Section six
Structures

Service Delivery

"People with a dual diagnosis, are in effect, a kind of mental health underclass. They find that their needs are not severe enough to meet the criteria of any single agency, so they can just fall below the threshold of all the 'helping' services. For example, they may have mild ideas of suspicion but may not be clearly psychotic. They may have been to prison but not long enough to be followed up by probation. They may have been squatting with friends, but not technically homeless. There may be no clear reason why social services should allocate a social worker. As a result, they have a dreadful quality of life, even though they may have six or seven major problems, they may receive either no help, or just bits and bobs of help without clear co-ordination."

Psychiatrist

Although this toolkit is focused on practical issues, there are also underlying issues around the structure and culture of services that have a significant impact on both workers and clients. Therefore, in this section we consider:

- The challenges of delivering an holistic approach
- Some ideas for better integration between services
- Identifying and meeting training needs
- Some good practice examples

The challenges of delivering an holistic approach

The basic underlying principle of supporting people with a dual diagnosis needs to be client-centred. This produces challenges at all levels - from strategic, to operational planning, to delivery at the front line. These challenges arise because most clients have a range of issues including physical health and social care needs. Whilst it can be easy to talk about the concept of holistic care, in practice it can be difficult to co-ordinate inputs across many disparate services with their own cultures and policy frameworks. We have already seen that there are problems in joint working between mental health and substance misuse. However, a truly holistic approach would also need to involve social services and a range of providers in both the statutory and voluntary sectors.

In this section we look at some of the issues around social care. We then consider issues between mental health and substance misuse.

Social care

In practice, it is often the social issues such as poverty, unemployment, housing and social isolation that have the greatest impact on a person's ability to engage with treatment. For example, housing is a major issue. Those who are homeless or have insecure housing tend to have greater difficulties in attending appointments and taking medication regularly. They may also suffer social isolation that exacerbates their mental health problems and increases their vulnerability to substance misuse and poor general health.

One study shows that homeless people with mental illness and substance dependency were five times more likely to lose contact with caring agencies as those who were not similarly dependent. Conversely, suitable housing can bring about increased stability, an improvement in engagement and treatment outcomes, promote recovery, lessen the likelihood of relapse and encourage social interaction.

Sadly, there is a huge shortfall in supported housing for many vulnerable groups and those with complex or multiple needs can find it extremely difficult to access and maintain suitable accommodation.

"Dual diagnosis patients are often the bed blockers – no-one will take them after hospital. Services like housing and day centres shy away. They want people who are drug-free."

Mental health nurse

A wide range of other social factors may also be relevant to this client group. The illegal nature of some drug taking may lead to a criminal record, which in turn makes it hard to find a job or meaningful daytime activity. People may become socially isolated and lose contact with friends or relatives. Poverty and problems with benefits can lead to rent arrears and then put housing in jeopardy. On top of this, people from ethnic minorities can face a range of cultural barriers.

Issues between health and substance misuse services

"Dual diagnosis clients are everybody's business, but nobody's priority. Substance misuse and mental health are two parallel universes with totally different cultures and commissioning practices."

Clinician and researcher

"There seem to be two conflicting models at work here. In mental health services, people can be seen as sick, their responsibility is taken away from them and gradually they become reliant on the services. In substance misuse services, current thinking is that people need to take responsibility for their own drug use and the problems that has brought on. These two models don't really come together. If you're the client in the middle of this, you may be receiving very contradictory messages".

Clinician and researcher

There is a range of issues at both a strategic and operational level:

- **Substance misuse and mental health operate differently**
  Although there is some joint thinking at a strategic and commissioning level, the two services still function differently at a planning, funding and operational level. This means that people with multiple needs are often passed from one service to another or fall through the gaps completely. A recent study by Turning Point and the IPPR '*Meeting Complex needs, The Future of Social Care, 2004*' has highlighted that, although the commissioning process has four distinct elements: assessment, planning, commissioning and monitoring, all four are rarely fulfiled.

- **Different cultures/ideologies**
  Although practice varies, substance misuse and mental health services are based around different treatment philosophies and so have developed in very different ways.

  Substance misuse services place more emphasis on a psycho-social perspective and offer treatment based on these ideas. It is generally necessary for the service user to be motivated and capable of engaging in treatment. Mental health services often adopt a more medical model of treatment and, if necessary, have powers under the Mental Health Act to provide treatment to an individual, even if they do not wish it.

  It is understandable that these different ideologies translate into different ways of operating. For example, Community Psychiatric Nurses are based in the locality and visit people in their homes whilst most substance misuse services tend to expect a client to attend an appointment.

- **Rigid professional boundaries and lack of training**
  Practitioners in either field may regard this client group as outside their professional remit. They may feel they lack the necessary understanding, skills or resources or that they have not received appropriate training. Others may feel that their particular specialism is being challenged. There will always be a need for specific and distinct skills, but this should not preclude collaboration with other practitioners.

- **Lack of clarity about roles and responsibilities**
  This can lead either to a duplication of work (for example with assessments) or a failure to take appropriate action.

- **Pessimism about outcomes**
  People who have co-existing needs are undoubtedly challenging to work with. Several studies have found poor records of compliance with treatment and worsening of psychiatric symptoms in comparison with people who have a single diagnosis.

It is important to recognise these factors. However practitioners should note that the difficulties might arise precisely because multiple needs cross professional structures. Hence the problems may arise from the services rather than the individual. Other studies have shown that treatment and care does work for this client group.

"People in mental health can see people's continuing use of drugs as sabotaging the care they are receiving. They forget to ask the reasons why people start or relapse."

Worker in substance misuse

"We need to have realistic goals for ourselves just as much as for clients. Sometimes it feels like taking down a wall with a teaspoon. We need to remember that change can happen even if can take years."

Dual diagnosis trainer

Ideas for better integration between services

Greater integration needs to be approached at both a strategic policy level and in terms of operating structures and practices on the ground.

Strategic level

- Links between government policies: For example, it would be helpful to link the current work of separate departments on social exclusion and mental health, guidance on personality disorders, delivery of services to people from different ethnic groups and changes to the Supporting People framework. The Social Exclusion Unit at the Office of the Deputy Prime Minister has made some encouraging moves in this direction as has the development of the National Institute for Mental Health in England (NIMHE)

- Co-ordinating commissioning and planning: It is essential that those planning, commissioning and delivering services are clear about the nature and extent of need. There is a need to develop clear commissioning protocols that promote co-ordinated care. At the same time, these processes need to be flexible to recognise local need and to identify which agency is best placed to provide which service in a given area

- Promoting mutual understanding: practitioners can do much here to understand what different services do, how to access and refer, set up systems and processes for interagency working and ensure that case working across agencies is working effectively. (The Networking Tool provided as part of this pack is intended to support practitioners in this process. See page 1 for details of how to order.)
  Informal networking between practitioners can also be extremely useful in building relationships and understanding

"What would be helpful is to share good practice about service development. There's the high-level policy advice and now some guidelines about working with individuals. The gap is – how have different services put the policy into practice? What works best in different areas? And, importantly, what hasn't worked. I often wish we had more courage to be honest about what doesn't work and then we could learn from that."

Worker in mental health

Operational level

This section looks specifically at opportunities for greater integration between substance misuse and mental health.

The Department of Health's '*Dual Diagnosis Good Practice Guide*' states that the primary responsibility for the treatment of individuals with severe mental illness and problematic substance misuse lies with mental health services. It describes three current models of service delivery in the UK:

- **The serial model:** "implies treatment of one condition before the other"
- **The parallel model:** "implies concurrent, but separate treatment of both conditions (by different teams)"
- **The integrated model:** "implies the concurrent provision of both psychiatric and substance misuse interventions but requires the same staff member or clinical team working in a single setting to provide relevant psychiatric and substance misuse interventions in a co-ordinated fashion"

The favoured approach is to work towards the integrated model. Services are recommended to agree a definition of dual diagnosis based on local need and to use this to guide service development.

There are several possible service models:

- **Dedicated dual diagnosis teams**
  In this model, all workers receive specialist training and lead the provision of dual diagnosis care. Whilst this is recommended in some circumstances, there can be difficulties. The model may be too expensive and too specialised to address a range of issues. Some people may be excluded because they do not meet the strict criteria for access.

  At the same time, there can be problems with heavy caseloads and staff burnout. This is particularly true if there are unrealistic expectations that this team should be responsible for all dual diagnosis clients.

- **Training of specialist dual diagnosis workers**
  Here the specialists would be placed within generic services and would spread expertise about dual diagnosis issues.

- **Networks of clinicians with expertise in dual diagnosis issues**
  These would be placed within teams where there are high levels of need.

  The choice of model will depend on service structures and situation locally. Every model has benefits and disadvantages.

- **Case Management**
  Whatever model is used, effective caseworking is central and this needs skilled caseworkers with capped caseloads[1].

  As Checinski[2] points out, whatever model is chosen, some individuals will not fit into it. Therefore it is important to have a strong keyworker system to broker a range of care. He sees this as a "virtual team" with a client and keyworker at the centre and a network of relevant agencies around them. Depending on the needs of the individual, this might include mental health nursing, substance misuse teams, psychiatry, clinical psychology, the primary care trust and the local authority providing housing and education. Checinski concedes that this has the advantage of flexibility, but not the cohesion of a "physical team".

Good practice recommendations

Map existing service provision and agencies

A wide range of additional agencies may be relevant to this client group including A&E, social services, primary care, housing associations, police, probation and other criminal justice agencies, specialist agencies working with diverse issues. It is recommended that a dual diagnosis steering group be formed to map out the full range of possible services. (A Networking (mapping) Tool is provided in association with this toolkit. Please see page 1 for details of how to order this.)

Good liaison and partnership between agencies

It is important to build relationships with a range of services, to understand their referral criteria and the care and support they provide. It is essential that practitioners are aware of acute inpatient services as well as those based in the community.

"Informing other professionals about what services are on offer, where they are based and how to refer can be as valuable as drug and alcohol awareness."

Senior Team Leader, Community Drug Project

Multi-agency approach

This requires joint ownership of goals as well as clarity about the roles and responsibilities of each agency. An agreed care plan is central to this approach (see page 30 on the '*Care Programme Approach*'). It is important that the treatment goals agreed for each individual are clarified between agencies and that they are felt to be realistic.

Issues to be covered by inter-agency protocols

- What each agency does and can offer for the client group
- Common assessment tools and procedures
- Agreed care pathways, including referral arrangements, assessments, service provision and arrangements for discharge from hospital or prison
- Confidentiality/data sharing
- Standardised data collection
- Discharge arrangements for all services
- Joint training plans
- Risk assessment

Pathways for referral

When the joint working as described above is still not able to support a particular individual, there should be a clear pathway for referral to more appropriate agencies.

Clear plan for ongoing care

An agreed strategy for continuing care is important in minimising relapse and maximising outcomes.

Identifying and meeting training needs

"Yes, we need skills training but we also need to work on changing staff attitudes. People in substance misuse are reluctant to work with "mad" people and people in mental health are nervous about working with substance misuses. Actually there are strong parallels with client work – we need to listen empathetically, to understand what workers are afraid of, what the barriers are and roll with that resistance. Just as with clients, one session won't do it – it will need time and ongoing support."

Dual diagnosis trainer

"We urgently need more dual diagnosis specialists on the wards to bridge the knowledge gaps. The levels of skills and knowledge are very low."

Dual diagnosis nurse

The Department of Health's '*Dual Diagnosis Good Practice Guide*' recommends that services undertake an audit of training needs. It also suggests core competencies that are relevant to all staff in all settings. These are:

- Knowledge of dual diagnosis
- Drug and alcohol awareness
- Assessment skills for substance misuse
- Assessment skills for mental health problems
- Risk assessment and management
- Knowledge of the management of substance misuse problems
- Knowledge of the management of mental health problems
- Engagement skills
- Care co-ordination
- Motivational enhancement strategies including Motivational Interviewing
- Relapse prevention for substance misuse
- Early warning sign monitoring and relapse prevention for mental health problems
- Mental health legislation

Training should be based on case discussion and debate that is relevant to the particular team's working practice. Wherever possible, services should promote internal sharing of information and expertise.

There should be an ongoing rolling programme to ensure that training is informed by the most recent research.

Ongoing supervision and continuing professional development is vital. Peer support networks and increased joint training can help to achieve this.

Given the issues discussed above in relation to culture, it is important that training addresses attitudes and perceptions as well as practical skills.

Training in relation to client need

The CASA Multiple Needs Service (MNS) suggests relating the need for specialist training to levels of client need. It outlines three levels of need:

- People with coexisting needs who would be able to use existing (generic substance misuse and mental health) services effectively if the workers in these services had additional training around dual diagnosis issues

- People whose mental health needs are best met within mental health agencies, but whose substance misuse is such that they also require the help of a specialist substance misuse counsellor

- People with serious and multiple needs, whose lifestyles have become chaotic and self-destructive, and who require sustained and intensive specialist support from people who are specialists in dual diagnosis

(See article: '*Perspectives on Multiple Needs CASA MNS 1998*')

Raising expectations

Training can also help to address negative attitudes to clients and low expectations for outcomes. It is also important to address low expectations with clients themselves.

Good practice examples

The following provide practical examples of how dual diagnosis issues are being addressed at a local level.

Barnet Dual Diagnosis Steering Group

This group has recently been set up by Turning Point's dual diagnosis lead at a community drug and alcohol project in Barnet called 'The Crossing'.

Its main purpose is to consolidate and improve referral pathways and systems of support for clients with co-existing substance misuse and mental health problems.

The group brings together primary leads of services working with dual diagnosis from voluntary and statutory agencies. It currently includes a lead consultant psychiatrist from Barnet, Haringey and Enfield Mental Health Trust, two social work department managers, the clinical drug and alcohol service manager, the Dual Diagnosis coordinator and clinical psychologist, the senior team leader of the community drug and alcohol service, the A&E psychiatric liaison nurse and will include a service user.

A number of problems in meeting client need were identified:

- Difficulty of agreeing a local definition of "dual diagnosis"
- Different views from psychiatry and substance misuse services on who should be responsible for a given person's package of care
- Confidentiality – there were no existing protocols about information sharing or referrals
- Time to attend meetings– many professionals had conflicting priorities

Many of the solutions were focused around better dialogue between a wide range of healthcare managers and practitioners. Each party became clearer about their own role and that of other agencies. As a result, referral and through care pathways became clearer, more consistent and more appropriate for the individual. There is also a locally agreed definition of dual diagnosis.

Another valuable improvement has been the extent to which service users and their representatives have been able to influence policy and practice. An example of this is described below.

Improving liaison between A&E and community services

A statutory psychiatric liaison team provides all-day and evening cover five days a week in the accident and emergency (A&E) department in Barnet hospital. The team consists of a co-ordinator and two nurses. The coordinator attends the dual diagnosis steering group in Barnet and is part of the community mental health team. Consequently the co-ordinator is well placed to refer and liaise with all mental health services.

The psychiatric liaison workers also have excellent links with other community and clinical services, including substance misuse. When making a referral to substance misuse services, the psychiatric liaison workers use standardised letters and include a copy of the assessment carried out in A&E. This details fully the reason or incident that brought the person to A&E and provides contact details of other professionals or agencies involved in the person's care. This is useful in pursuing letters or reports that may be relevant to compiling a risk assessment and also helps to foster joint working.

A copy of the Care Plan is also attached to the referral. This will include a plan to attend The Crossing, or another agency, for support regarding their substance use. A letter is then sent out from the substance misuse service, inviting the client to attend their service for a more comprehensive assessment or a specific type of support that is offered.

Patients from A&E are regularly referred to The Crossing's drop-in service and Barnet Drug and Alcohol Service (the clinical substance misuse service), where an initial/triage assessment is carried out. Every week during one of these drop-ins, a dual diagnosis co-ordinator, employed by Barnet Drug and Alcohol Service, attends the drop-in to provide support with the high volume of 'dual diagnosis' clients.

This is a good example of effective joint working between substance misuse services and between statutory and voluntary agencies.

The psychiatric liaison co-ordinator has invited substance misuse services to provide training to community mental health team staff. This has included community psychiatric nurses, mental health social workers, A&E and other hospital staff. The training covers both issues relating to drugs and/or alcohol and the services available. Reciprocal training has also been arranged.

Turning Point: Druglink Hammersmith and Fulham Complex Needs Service

Druglink Hammersmith and Fulham is a street agency providing a wide-range of project-based and outreach services to people affected by their own problematic drug use. It also offers advice and support to families, friends and other professionals. The Complex Needs Service was developed in 2002 to meet the needs of a growing number of clients with severe and enduring mental health problems, complicated by substance misuse and often further compounded by physical and/or learning disabilities.

This client group had high and multiple levels of need, but were 'falling through the gaps' between mental health and substance misuse services whilst staff lacked the confidence and training to provide adequate help.

The service provides individual sessions based on psycho education and cognitive behavioural therapy, alongside a series of life skill workshops and complementary therapies. To ensure accessibility and maximise engagement, it is flexible in terms of times and locations. It provides satellite services at supported accommodation projects as well as in-reach into in-patient psychiatric wards and home visits. The service is currently led by one specialist Complex Needs Worker. This person shares expertise locally by offering training, support and consultancy to a wide range of professionals from both specialist and generic services.

Resulting improvements include better communication and relationships between agencies in the borough, clearer pathways and continuity of care, and greater support for clients and workers. It is also demonstrating successful collaborative working with a diverse range of services in difficult situations. For example providing a multi-agency in-reach service to long-term in-patients to enable a seamless transition from hospital into the community.

A whole person approach to a range of needs

Mark is typical of the clients coming to Turning Point's Housing Link service in Hemel Hempstead. He had clinical depression and had just completed his third residential alcohol detox. He was in an impossible situation, trying to stay alcohol free whilst living in a shared house with people who were still using drugs and alcohol. Rent arrears were intensifying his problems. Although registered with the council housing department for alternative accommodation, he was considered a 'low priority'.

Carol, a Support Worker, worked with Mark over 18 months to address a number of issues. Partnership working is considered vital to empower clients and equip them with the skills they need for the future. The first task was for Mark to claim Disability Living Allowance and other benefits to which he was entitled. Through applying for back dated Housing Benefit, Carol was able to support Mark to clear his rent arrears, this enabled him to move more quickly. She also liaised with the Council and Housing Association providing his current housing to eventually secure his own flat.

Mark had not been in contact with a GP or the Community Mental Health Team for several years. So, to address his anxieties about explaining his needs and engaging with other services, Carol accompanied him to initial appointments if requested. He realised that living on his own would bring different challenges and Carol helped him to find out about local drop in services as well as pottery and art classes. She also encouraged him to renew contact with his family.

Carol continued to visit regularly for several months and Mark was able to access the service again to help him through a difficult period some months later.

Action points for practitioners

- Use the networking tool provided with this toolkit to identify the range of relevant services in your area
- Check that you have up to date contact details for these together with descriptions of the service provided and details of their referral criteria and procedures
- Agree a local definition of dual diagnosis
- Look at the protocols that exist for inter-agency working and do a reality check. Do the protocols describe what actually happens or are there gaps in practice?
- Involve service users and carers in mapping people's actual experiences of services against the theoretical models. Use this to identify actions and develop a clear plan for ongoing care that is shared with all services
- Where there are gaps/problems alert your managers and/or arrange a multi-agency meeting to discuss the issues so that each party understands their role and that of other agencies
- Do a training needs audit within your team and act upon identified needs. Consider reciprocal training between mental health and substance misuse services