ,without much real change. This was frustrating. Time and again, I saw the same systemic barriers cropping up, as if the system had been stuck in place for years. Later, I came to understand this through Archer's concept of morphostasis ,the tendency of structures to resist change, even when that change is badly needed. Hearing the same struggles repeated in my interviews only reinforced that frustration, making it clear that we don't just need more research documenting the problem ,we need real solutions that push for morphogenesis, for meaningful transformation.

As I listened to people talk about navigating fragmented services, facing stigma, and trying to assert themselves in a system that often dismissed them, I realised just how deeply these structural and cultural factors shape their experiences. I expected these issues to be important but hearing them first-hand made me see how profoundly they impact every part of a person's life. It became impossible to ignore the limitations of biomedical approaches that reduce addiction and mental health struggles to individual pathology rather than recognising the wider structural and social realities that shape them. These insights became the foundation for the Integrated Morphogenetic Care Model (IMCM) ,a response not just to what I had read in the literature but to what people told me about their own lives.

What also surprised me was the resilience and agency of the people I spoke to. I had expected the research to focus primarily on how structures and cultural barriers limited people's choices, but what I found was that, despite everything, people were actively navigating, resisting, and adapting to these constraints in ways that were both powerful and inspiring. This shifted my focus. Instead of just documenting barriers, I became more interested in exploring how systems could do a better job of supporting and strengthening people's agency, rather than constantly shutting them down.

Working with Archer's morphogenetic framework also became a challenge of its own. Applying such a complex theoretical model to a real-world issue like CEMS wasn't straightforward. I had to be careful about how I used it, making sure it helped explain the dynamics at play without forcing them into a rigid framework. But by the end of this process, I was more convinced than ever that critical realism offers a valuable way to understand social issues ,not as fixed problems, but as constantly evolving systems that can be changed.

Beyond the academic side of things, this research made me even more aware of how much real-world change is needed. By bringing together theory and lived experience, this thesis does more than just critique existing approaches ,it presents a practical model for change. The IMCM isn't just a theoretical concept; it's a blueprint for real service transformation, built on evidence and shaped by the voices of those who have been failed by the current system. I hope this work contributes to ongoing conversations in both research and practice, pushing for more compassionate, effective, and person-centred care for individuals with CEMS.

Closing Thoughts

At its core, this thesis is about bridging the gap between theory and practice in mental health and substance use care. Using Archer's morphogenetic framework and developing the IMCM, I've argued for an approach that sees people as more than their diagnoses ,one that acknowledges structural and cultural barriers while also recognising individual agency.

The importance of this work goes beyond its theoretical contributions. If anything, this research has reinforced my belief that we don't need more reports that sit on shelves, diagnosing the problem without pushing for action. The IMCM is meant to be a practical tool, something that policymakers, healthcare providers, and social workers can use to rethink how services are designed. The challenges in mental health and substance use care are only growing, and we need models that are flexible, person-centred, and built for real-world application.

More than anything, this research has confirmed for me that integrating social theory with empirical research is essential if we want to create real change. This thesis is just one piece of a much bigger conversation about how we treat people struggling with coexisting mental health and substance use challenges. But if it helps move the conversation forward, challenge outdated approaches, and push for more humane, equitable, and effective care, then it will have done its job.

11.12 Summary

This thesis began with a simple but pressing question: why do individuals with co-existing mental health and substance use difficulties continue to fall through the cracks despite decades of reform rhetoric? Through historical analysis, policy scrutiny, FOI data, and lived experience accounts, it has shown that fragmentation is not incidental but structural, not temporary but enduring. Archer's morphogenetic framework revealed how entrenched logics of separation, stigma, and responsibilisation reproduce morphostasis even as policies promise integration.

Yet the findings also showed that change is possible. Where services aligned funding, governance, and cultural openness, outcomes improved, engagement deepened, and trust was rebuilt. The IMCM emerges from these insights as a blueprint for morphogenesis, systemic transformation that is not rhetorical but real. It is not a static solution but a principled, adaptive framework that embeds flexibility, social determinants, agency, and contextual responsiveness into the architecture of care.

The contribution of this thesis is therefore threefold. First, it advances theory by applying morphogenetic analysis to CEMS, showing how structure, culture, and agency interact in the persistence, and potential disruption, of fragmentation. Second, it contributes methodologically by combining FOI analysis with phenomenology to uncover both institutional patterns and lived consequences. Third, it offers a practical innovation in the form of the IMCM, a model capable of guiding reform at local and national levels.

The limitations of the study, its qualitative scale, geographic specificity, and pandemic context, are acknowledged, but they do not detract from the central claim: that integration will remain elusive unless services are structurally flexible, socially responsive, and co-produced with those who use them. Future research should test and refine the IMCM across contexts, track its long-term outcomes, and adapt it for diverse populations.

The final reflection is clear: the persistence of fragmentation is not inevitable. It is sustained by choices, cultures, and policies that can be changed. The IMCM provides a route forward, not as a finished product, but as a scaffold for ongoing reform. By aligning theory, evidence, and lived experience, this thesis contributes to the work of building services that are humane, integrated, and just.

This final chapter demonstrates how the study’s aims have been achieved. It has developed an understanding of the challenges faced by people with CEMS, evidenced both through historical legacies and contemporary barriers. It has explored stigma and discrimination not as marginal issues but as structural and cultural logics that define access and outcomes. It has identified the lived difficulties of seeking support, showing how service silos, eligibility thresholds, and long waits manifest in everyday life. And it has proposed solutions through the IMCM, which offers a theoretically grounded and practically viable framework for redesigning services.

The objectives are likewise fulfilled. Service-user and professional insights were gathered and analysed through phenomenology, showing how stigma and exclusion operate in practice. FOI data provided evidence of systemic gaps, funding inequities, and structural inertia. The analysis clarified how substance use often functions as self-medication, how co-existence is the norm rather than the exception, and how treatment is rendered unavailable by structural design rather than clinical impossibility. Each objective is therefore carried through the analysis and crystallised in the IMCM as a response.

In conclusion, this thesis contributes both to scholarship and to practice by diagnosing the persistence of morphostasis and offering a pathway to morphogenesis. Its final claim is both analytical and normative: that integrated care for CEMS must be structurally embedded, culturally reoriented, and agentially inclusive. Only then will the longstanding rhetoric of “no wrong door” move from aspiration to lived reality.

12. References

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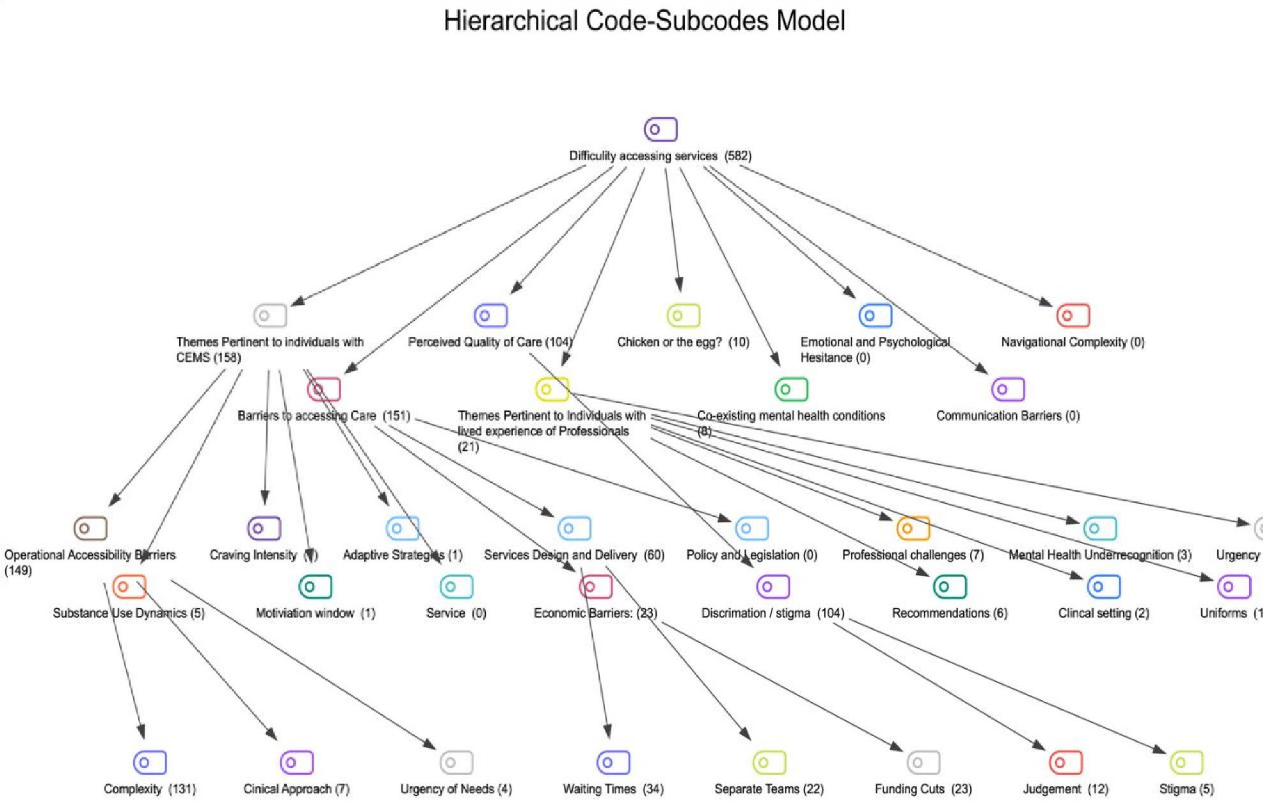
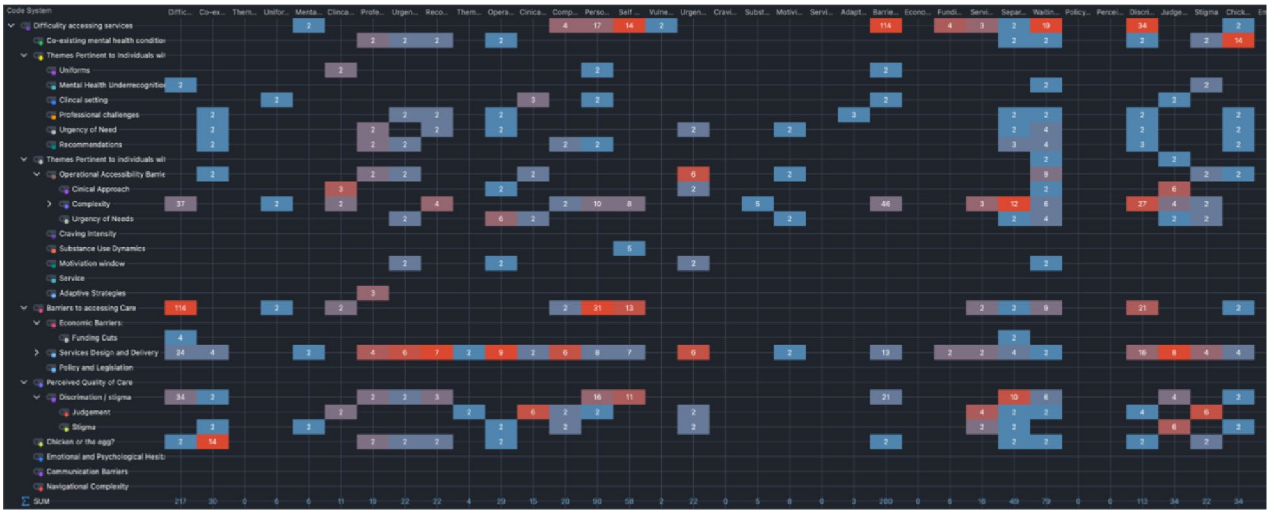
Appendix 1





Code System	Diffic...	Co-ex...	Them...	Unifor...	Menta...	Clinca...	Profe...	Urgen...	Reco...	Them...	Opera...	Cinica...	Comp...	Perso...	Self ...	Vulne...	Urgen...	Cravi...	Subst...	Motivi...	Servi...	Adapt...	Barrie...	Econo...	Fundi...	Servi...	Separ...	Waitin...	Policy...	Percei...	Discri...	Judge...	Stigma	Chick...	Em
Difficulty accessing services					2								4	17	14	2							114		4	3	2	19			34			2	
Co-existing mental health conditio							2	2	2		2																2	2			2		2	14	
Themes Pertinent to individuals wi																																			
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Mental Health Underrecognitio	2																											2					2		
Clincal setting				2								3		2									2									2			
Professional challenges		2						2	2		2											3					2	2			2			2	
Urgency of Need		2					2		2		2						2			2							2	4			2			2	
Recommendations		2					2	2					2	2													3	4			3			2	
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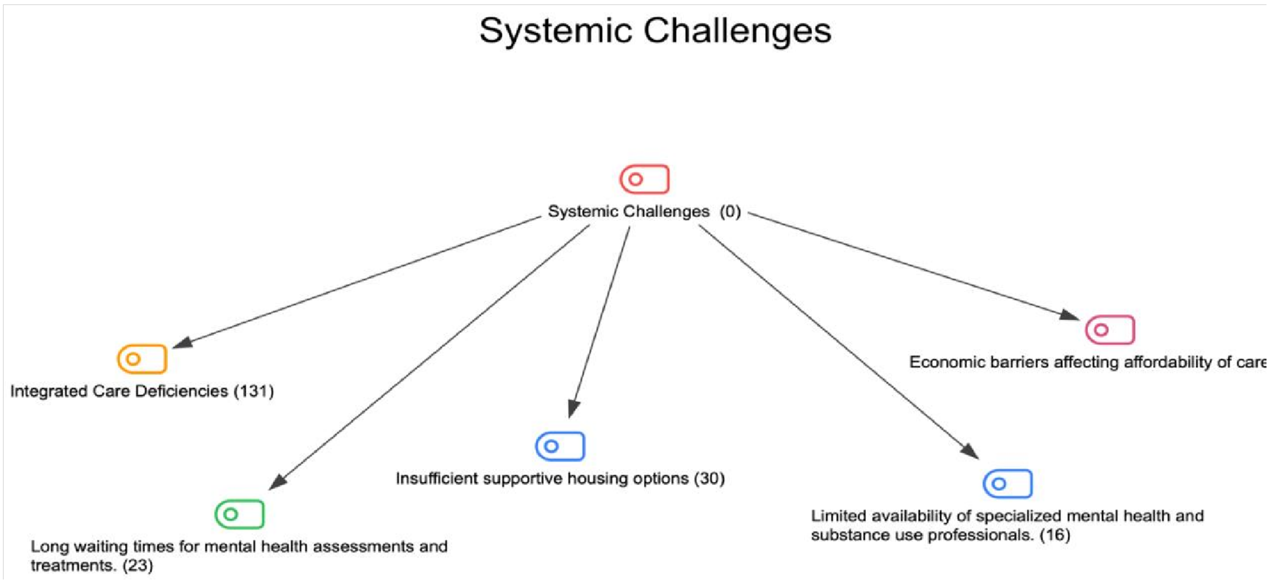
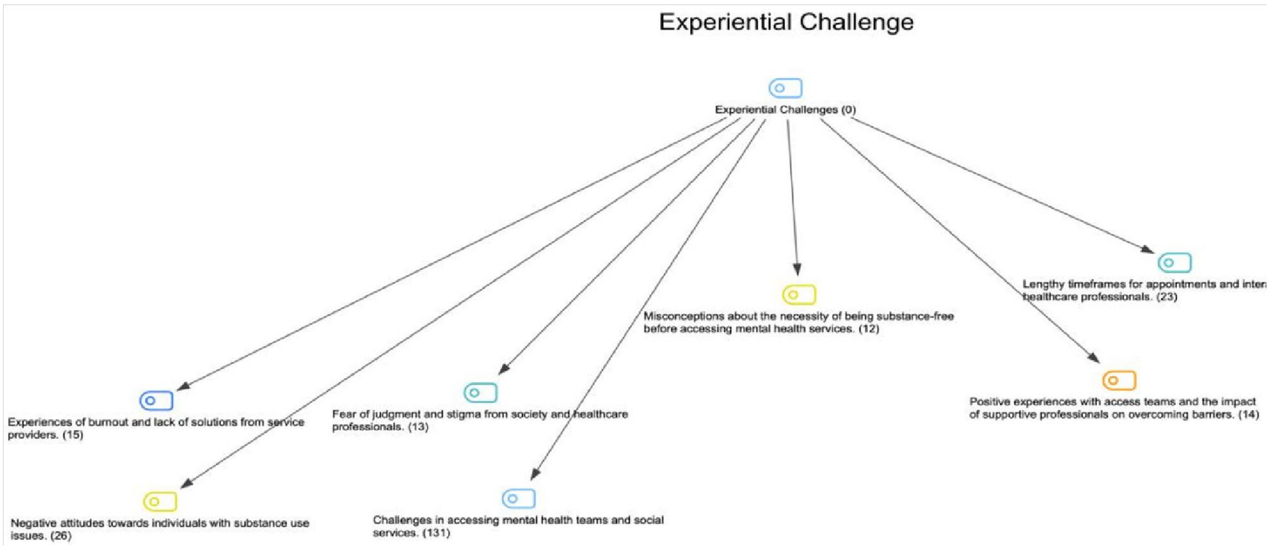
Operational Accessibility Barrie		2					2	2				2					6			2								9					2	2	
Cinical Approach						3					2						2											2				6			
Complexity	37			2		2			4				2	10	8				5				46			3	12	6			27	4	2		
Urgency of Needs								2			6	2								2							2	4				2	2		
Craving Intensity																																			
Substance Use Dynamics															5																				
Motiviation window								2			2						2											2							
Service																																			
Adaptive Strategies							3																												
Barriers to accessing Care	114			2		2							2	31	13											2	2	9			21			2	
Economic Barriers:																																			
Funding Cuts	4																										2								
Services Design and Delivery	24	4			2		4	6	7	2	9	2	6	8	7		6			2			13		2	2	4	2			16	8	4	4	
Policy and Legislation																																			
Perceived Quality of Care																																			
Discrimation / stigma	34	2					2	2	3					16	11								21				10	6				4		2	
Judgement						2				2		6	2	2			2									4	2	2			4		6		
Stigma		2			2						2		2				2									2	2					6		2	
Chicken or the egg?	2	14					2	2	2		2												2				2	2			2		2		
Emotional and Psychological Hesit																																			
Communication Barriers																																			
Navigational Complexity																																			
∑ SUM	217	30	0	6	6	11	19	22	22	4	29	15	20	90	58	2	22	0	5	8	0	3	200	0	6	16	49	79	0	0	113	34	22	34	

Appendix 4


Systemic Challenges


Experiential Challenge

Appendix 5

Category	Number of Interviews	Pseudonym	Description

Person with a lived experience of CEMS	12	LE 1	Individuals who have personally navigated the complexities of coexisting mental health and substance use issues.
NHS Professionals	7	NHS 1	Healthcare professionals within the National Health Service who work directly with people affected by CEMS.
Non-Statutory Services Workers	4	NSW 1	Individuals working in organisations outside the NHS framework yet supporting people with CEMS.

Prison Worker	1	PS 1	A professional working within the prison system, providing insights into how CEMS is addressed in correctional settings.