

Lancashire Care
NHS Trust



**Dual Diagnosis Strategy
For Mental Health and Substance Misuse
Services**

For further information contact:

**Rimpy Batta
Dual Diagnosis Lead
Substance Misuse Services
Lancashire Care NHS Trust
5 Fulwood Park
Caxton Road
Preston
PR2 9NZ**

**Tel: 01772 773538
Email: rimpy.batta@lancashirecare.nhs.uk**

'Our key message is that substance misuse is already part of mainstream mental health services and that is the right place for skills and services to be developed. It also suggests that mental health services must also work closely with specialist substance misuse services to ensure that care is comprehensive and well co-ordinated'

**Professor Louis Appleby, National Director of Mental Health
Mental Health Policy Implementation Guide Dual Diagnosis Good
Practice Guide
Department of Health (2002)**

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Foreword



Executive Summary

This strategy is addressed to all those involved in the care of people affected by dual diagnosis. It provides a case for improving access to treatment services, clearer treatment interventions and measurable clinical outcomes for people with dual diagnosis. Implementation will require the creation of stronger partnerships and dialogue between practitioners, service users and carers, managers and commissioners. The focus should be on recognising the need to deal with the pressures and shortcomings of existing ways of working. The aims are to encourage and assist service modernisation that meets the needs of service users and carers.

It has been developed to ensure there is a visible positive commitment to dual diagnosis clinical and operational issues within all service areas within Lancashire Care Trust. It will be influenced by and inform the Trust's Service Transformation Programme and thus will provide a clear direction for the future development of services that support people with dual diagnosis. Progress will be monitored via locality Treatment Effectiveness Groups for drug and alcohol services and Local Implementation Teams for mental health services.

The strategy is developed by reference to national policy – Mental Health Policy Implementation Guide Dual Diagnosis Good Practice Guide (Department of Health, 2002)

Dual Diagnosis can be defined as severe and enduring mental illness with dependant substance misuse. The term 'Dual Diagnosis' covers a broad spectrum of mental health and substance misuse problems that an individual might experience concurrently. The nature of the relationship between these two conditions is complex.

- A primary psychiatric illness precipitating or leading to substance misuse
- Substance misuse worsening or altering the course of a psychiatric illness
- Intoxication and/or withdrawal leading to psychiatric symptoms or illness

(Dual Diagnosis Policy Implementation Guidelines, Department of Health, 2002)

Strategy Objectives

The strategy will deliver defined objectives that are to be implemented. Practitioners and managers will complete this in collaboration with service users and carers and commissioners. The emphasis is to build stronger relationships between partnerships whether this is related to clinical practice between services, operational design or how services are commissioned. The objectives are outlined in further detail within the main document, and described briefly below:

Strategy Objective One:

Delivery of Care

To develop a coherent and collaborative approach for the needs of dually diagnosed clients and develop best practice

To implement integrated care pathways

To implement Models of Care for Substance Misuse Services

To implement National Service Framework for Mental Health Services

Strategy Objective Two:

Directory of Service Information

Produce a service directory for users and carers and services, which clearly explains the availability of services and how to access them

Strategy Objective Three:

Education and Training

Conduct a formal training needs analysis with reference to the Knowledge Skills Framework

Deliver a comprehensive training package for staff within mental health services and drug and alcohol services

Strategy Objective Four:

Audit, Evaluation and Research

To audit referral and liaison pathways between mental health and drug and alcohol services

Strategy Objective Five:

Positively influencing Commissioning

To positively influence and inform commissioning plans which ensure services are configured appropriately to meet the needs of this client group

This strategy outlines operational issues including models of working and provides a rationale for the liaison model which is the preferred model of working. The liaison model of joint working between mental health services and drug and alcohol services is an attempt to respond to the growing gaps between both services to minimise concerns regarding safety, care and treatment of people with dual diagnosis. The aim of the model is to provide a set of interventions from both services in a flexible but co-ordinated way in the spirit of joint working to engage, stabilise and treat people with a dual diagnosis.

The strategy outlines integrated care pathways which services will be expected to follow. These focus on severe and enduring mental illness and common mental health issues and pathways for drug and alcohol using clients admitted to acute inpatient services. It also aims to ensure that the services offered to service users and carers are in line with good practice

guidelines. The strategy promotes joint working as described in the national policy implementation guidelines. These will be implemented locally at an operational level, between mental health and drug and alcohol services. For too long there have been significant variations in the quality of dual diagnosis services. This is not acceptable. This is a strategy that addresses the need to raise standards of services in line with these guidelines. Finally, the strategy aims to ensure that partnership working as described in the good practice guidelines will be implemented locally at a strategic level, bringing together the Local Implementation Teams, Primary Care Trusts, Drug and Alcohol Action Teams, Third Sector, Service Users and Carers and by working collaboratively with other local strategies.

Key to achieving this work will be to:

- Identify the strengths and weakness of current local arrangements
- Stimulate appropriate action
- Sustain a momentum of change

Clinical Profiles

A glance at the incidence and prevalence rates of dual diagnosis within the Trust reveals emerging trends from which we can build a profile of the local population. However, we must be mindful that we need to refine how we record all our data requirements in order to truly reflect our activities within our performance management frameworks.

CPA data from mental health services for 2006/07 highlights

- 70% of service users are male
- 55% are White British
- 20% are in their mid thirties
- 83% are registered on Enhanced Level CPA
- 59% are known to the Community Mental Health Teams
- 20% are known to the Assertive Outreach Teams
- 33% experience Schizophrenia
- 38% experience alcohol misuse
- 35% experience drug misuse issues
- HoNOS data highlights 21% of service users experience drug and alcohol issues that are severe to merit intervention from specialist drug and alcohol services.

Data from substance misuse services within the Trust reveals

- 70% of service users are male
- 97% are White British
- 54% are in their thirties
- The primary drug of choice is heroin 67%
- The secondary drug of choice is alcohol 29%
- 31% experience Schizophrenia and Depression as their mental health issues

Data from alcohol services within the Trust reveals

- 58% are Male
- 98% are White British
- 30% are in their thirties
- 26% experience depression

We can conclude this data is consistent with national trends and the profile of a person with dual diagnosis.

A SWOT analysis (strengths, weaknesses, opportunities and threats) is provided highlighting the current picture. It shows the Trust is in a strong position to implement the liaison model of working, between drug and alcohol and mental health services and also with our partner agencies ensuring a whole systems approach. This ensures compliance with Models of Care for substance misuse services and the National Service Framework for mental health services.

Conclusions are included to support the implementation of the strategy. These recognise that dual diagnosis is a complex issue affecting not just service users and carers but also pose a challenge to the clinical, operational and strategic partnerships that affect practitioners, managers and commissioners alike. We believe the liaison model of working and integrated care pathways are a step closer to supporting these issues. These must be followed to ensure service delivery matches client need. References, which support the main body of the text, are also provided.

1 Introduction

These are exciting times within Lancashire Care Trust as we are working towards achieving Foundation Trust status. In 2005, the Trust issued its strategic plans for the next five years with the goal of being the provider of choice for mental health and substance misuse services in Lancashire. It outlined five strategic objectives:

1. To deliver better services
2. To improve the working lives of staff
3. To engage with local communities
4. To succeed through partnership
5. To effectively govern the organisation and services we provide.

Also, the Trust is now working towards achieving its Service Transformation Programme and the principle aim here is to set clearer tasks and outcomes in all areas of service delivery. This will ensure that clinical experiences of our service users and carers are appropriate to and meet their individual needs. The introduction of the dual diagnosis strategy is therefore very timely as it is a cross cutting theme in all of our mental health services as well as a major work stream for Substance Misuse Services.

Particular recognition must be given to the successful development and implementation of a Dual Diagnosis Strategy within the Blackburn with Darwen area of the Trust. This strategy was developed in response to a local independent confidential inquiry following a serious and untoward incident (2003). Lancashire Care Trust has developed its trustwide strategy based on the local strategy.

Trustwide, the Dual Diagnosis Strategy is aimed at achieving the standards of the Mental Health National Service Framework (1999). The Mental Health National Service Framework, Five Years On (2004) continues to acknowledge that dual diagnosis is the most challenging clinical problem that we face. The purpose of this strategy is to re - design current service delivery for those with a dual diagnosis via the existing mental health and substance misuse services within the Trust. The Trust's Service Transformation Programme will lend considerable support to this. The strategy is also responsive to Level Two of the Trusts Patient and Public Involvement Strategy that focuses on collectively engaging service users and carers in developing and monitoring services. It will also achieve implementation of the liaison model of working, supported by implementation of integrated care pathways. Using a SWOT analysis it will recognise good practice, suggest where improvements can be made and identify opportunities. It will highlight the main strategic aims, how they are to be achieved by whom and when. It must be emphasised that the strategy is a springboard for a sustained programme of development and not an isolated effort.

We can conclude that for the strategy to be effective, implementation should be underpinned by four underlying principles:

- **Integrated and co-ordinated** – care should be joined up and embedded into mainstream services
- **Positive and inclusive** – key stakeholders should have a positive approach to joint working at strategic and operational levels
- **Flexible and individualised** – services should be person centred reflecting diversity
- **Accessible and responsive** – service development plans that are currently underway will ensure that the above are in place

2 Background

There is a wealth of literature regarding theories, treatment interventions and debate focusing on all aspects of dual diagnosis. (Afuwape, 2003; Crawford 2001) It is recognised that there are many variations in people's understanding of dual diagnosis. Steel (1997) states that 'dual diagnosis is a misleading term as it infers that only two components exist in a particular presentation', whilst it is suggested by Scott and Johnson (1998) that it is often more likely that there is a complex assortment of behaviours and problems. Unfortunately as is the case for all popular terminology it appears to be suffering from exhaustive use and it is intended that this document will provide an accepted universal definition and this in turn will enable a consistent approach.

For the purpose of this strategy, based on the available literature, dual diagnosis is defined as follows:

The co-existence of mental illness with substance misuse which has an adverse effect on an individuals biological, psychological and social well being

We have to accept that dual diagnosis is likely to be the norm rather than the exception. This client group is likely to be cared for by default rather than design.

The Department of Health Information Manual 2002, states: -

'In the UK it is estimated that approximately one third of psychiatric patients with serious mental illness have a substance misuse problem'.

In drug and alcohol services approximately half of clients also have some form of mental health problem (most commonly depression or personality disorder). There are consistent reports of increased prevalence in forensic mental health services and inpatient psychiatric units. The Dual Diagnosis Good Practice Guide recognises that there are varying degrees of substance misuse and mental illness. The diagram below is intended to assist all those involved in the care of people with dual diagnosis in their understanding of the possible range of presenting problems and identify the most appropriate service for the client.

Diagram 1: The scope of co-existent psychiatric and substance misuse disorders: -

Severity of problematic Substance misuse	
	High
E.g. a dependent drinker who experiences increasing anxiety	E.g. an individual with schizophrenia who misuses cannabis on a daily basis to compensate for social isolation
Severity of Mental Illness	
Low	High
E.g. a recreational misuser of 'dance drugs' who has begun to struggle with low mood after weekend use	E.g. An individual with bi-polar disorder whose occasional binge drinking and experimental misuse of other substances de-stabilises their mental health
	Low

Primary Diagnosis - It is well documented that services continually seek to identify a primary diagnosis of either mental illness or substance misuse. This then leads to services feeling justified in referring on to their colleagues. However this often excludes the client and results in them 'falling in the gap between services'

Personality Disorder

We must be mindful that personality disorders in association with major mental illness and substance misuse are common. This client group is also faced with a higher potential for exclusion based on the stigma associated with the diagnosis and the uncertainty issues pertaining to their care and management. However, they are also high volume consumers of multi agencies. The Department of Health reaffirms the need for assessment and access to services within the document 'Personality Disorder – 'No Longer a Diagnosis of Exclusion' (Department of Health 2003) advising that this client group should be offered treatment options within specialist mental health services. The Trust's Service Transformation Programme for Personality Disorder are developing strategies to manage the dually diagnosed within services, in particular Psychological Services.

Forensic Services

Similarly, we must be mindful that people with dual diagnosis pose major challenges to forensic services, both clinically and operationally. Forensic

services within the Trust are developing strategies to manage the dually diagnosed within secure environments.

It should therefore be acknowledged that both substance misuse and mental illness are chronic relapsing conditions, which manifest alongside other complex issues, both clinically and operationally. Practitioners, managers and commissioners need to adopt a longitudinal and inclusive stance in relation to dual diagnosis and dispense with the historical response that has so far been 'no motivation, no service'. This does not compliment the recovery model. Clear well thought out integrated care pathways that are practical at an operational level will enhance the care afforded to dual diagnosis clients. They will also identify the responsibilities of respective agencies at key stages of delivery and provision of care.

To enable practitioners to gain a better understanding of the management of those with a dual diagnosis it is imperative that they are provided with the requisite training opportunities. However, programmes of education promoting mutual learning will be ineffective if undertaken in isolation and need to be embedded in the ongoing training and education strategy of the Trust.

Dual Diagnosis is often associated with various difficulties, including:

- Service user's ability to access services
- Engaging service users
- Disengagement from services
- Negative impact on family and carers
- Management of waiting lists
- Higher treatment costs
- More frequent hospital admissions
- Lack of integrated working
- Dispute resolution
- Worsening psychiatric symptoms
- Ineffective treatment outcomes
- Serious and untoward incidents
- Clinical risk assessment
- Clinical risk management
- Confidentiality
- Information Sharing
- Violence
- Suicide
- Drug related death
- Increased risk of blood borne virus transmission
- Homelessness
- Poor adherence to medication
- Poor social outcomes
- Criminal activity
- Isolation and social withdrawal
- Greater levels of unemployment

- Increased risk of poverty
- Workforce development issues
- Commissioning of services

These issues present challenges to services, practitioners, managers and commissioners, not least of all to service users and carers. It is anticipated that the strategy will try to minimise these issues and to bring about positive change in the lives of service users and carers affected by these issues and to highlight the support that services need to provide care and treatment to this vulnerable group.

In December 2005, the Clinical Governance Network facilitated a 'Daring to Share' event that included a dual diagnosis theme. The event focused on the lessons learnt from serious and untoward incidents and showcased positive practice examples which have subsequently been implemented. Workshops on dual diagnosis identified training needs, care pathways and service information. These have been developed further into the strategy objectives.

The strategy has been written from a Lancashire Care Trust perspective in the first instance recognising that the involvement of other agencies is vital to provide a comprehensive approach to the care of the dually diagnosed. There is every intent to involve agencies external to the Trust at the next phase of planning.

The Trust is a member of the northwest region dual diagnosis network; a forum led by CSIP (Care Services Improvement Partnership) and NTA (National Treatment Agency for Substance Misuse) and has contributed to their published report Changing Habits North West Dual Diagnosis Intelligence Report (CSIP, 2007). The Trust is also in a strong position to lend support to the region's Strategic Collaborative Network, a forum promoting access to mental health services for drug and alcohol misusers, the development of integrated care pathways and the need for access to psychological therapies using the Stepped Care Model.

The strategy will evolve as new priorities emerge. The approach may need to be adapted as we gather evidence, learn from experiences and overcome issues raised during implementation. Such a coherent and co-ordinated strategy therefore needs the collaboration of a wide range of organisations and individuals. It is our collective responsibility to provide an evidence based, effective service.

2.1 Dual Diagnosis Lead Post

The dual diagnosis lead has a specific remit to lead on the development and implementation of the dual diagnosis strategy and to promote care pathways within mental health and substance misuse services across Lancashire Care Trust. Other aspects of the role include developing education and training strategies and contributing to staff and service development, through research and evaluation of provision.

Key areas of responsibilities of the lead post are outlined below

Policy

To lead on the development of the Dual Diagnosis Strategy as outlined in the Mental Health Policy and Implementation Guidelines.

To take a lead role in the implementation by health and social care professionals of relevant policy guidance i.e. Mental Health National Service Framework and Models of Care for Substance Misuse.

Clinical

Working with mental health and substance misuse services to take a lead in developing assessment tools and care pathways for those clients with a dual diagnosis.

To promote awareness of issues relating to dual diagnosis amongst all staff, including senior clinicians and managers, through participation in strategic developments and through promotion of education events such as conferences, seminars and workshops.

Training

To take a lead role in the training needs analysis, to ensure effective integrated education and training programmes are developed to improve quality of care, and service user/carer experience.

Research

To develop effective links with academic and educational bodies in the development of joint training initiatives and shared learning opportunities. These will include the University of Central Lancashire and the training departments of partner organisations.

Audit

To take a lead role in the clinical audit cycle of evidence based practice for this complex client group against best practice benchmarks.

These key areas form some of the strategy objectives.

3 Supporting Data

There are various international, national and local data sources relating to dual diagnosis, some of which are presented below. Current research is included to highlight the evidence base in this rapidly growing area. Local results include evidence of prevalence and incidence that currently exists within the Trust.



3.1 International Research and Evidence Base

- **The relationship between substance misuse, mental illness and violent crime**

The mental illnesses, such as schizophrenia and other psychoses, and personality disorders are continually the central focus of debate about potentially modifiable psychiatric determinants of violent crime in most western countries. Alcohol and drug abuse disorders receive less attention in news media and the public debate, but growing empirical evidence from Sweden suggests that the substance use disorders may play a role more crucial to the risk of violence than the mental illness and personality disorders. (Fazel and Grann, 2004; Grann and Fazel, 2004)

- **Early Intervention in Psychosis**

The incidence of problematic cannabis use amongst young people presenting with a first episode of psychosis is high and of concern. An expanding evidence base has indicated persistent cannabis use is associated with earlier onset of psychosis, longer time to remission and increased likelihood of relapse. The objective of the Cannabis and Psychosis Project, CAP (Melbourne, Australia) was to evaluate a brief, individual, cannabis focused intervention for young people following entry to treatment for first episode psychosis in a randomised controlled trial.

There were no significant differences between CAP (N=24) and a control condition psycho-education (N=22) on cannabis use at the end of treatment and 6 months post intervention. Patterns of 'readiness to change' were similar across conditions and there were no significant differences between groups on mean scores for psychopathology and psychosocial functioning at follow up. There was a highly significant reduction in cannabis use over time for both groups and this held for regular cannabis users and individuals with schizophrenia/schizophreniform disorders. The study has implications for further research and clinical practice (Gleeson and McGorry, 2004)

3.2 National Data and Studies

A study of the causal relationship between substance misuse and psychiatric illness in general practice.

This study examines the hypotheses that:

- Prior substance use is a risk factor for later psychiatric illness
- Prior psychiatric illness is a risk factor for later substance use

Rey and Tennant (2002) state that 'use of cannabis increases the risk of schizophrenia and depression but baseline psychiatric illness is not associated with an elevated risk of substance use'.

Using the General Practice Research Database (GPRD), 1.8 million patients were followed, examining the temporal sequence of diagnosed substance abuse and psychiatric illness from 1993 – 1998. The baseline prevalence of psychiatric illness over the study period was 15% and 0.3% for substance abuse. The relative risk for psychiatric illness for substance abusers vs. non substance abusers was 1.54% while the relative risk for substance abuse among psychiatric vs. non psychiatric cases was 2.09%. Combining the data indicated that psychiatric illness potentially attributable to substance abuse was 0.2%, while substance abuse potentially attributable to psychiatric illness was 14.2%.

The study does not support the hypotheses that co – morbidity between substance abuse and psychiatric illness is primarily the result of substance abuse or that increasing co – morbidity is largely attributable to increasing substance abuse.

The prevalence of co – morbid substance misuse and mental illness. Implications for service development

There is limited evidence about prevalence of mental illness and substance misuse co – morbidity and its current management. This hampers service development in the UK. The COSMIC study measured the prevalence of co-morbidity in community mental health teams and drug and alcohol services in four urban UK centres. It also described the patterns of co – morbidity, assessed the health and social care needs of patients and described current management.

In both treatment settings, the prevalence of co-morbidity was high but clinical presentation was heterogeneous and varied markedly between treatment settings. In each population, most co-morbid patients exhibited multiple disorders and had greater community care needs than non co-morbid patients. Co – morbid status did not restrict access to interventions provided through the patients allocated service but joint management between services was uncommon.

This study poses implications for service development. Resources need to be developed to enable substance misuse services to provide evidence based interventions to a higher proportion of co-morbid patients. The treatment needs of co-morbid community mental health team patients are likely to be met by mainstream mental health services. However, community mental health teams need to develop these competencies through staff training and research into effectiveness of novel interventions tailored to UK service contexts.

The incidence of co-morbidity

The incidence of co-morbidity of mental health problems coupled with a substance misuse problem is increasingly recognised (Menezes et al, 1996; Johnson et al 1997).

It is hard to assess the exact levels of substance misuse both in the general population and in those with mental health problems. UK data from national survey and from local studies generally show that:

- Increased rates of substance misuse are found in individuals with mental health problems affecting around a third to a half of people with severe mental health problems
- Alcohol misuse is the most common form of substance misuse
- Where drug misuse occurs it often co – exists with alcohol misuse
- Homelessness is frequently associated with substance misuse problems
- Community Mental Health Team's typically report 8-15% of their clients have dual diagnosis problems although higher rates may be found in inner cities
- Prisons have a high prevalence of drug dependency and dual diagnosis

(Department of Health, 2002)

Substance misuse and psychiatric morbidity within the prison setting

The scale of problems within prisons and the broader criminal justice system is monumental. To date, the input of services has not been adequate or matched to the size or severity of the problem. Approximately, 10% of the prison population is estimated to be psychotic. There are very high rates of reported non psychotic illnesses including personality disorder. The rates of alcohol and drug dependence are very high. Indeed the rates of overlapping disorders are such that the term dual diagnosis does not properly describe the problem. Entry to prisons is a time of high stress. For many, drug dependence needs to be recognised and properly managed. The risk of death by suicide is particularly high in the first month and two thirds of these deaths have been associated with substance misuse problems.

Studies indicate that many of these prisoners have not had access to health services prior to imprisonment. The risk of a drug related death is substantially elevated in the first two to four weeks of release. New approaches to the management and recognition of these problems are required and there needs to be better links between community services with mental health in-reach and prison based substance misuse teams.

Treatment of psychosis and substance misuse: development of the MIDAS trial

Despite high rates of problematic substance use in psychosis, the evidence base available to inform treatment remains limited. An individual treatment intervention that combines motivational interviewing and cognitive behavioural

therapy has been developed by Manchester University (MIDAS – Motivational Interventions for Drug and Alcohol Use in Schizophrenia) is a large multi site randomised controlled trial aiming to evaluate an approach to improving mental health outcomes for people with psychosis and substance misuse. It is funded by the Medical Research Council and the Department of Health and is currently running in the UK from the Universities of Manchester and London in collaboration with local NHS mental health trusts. The treatment is delivered over 12 months alongside the patient's routine care and is an integration of motivational interviewing and cognitive behaviour therapy aiming to take account of the dual and interactive nature of substance use and psychosis problems and the motivational stage of the patient.

3.3 Local Evidence

In order to have a good grasp of the dual diagnosis needs of people for whom a service is to be provided it has been important to gather information about service demand. Two approaches to forecasting demand have been used:

- Identify the needs of those in contact with services and forecast changes based on previous experience
- Estimate the demand from epidemiological data as this is likely to reveal current and hidden demand

eCPA (electronic version of Care Programme Approach) data from adult mental health services from across the Trust for the year, 2006/2007 is presented below.

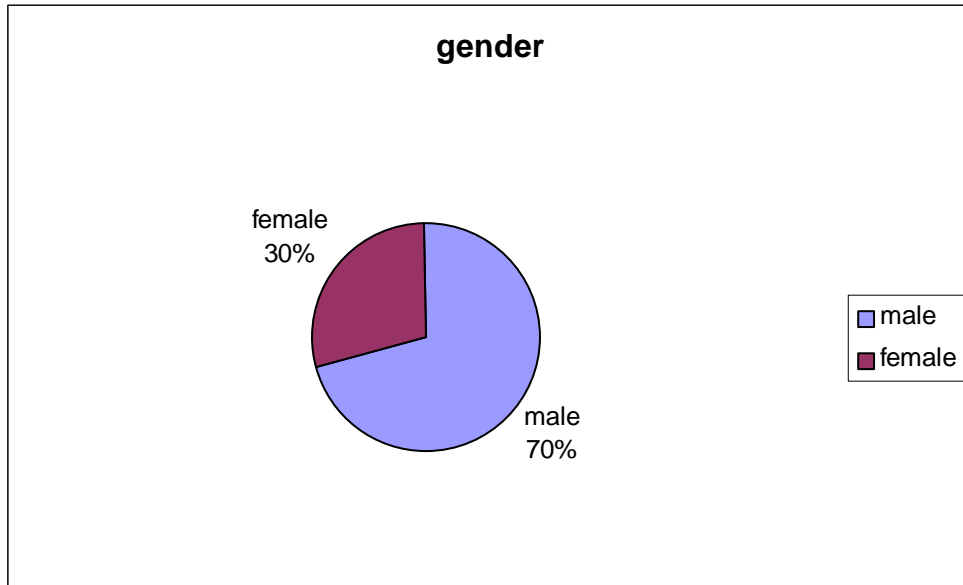
Trust data is presented below giving an overall impression of the incidence of dual diagnosis. This is then further broken down into the various Primary Care Trust catchment areas for mental health in order to provide local pictures of the rate of dual diagnosis. Unfortunately, data from Morecambe and Lancaster areas are not included as this data is not available. Lancashire Care Trust was not the service provider for mental health services in these areas until October 2006 and as such different recording systems were in place that did not routinely capture dual diagnosis issues. This is not unusual, as commissioners and managers nationally, have not previously asked services to record data in this way. These areas will now record patient information using the electronic Care Programme Approach database (Methincs). This will ensure standardisation of patient information.

Data is also presented from a drug and alcohol perspective and this is aligned to the Drug and Alcohol Action Teams catchment areas.

It is also important to note, that currently mental health services and substance misuse services do not record patient information via the same database system. This data is therefore limited in what it shows.

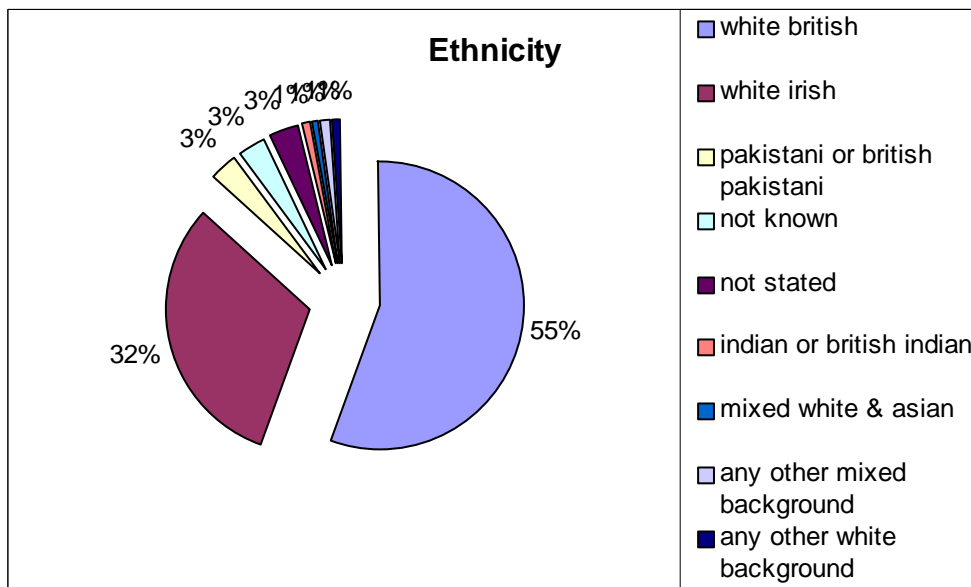
Lancashire Care Trust overall impression of dual diagnosis prevalence in adult mental health services

Figure 1 Gender



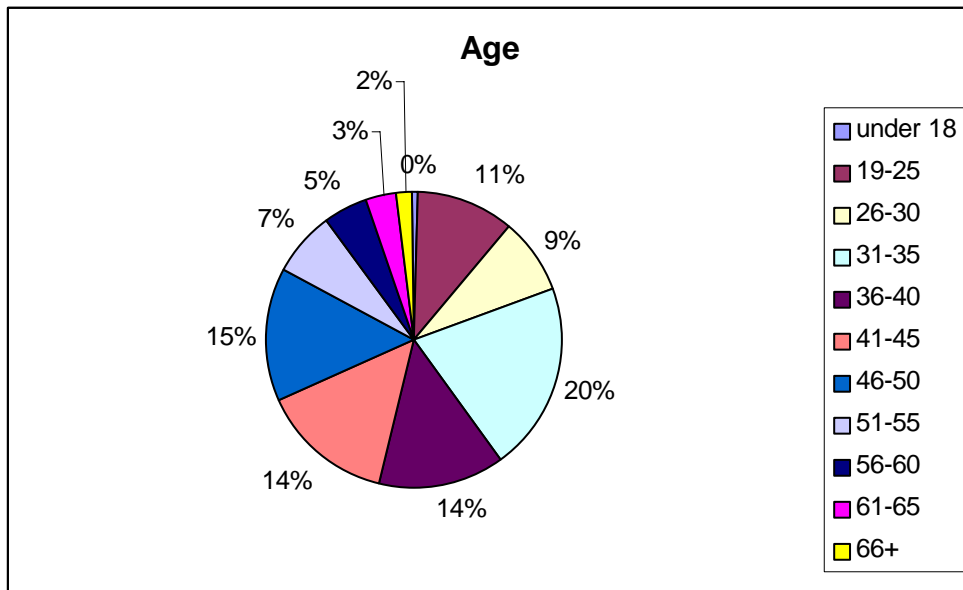
Of 222 patients, 156(70%) are male and 66(30%) are female

Figure 2 Ethnicity



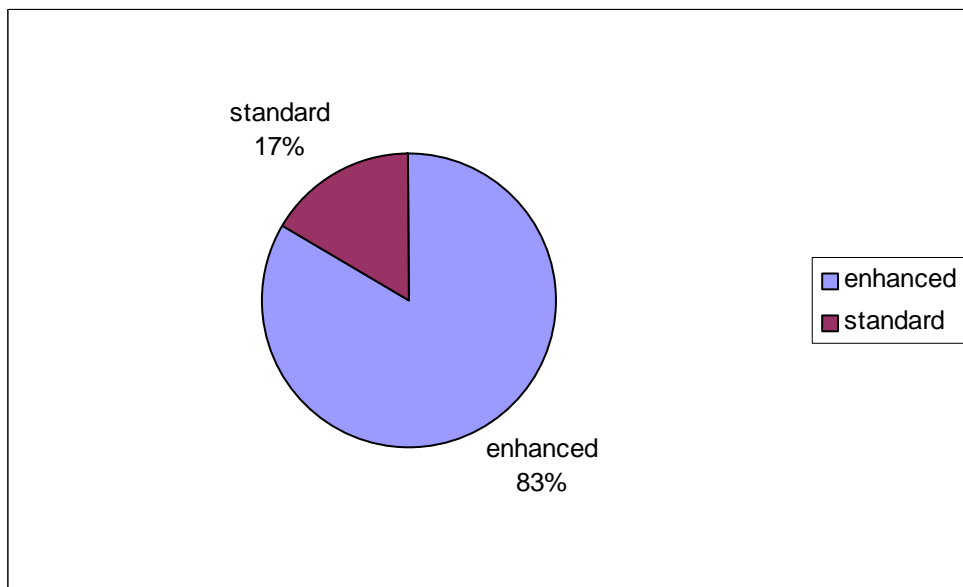
Of 222 patients, 121(55%) are White British; 69(32%) are White Irish; 7(3%) are Pakistani or British Pakistani; 7(3%) ethnicity is not known; 7(3%) ethnicity is not stated; 2(1%) are Indian or British Indian; 2(1%) are Mixed White and Asian; 2(1%) are any other mixed background and 2(1%) are any other white background

Figure 3 Age



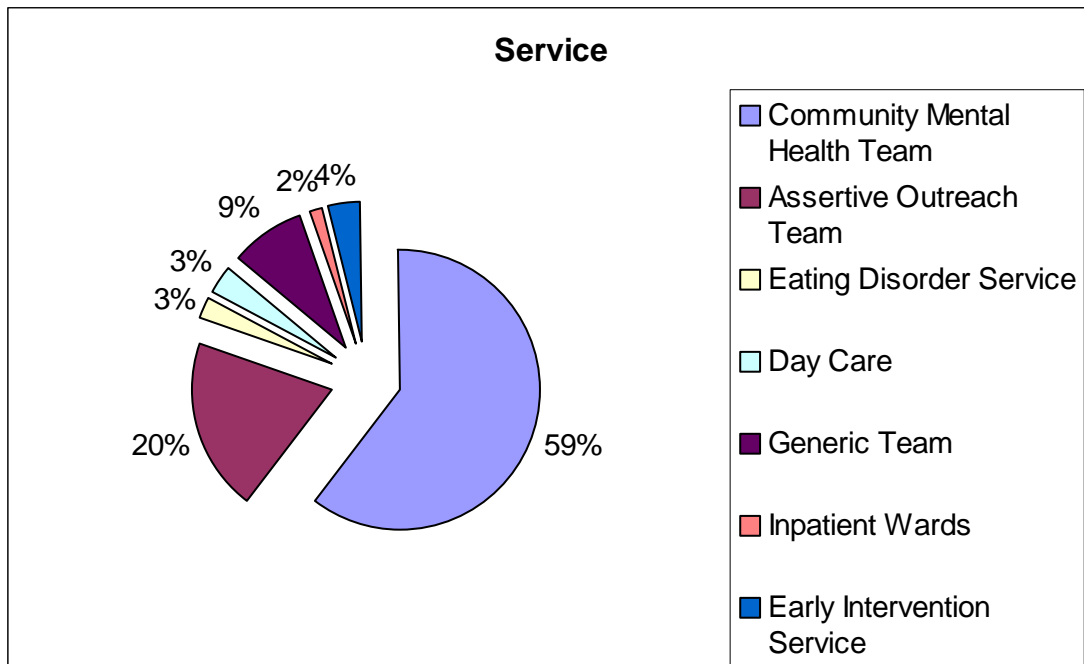
Of 222 patients, 1(0%) is under 18; 24(11%) are 19-25; 19(9%) are 26-30; 45(20%) are 31-35; 30(14%) are 36-40; 32(14%) are 41-45; 33(15%) are 46-50; 16(7%) are 51-55; 11(5%) are 55-60; 7(3%) are 61-65 and 4(2%) are 66+ years of age

Figure 4 CPA Level



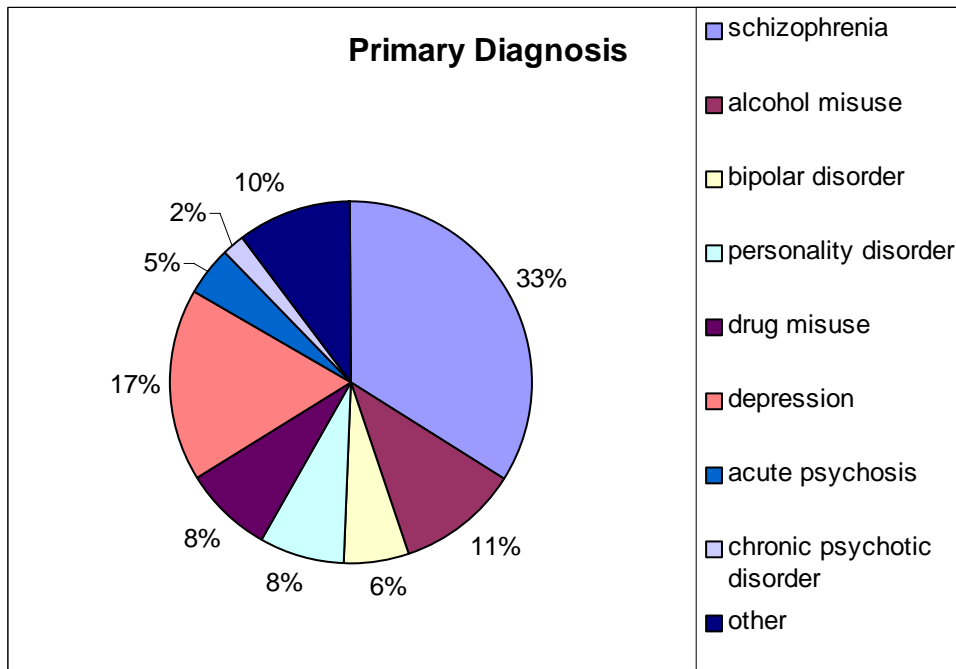
Of 222 patients, 185(83%) are registered on enhanced level CPA and 37(17%) are registered on standard level CPA

Figure 5 Service



Of 222 patients, 133(59%) are known to the community mental health teams; 45(20%) to the assertive outreach teams; 6(3%) to the eating disorder services; 7(3%) to day care; 19(9%) to the generic team; 4(2%) are inpatients and 8(4%) are known to the early intervention service

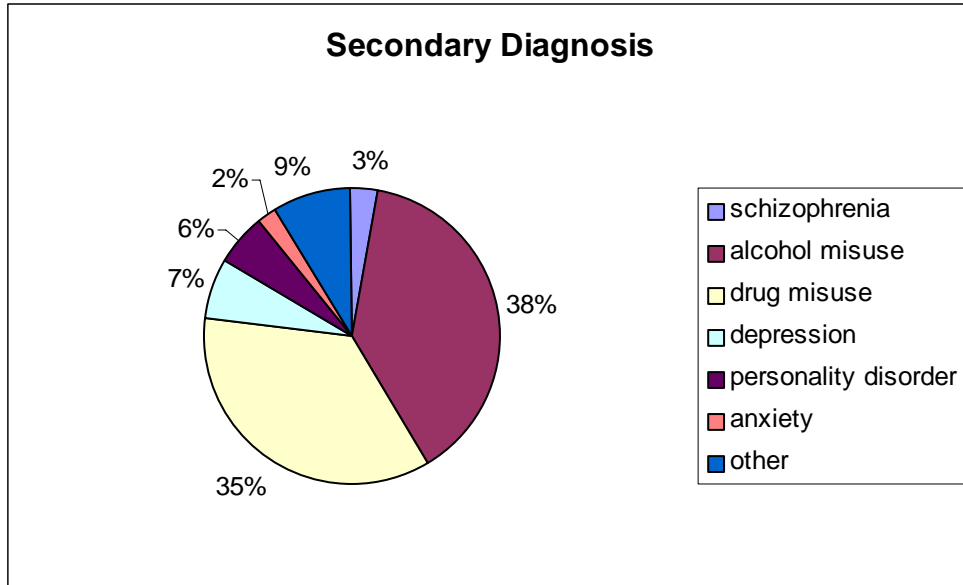
Figure 6 Primary Diagnosis



Of 222 patients, 75(33%) experience schizophrenia; 24(11%) experience alcohol misuse; 13(6%) experience bipolar disorder; 17(8%) experience

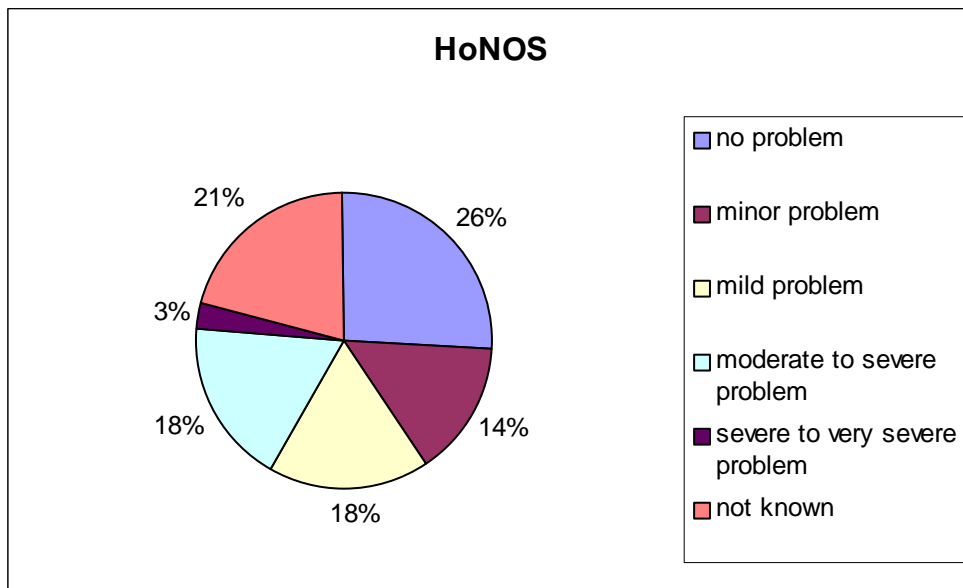
personality disorder; 18(8%) experience drug misuse; 38(17%) experience depression; 10(5%) experience acute psychosis; 4(2%) experience chronic psychotic disorder and 23(10%) experience other mental health issues

Figure 7 Secondary Diagnosis



Of 222 patients, 7(3%) experience schizophrenia; 85(38%) experience alcohol misuse; 78(35%) experience drug misuse; 15(7%) experience depression; 13(6%) experience personality disorder; 5(2%) experience anxiety and 19(9%) experience other mental health issues

Figure 8 HoNOS



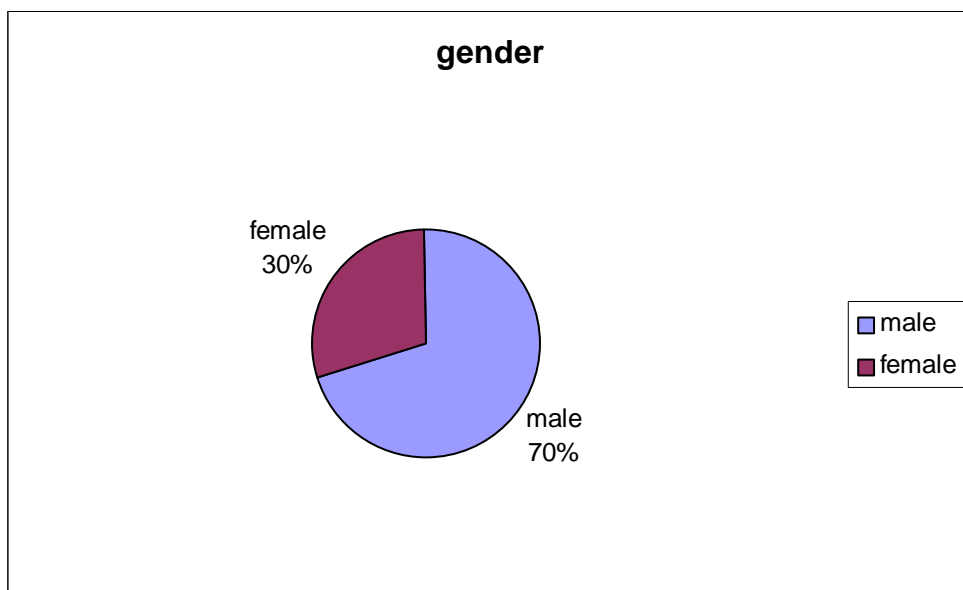
Of 222 patients, 58(26%) have no problem with their drug or alcohol use; 32(14%) have a minor problem; 39(18%) have a mild problem; 40(18%) have

a moderate to severe problem; 6(3%) have a severe to very severe problem and 47(21%) patients rating for this scale was not known

Data is also presented below for the various localities within the Trust. These are shown as geographical entries for the various catchment areas of the Primary Care Trust's.

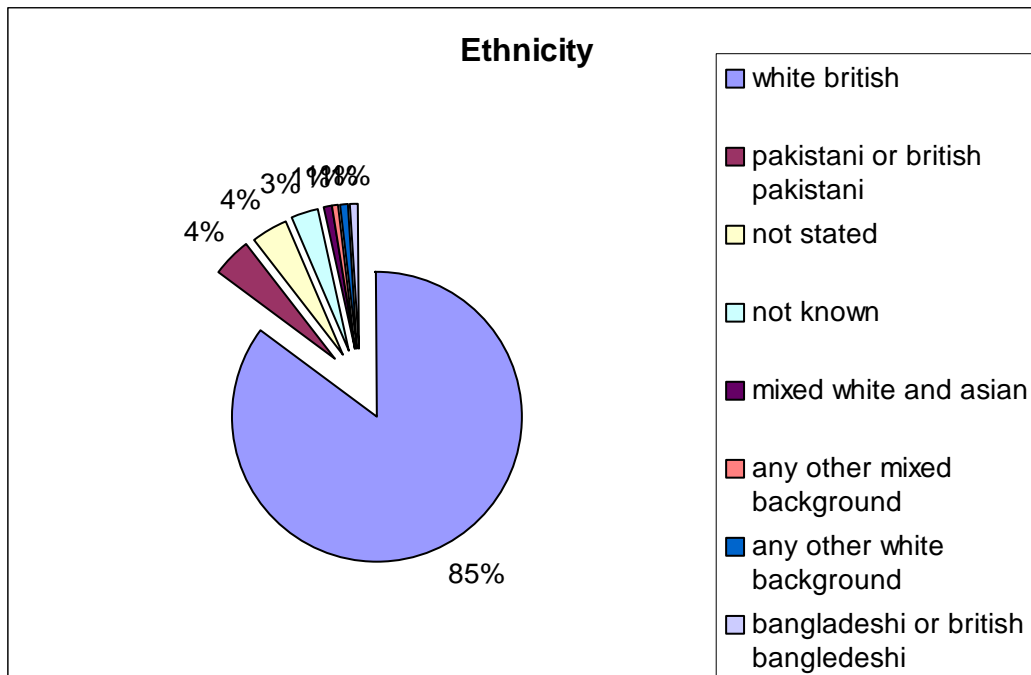
Data from East Lancashire Primary Care Trust catchment area is presented below. This includes Hyndburn and Ribble Valley, Burnley, Pendle and Rosendale. 123 patients of the total with dual diagnosis were recorded in the locality.

Figure 1 Gender



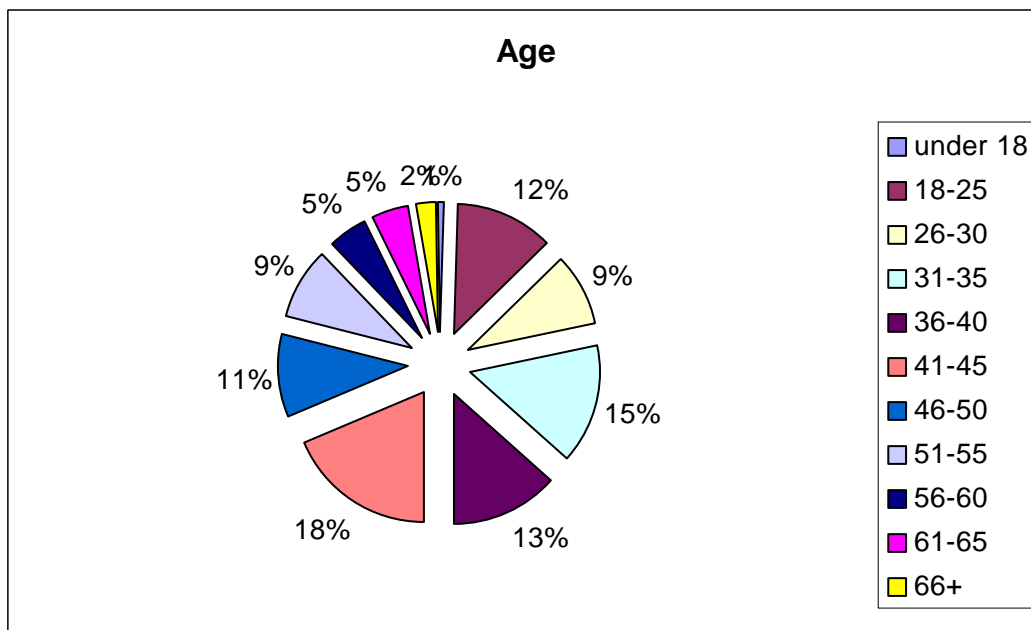
Of 123 patients, 86(70%) are male and 37(30%) are female

Figure 2 Ethnicity



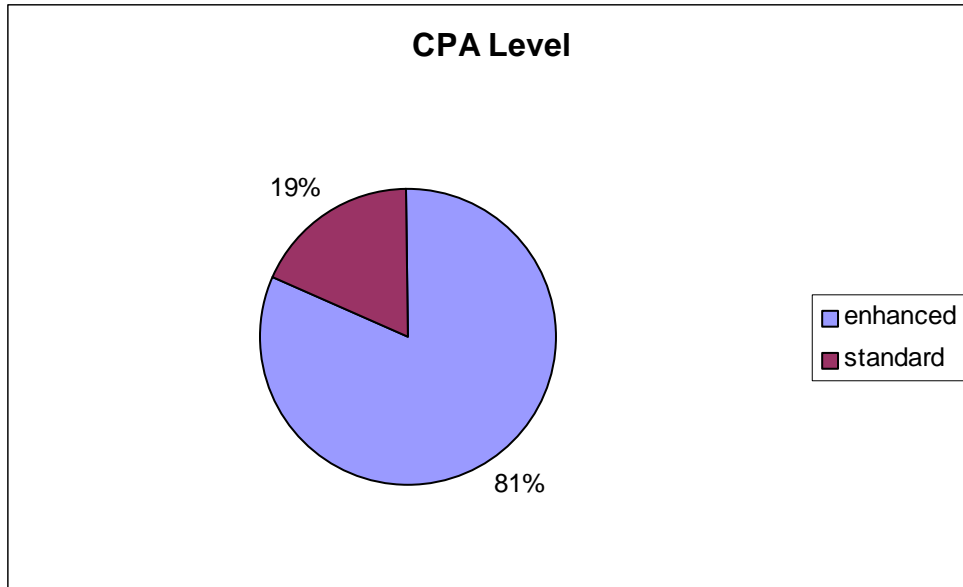
Of 123 patients, 105(85%) are White British; 5(4%) are Pakistani or British Pakistani; 5(4%) clients ethnicity is not stated; 4(3%) clients ethnicity is not known; 1(1%) are Mixed White and Asian; 1(1%) are any other mixed background; 1(1%) are any other white background and 1(1%) are Bangladeshi or British Bangladeshi

Figure 3 Age



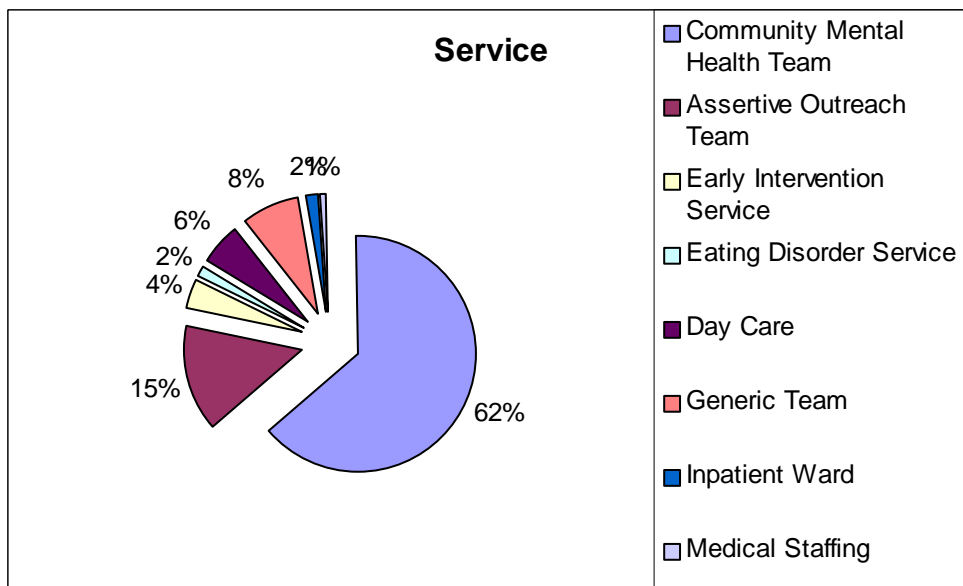
Of 123 patients, 1(1%) is under 18 years of age; 15(12%) are 18-25; 11(9%) are 26-30; 18(15%) are 31-35; 16(13%) are 36-40; 23(18%) are 41-45; 13(11%) are 46-50; 11(9%) are 51-55; 6(5%) are 56-60; 6(5%) are 61-65 and 3(2%) are aged 66+ years

Figure 4 CPA Level



Of 123 patients, 23(19%) are registered on Standard Level CPA and 100 (81%) are registered on Enhanced Level CPA

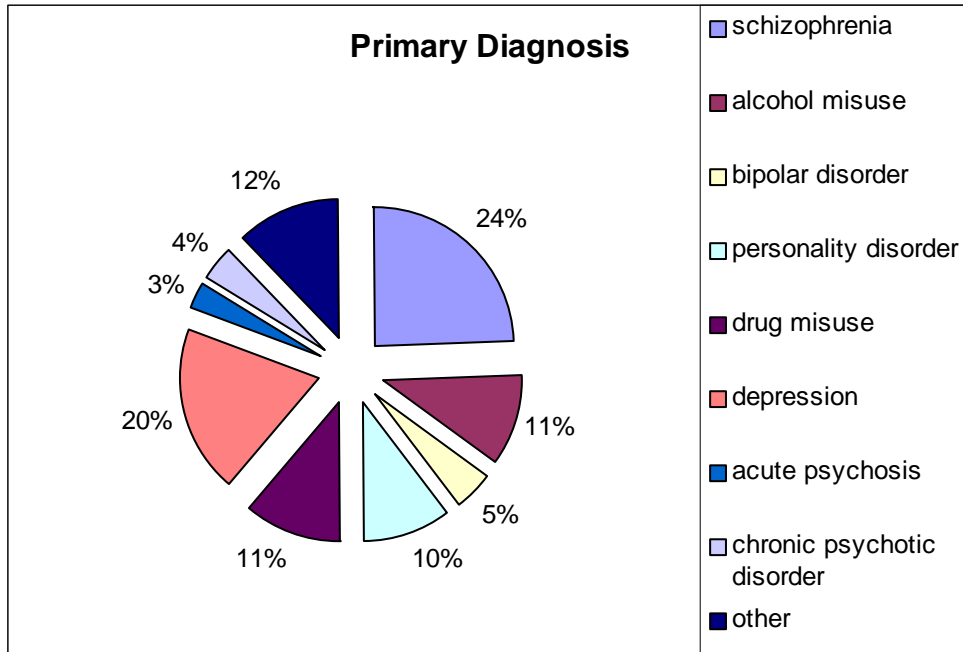
Figure 5 Service



Of 123 patients, 78(62%) are known to community mental health teams; 18(15%) are known to the assertive outreach teams; 5(4%) are known to the early intervention services; 2(2%) are known to the eating disorder services;

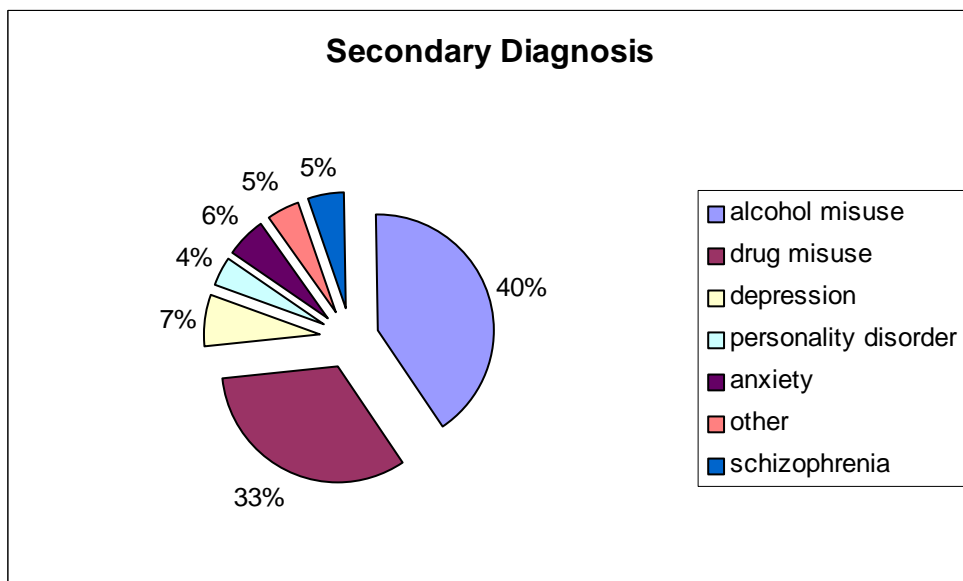
7(6%) are known to day care; 10(8%) are known to the generic team; 2(2%) are known to inpatient services and 1(1%) are known to medical staffing

Figure 6 Primary Diagnosis



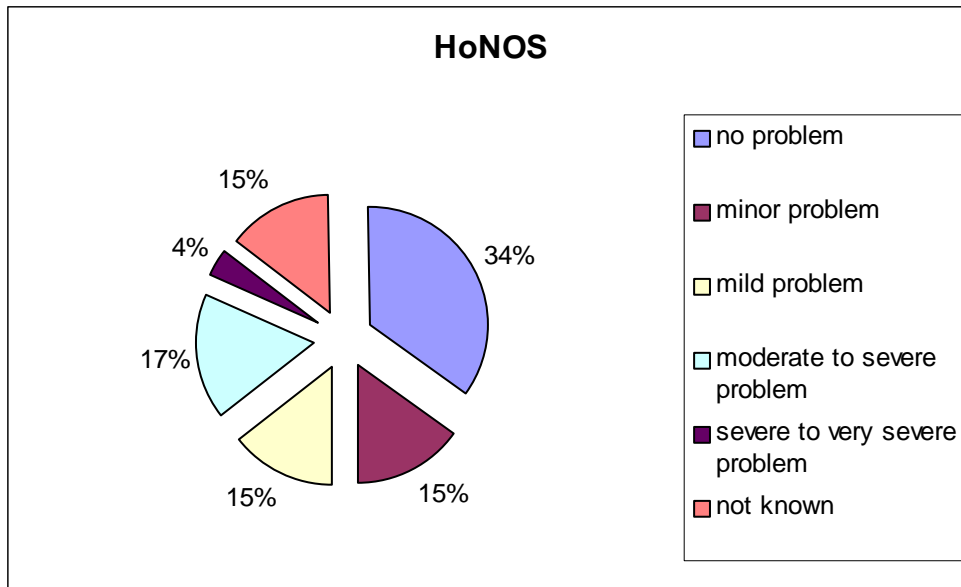
Of 123 patients, 30(24%) experience schizophrenia, 13(11%) experience alcohol misuse; 6(5%) experience bipolar disorder; 12(10%) experience personality disorder; 14(11%) experience drug misuse; 24(20%) experience depression; 4(3%) experience acute psychosis; 5(4%) experience chronic psychotic disorder and 15(12%) were recorded as experiencing other mental health issues.

Figure 7 Secondary Diagnosis



Of 123 patients, 50 patients (40%) experience alcohol misuse, 40 patients (33%) experience drug misuse; 9(7%) experience drug misuse; 5(4%) experience personality disorder; 7(6%) experience anxiety; 6(5%) experience other mental health issues and 6(5%) experience schizophrenia

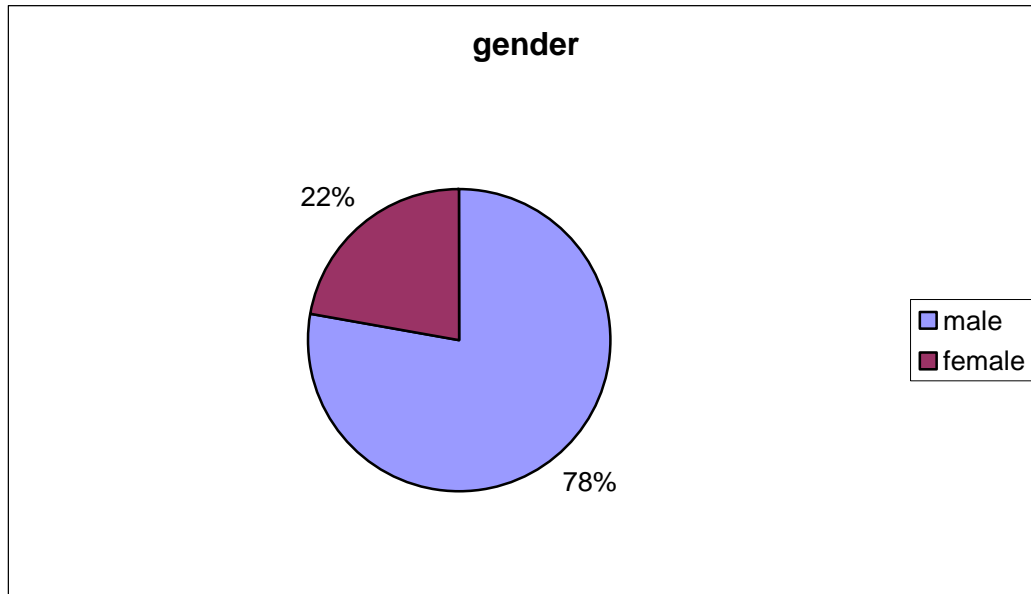
Figure 8 HoNOS



Of 123 patients, 43(34%) are recorded as having 'no problem', 18(15%) are recorded as having a 'minor problem'; 18(15%) are recorded as having a 'mild problem'; 21(17%) are recorded as having a 'moderate to severe problem'; 5(4%) are recorded as having a 'severe to very severe problem' and 18(15%) patients HoNOS rating are 'not known'.

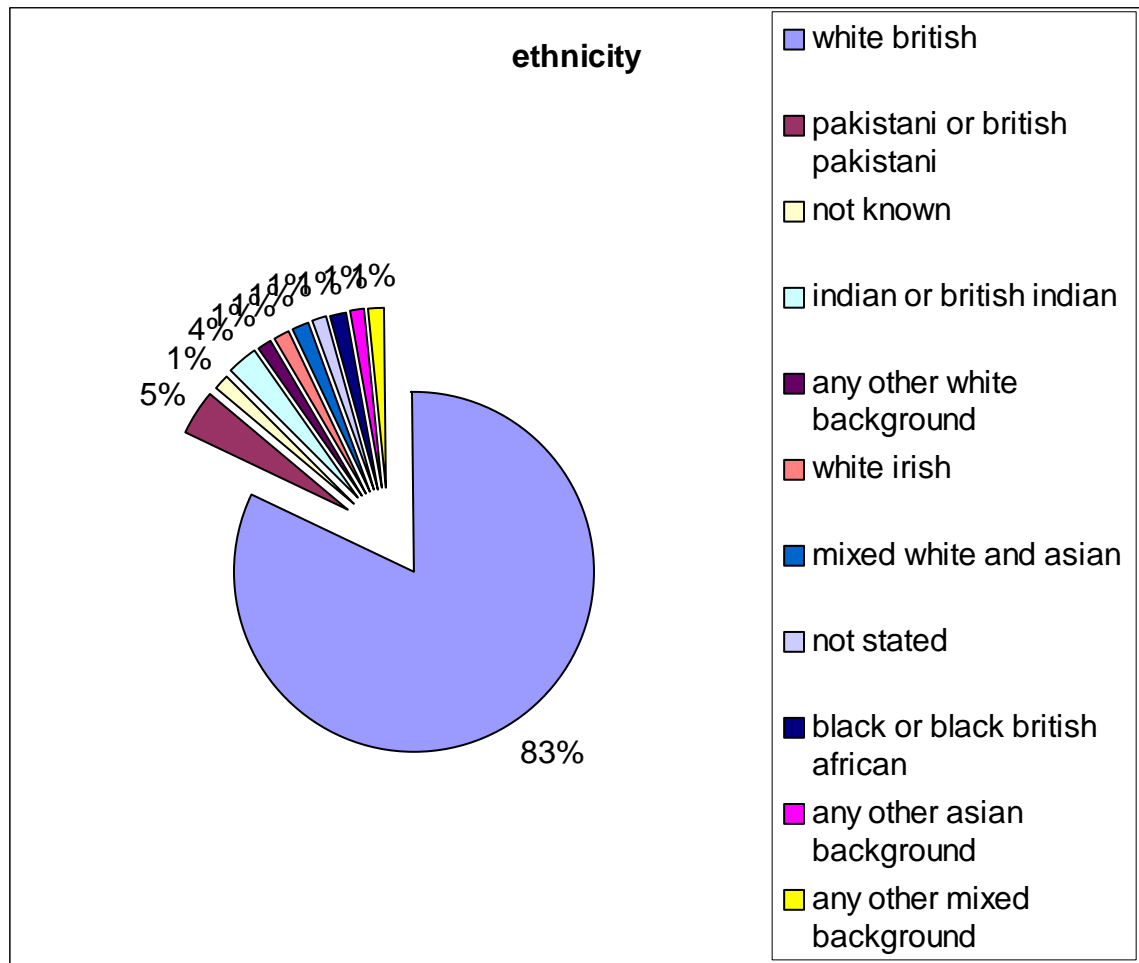
Data from Blackburn with Darwen Primary Care Trust catchment area is presented below. Seventy two patients of the total were recorded in the locality.

Figure 1 Gender



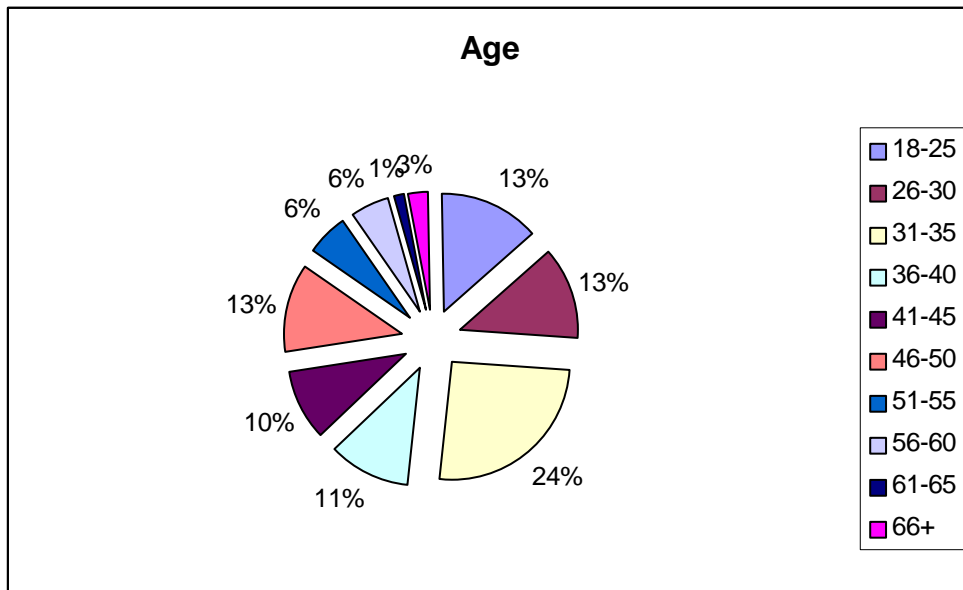
Of 72 patients, 56 (78%) are male and 16 (22%) are female.

Figure 2 Ethnicity



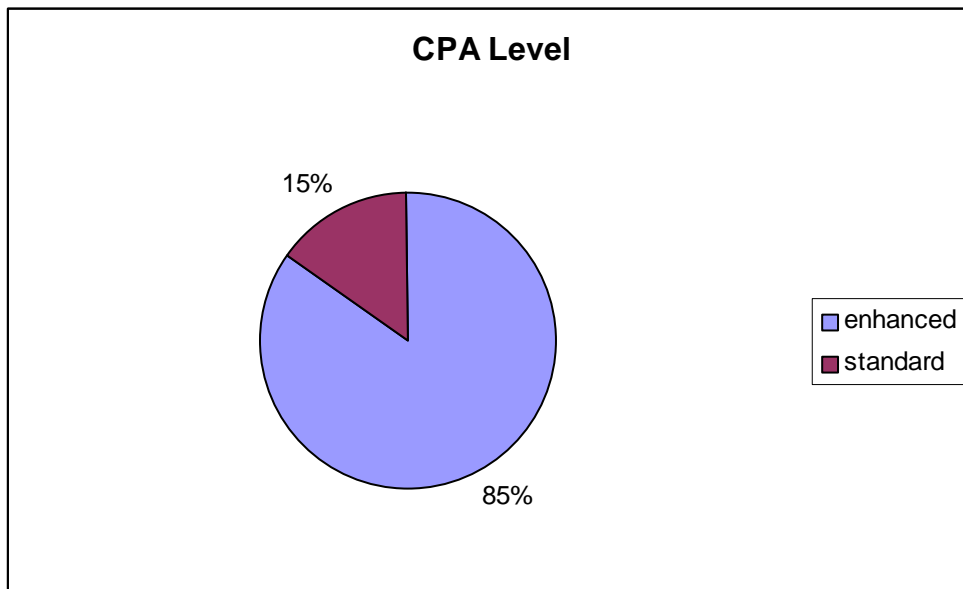
Of 72 patients, 59(83%) are White British and 3(5%) are Pakistani or British Pakistani; 1(1%) ethnicity is not known; 2(4%) are Indian or British Indian; 1(1%) are any other white background; 1(1%) are White Irish; 1(1%) are mixed white and Asian; 1(1%) ethnicity is not stated; 1(1%) are black or black British African; 1(1%) are any other Asian background and 1(1%) are any other mixed background

Figure 3 Age



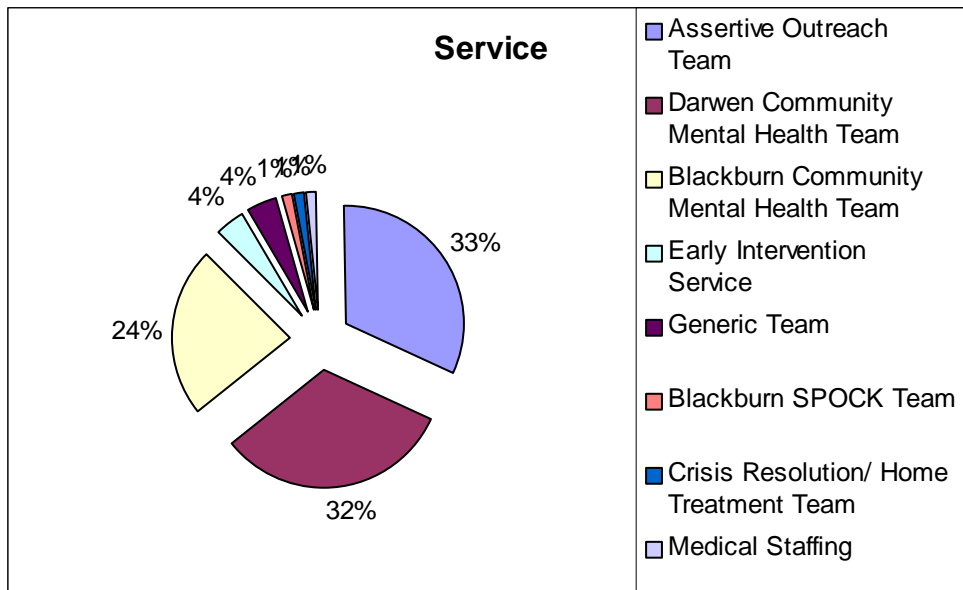
Of 72 patients, 10(13%) 18-25; 9(13%) 26-30; 18(24%) 31-35; 8(11%) 36-40; 7(10%) 41-45; 9(13%) 46-50; 4(6%) 51-55; 4(6%) 56-60; 1(1%) 61-65 and 2(3%) 66+

Figure 4 CPA Level



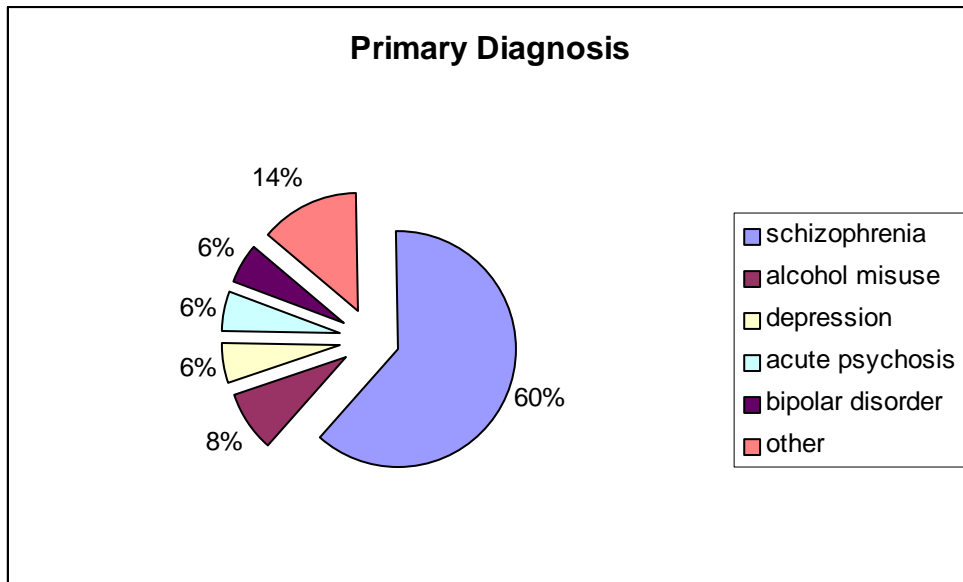
Of 72 patients, 61(85%) are registered on Enhanced Level CPA and 11(15%) are registered on Standard Level CPA

Figure 5 Service



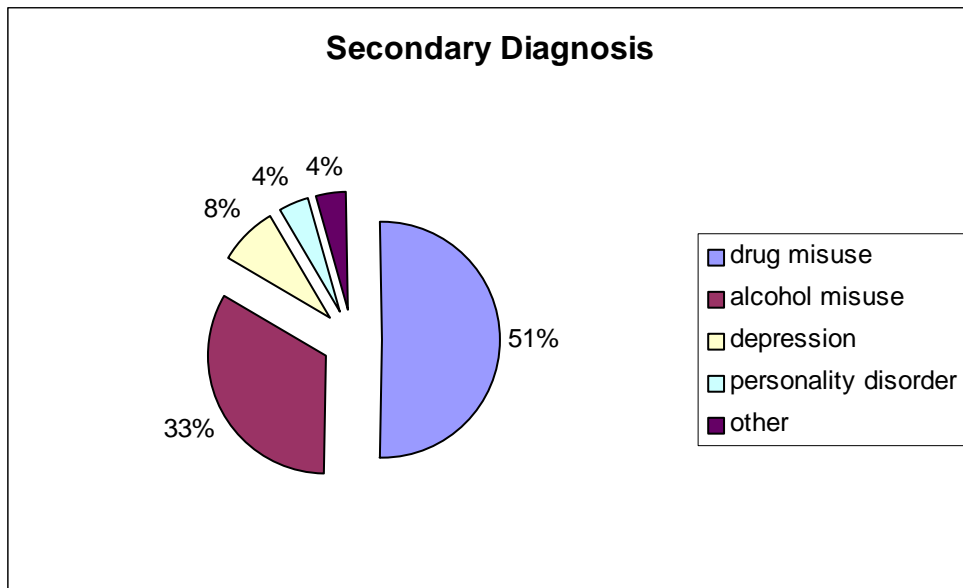
Of 72 patients, 23(33%) are known to the Assertive Outreach Team; 23(32%) are known to Darwen Community Mental Health Team; 17(24%) are known to Blackburn Community Mental Health Team; 3(4%) are known to the Early Intervention Service; and 3(4%) are known to the generic team; 1(1%) are known to the Blackburn SPOCK team; 1(1%) are known to the Crisis Resolution/Home Treatment Team and 1(1%) is known to medical staffing.

Figure 6 Primary Diagnosis



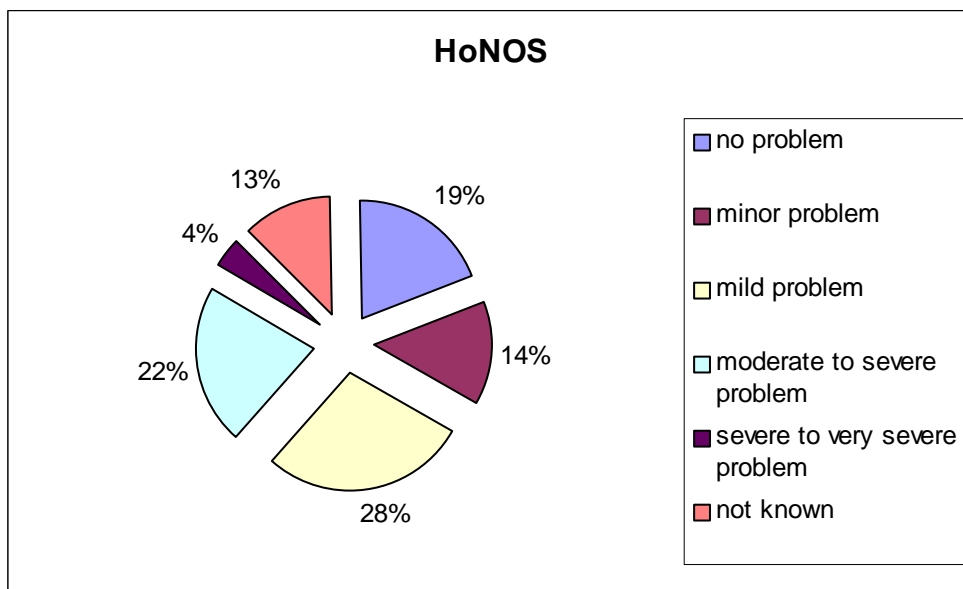
Of 72 patients, 44(60%) experience schizophrenia; 6(8%) experience alcohol misuse; 4(6%) experience depression; 4(6%) experience acute psychosis; 4(6%) experience bipolar disorder and 10(14%) experience other mental health issues

Figure 7 Secondary Diagnosis



Of 72 patients, 36(51%) experience drug misuse, 24(33% experience alcohol misuse; 6(8%) experience depression; 3(4%) experience personality disorder and 3(4%) experience other mental health issues

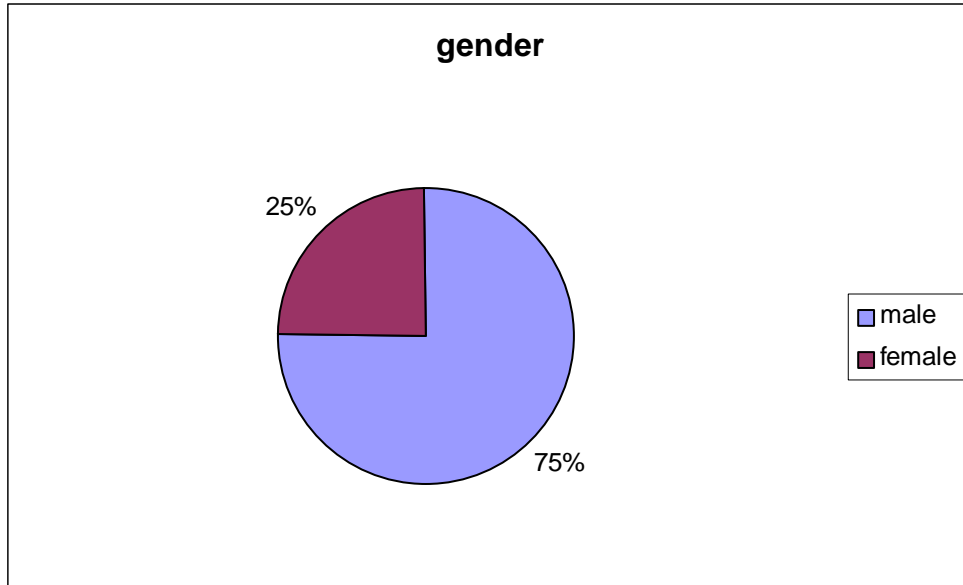
Figure 8 HoNOS



Of 72 patients, 14(19%) are considered to have no problem, 10(14%) are considered to have a minor problem, 20(28%) have a mild problem, 16(22%) have a moderate to severe problem with their substance misuse and 3(4%) have a severe to very severe problem. 9 patients (13%) HoNOS rating is not known.

Data from Blackpool Primary Care Trust catchment area is presented below. 4 patients of the total with dual diagnosis were recorded in the locality

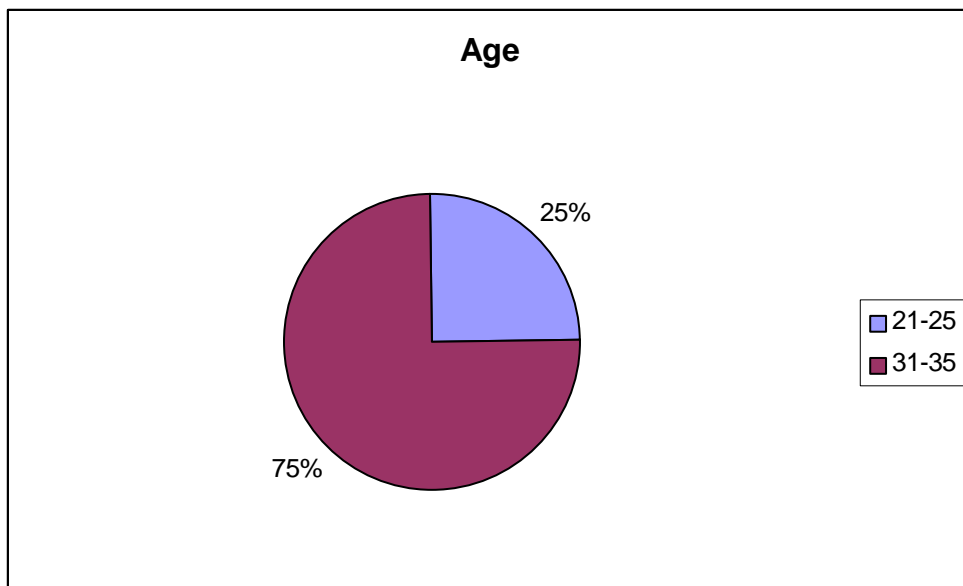
Figure 1 Gender



Of 4 patients, 3(75%) are male and 1(25%) is female

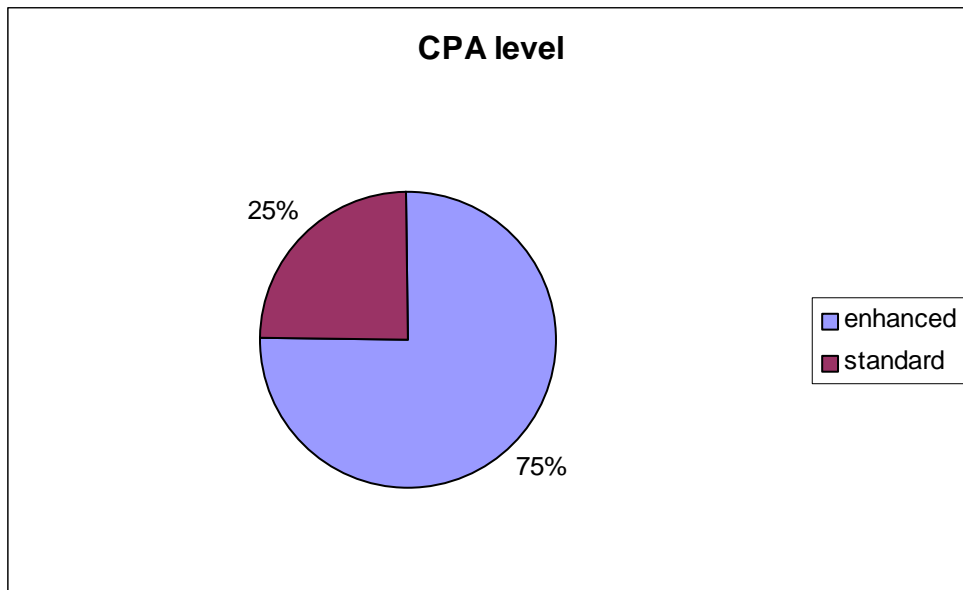
All four patients ethnicity is recorded as White British

Figure 2 Age



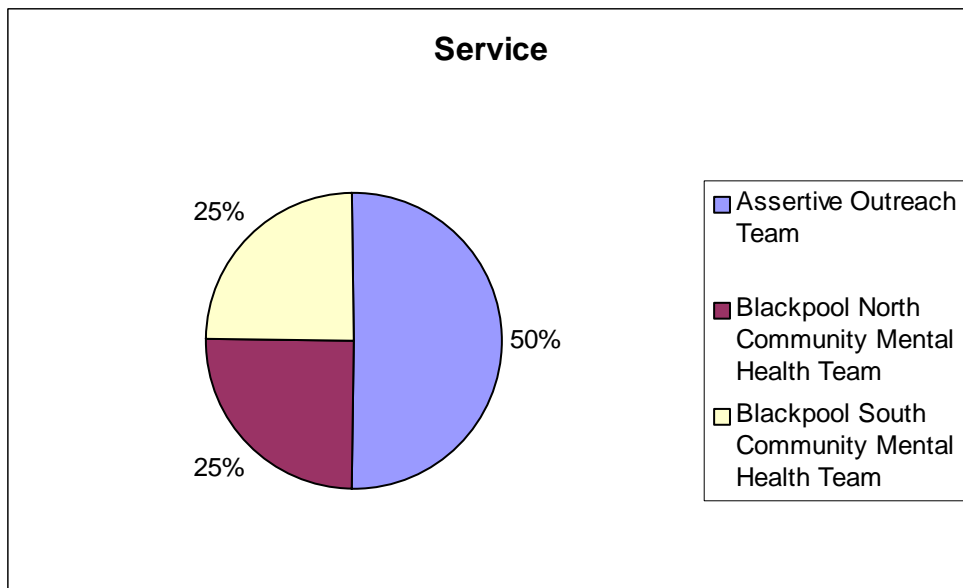
Of 4 patients, 1(25%) is aged 21-25 and 3(75%) are 31-35 years of age.

Figure 3 CPA Level



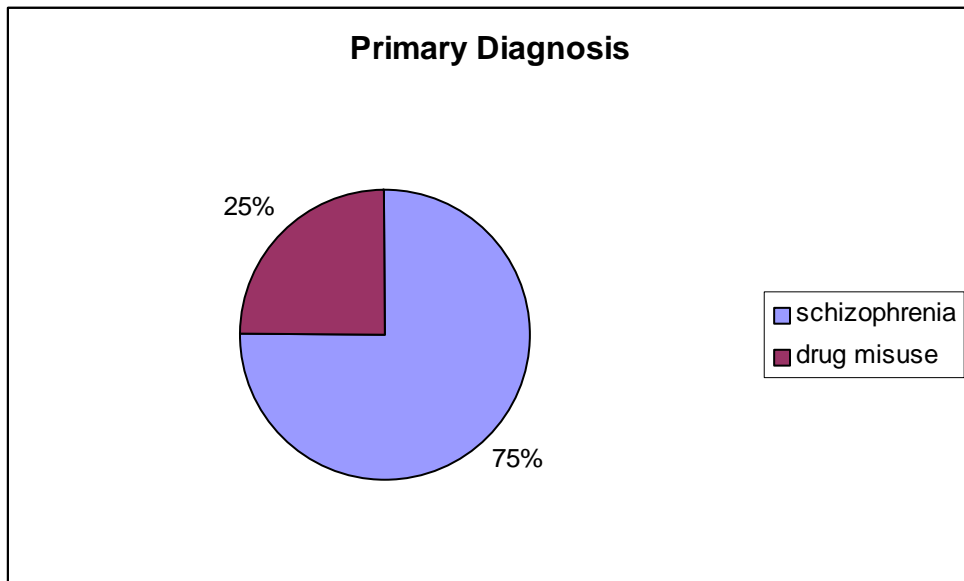
Of 4 patients, 3(75%) are registered on Enhanced Level CPA and 1(25%) is registered on Standard Level CPA

Figure 4 Service



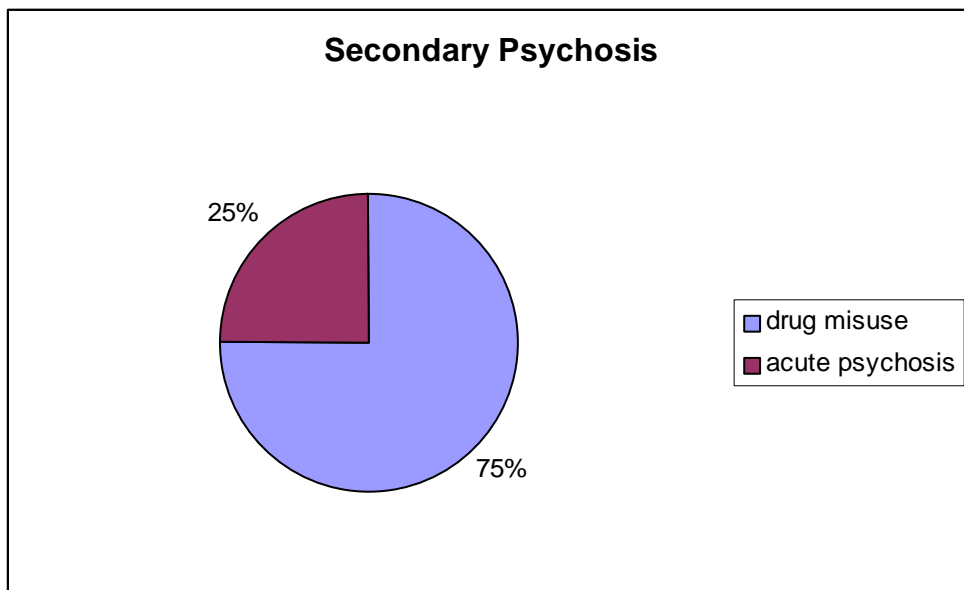
Of 4 patients, 2(50%) are known to the Assertive Outreach Team. 1(25%) is known to the Blackpool North Community Mental Health Team and another patient (25%) is known to the Blackpool South Community Mental Health Team

Figure 5 Primary Diagnosis



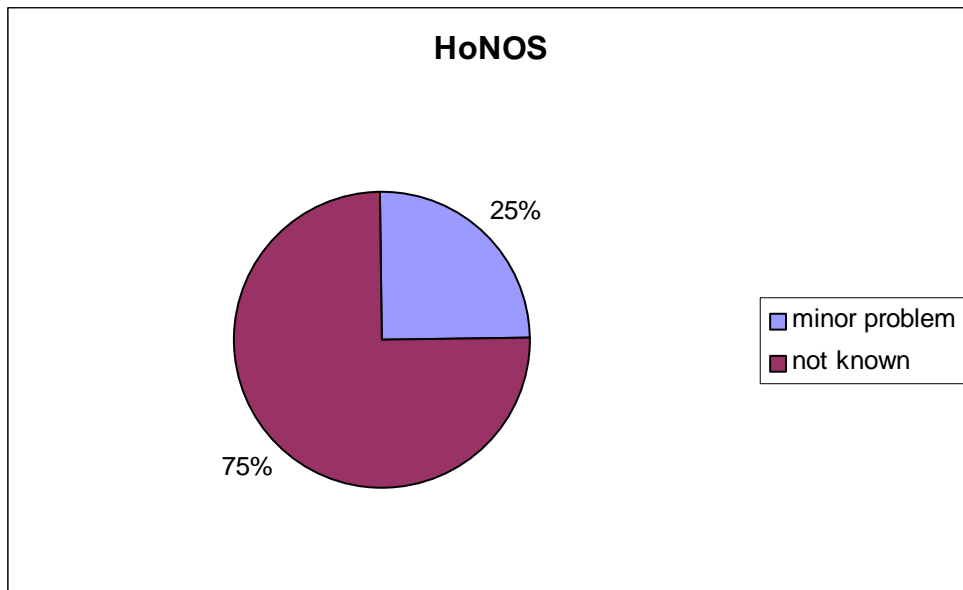
Of 4 patients, 3(75%) experience schizophrenia and 1(25%) experience drug misuse

Figure 6 Secondary Diagnosis



Of 4 patients, 3(75%) experience drug misuse and 1(25%) experiences acute psychosis

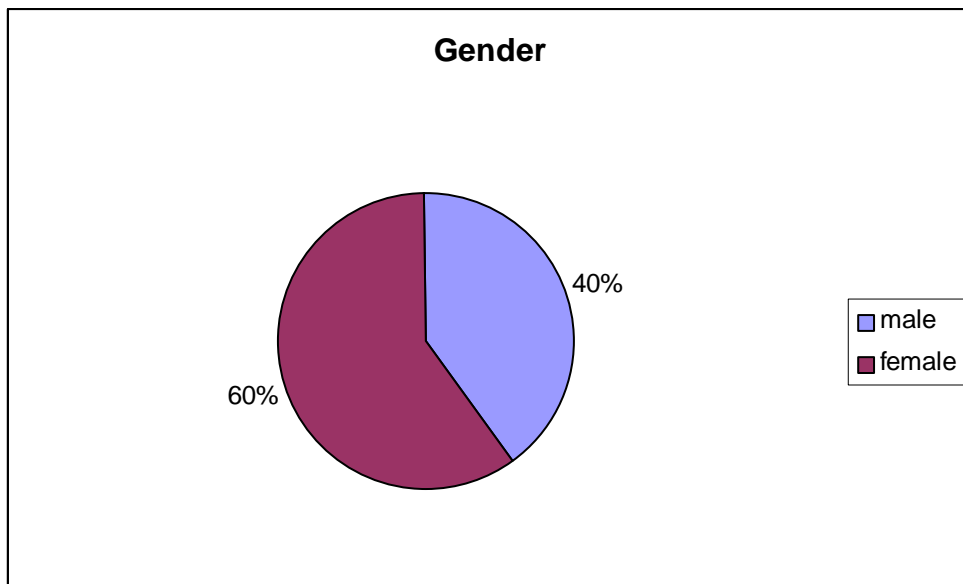
Figure 7 HoNOS



Of 4 patients, 1(25%) is considered to have a minor problem and 3(75%) patients HoNOS score is not known.

Data from North Lancashire Primary Care Trust catchment area is presented below. 5 patients of the total with dual diagnosis were recorded in the locality.

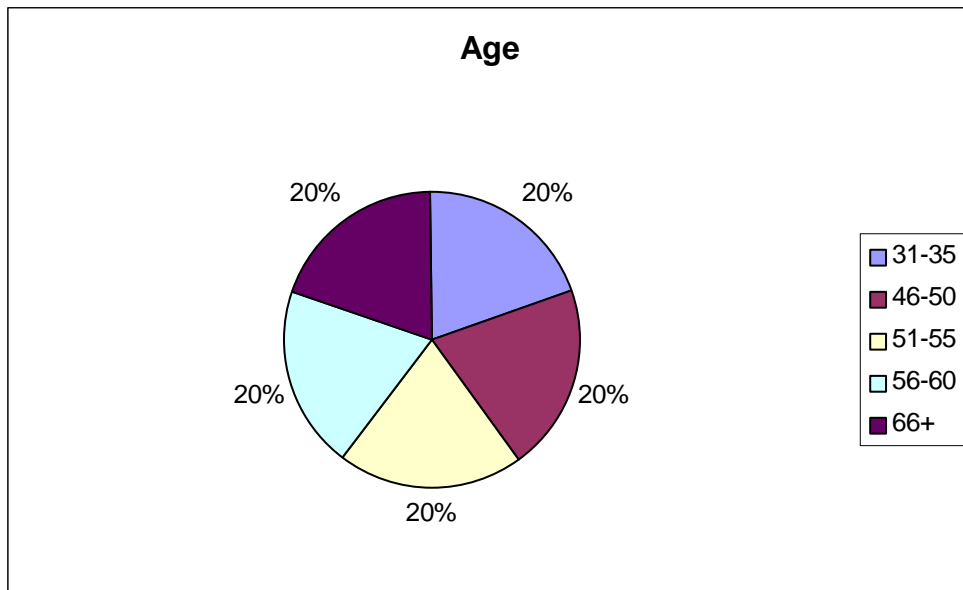
Figure 1 Gender



Of 5 patients, 2(40%) are male and 3(60%) are female

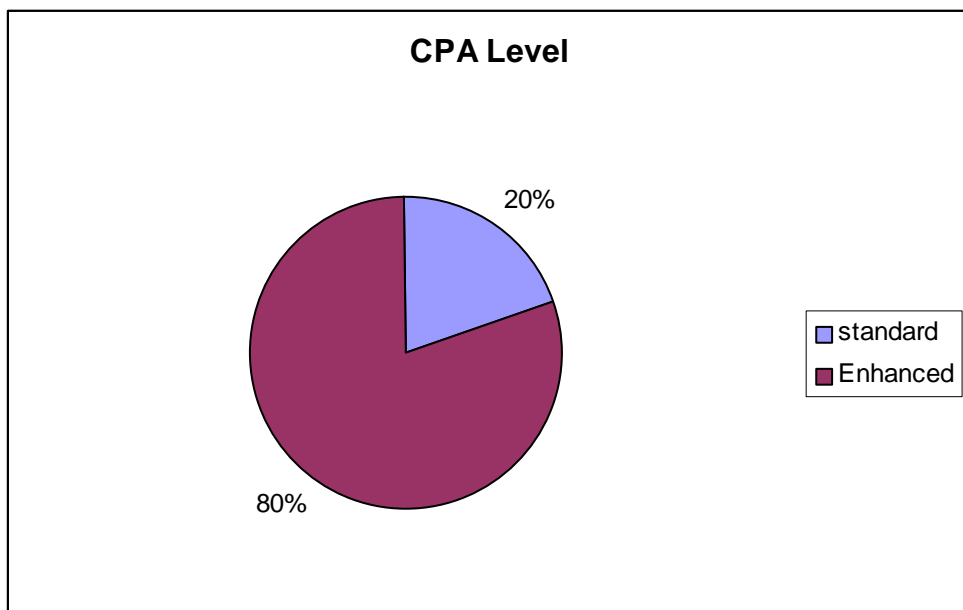
All five patients ethnicity is recorded as White British

Figure 2 Age



Of 5 patients, 1(20%) is 31-35 years of age; 1(20%) is 46-50; 1(20%) is 51-55; 1(20%) is 56-60 and 1(20%) is 66+

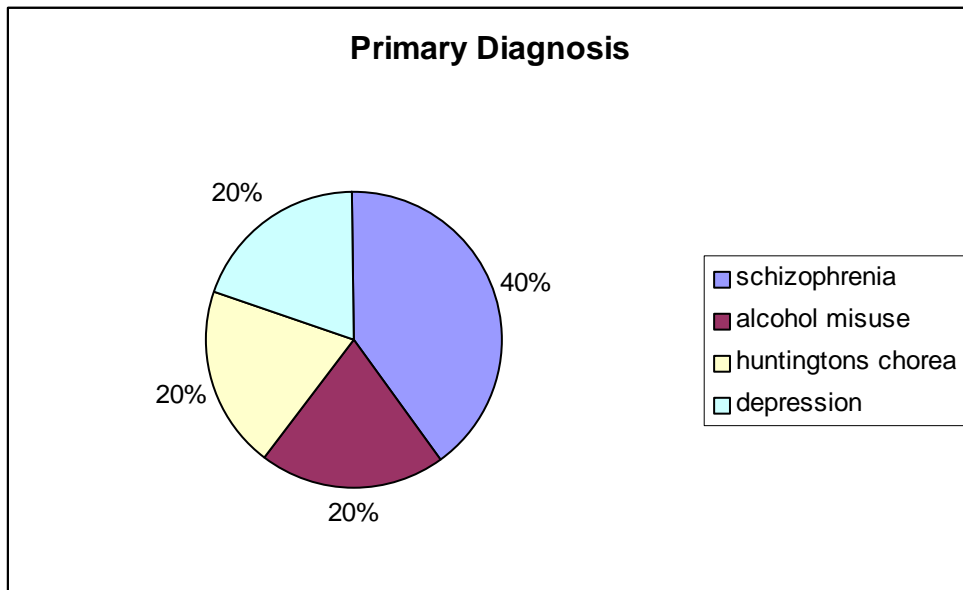
Figure 3 CPA Level



Of 5 patients, 1(20%) is registered on Standard Level CPA and 4(80%) are registered on Enhanced Level CPA

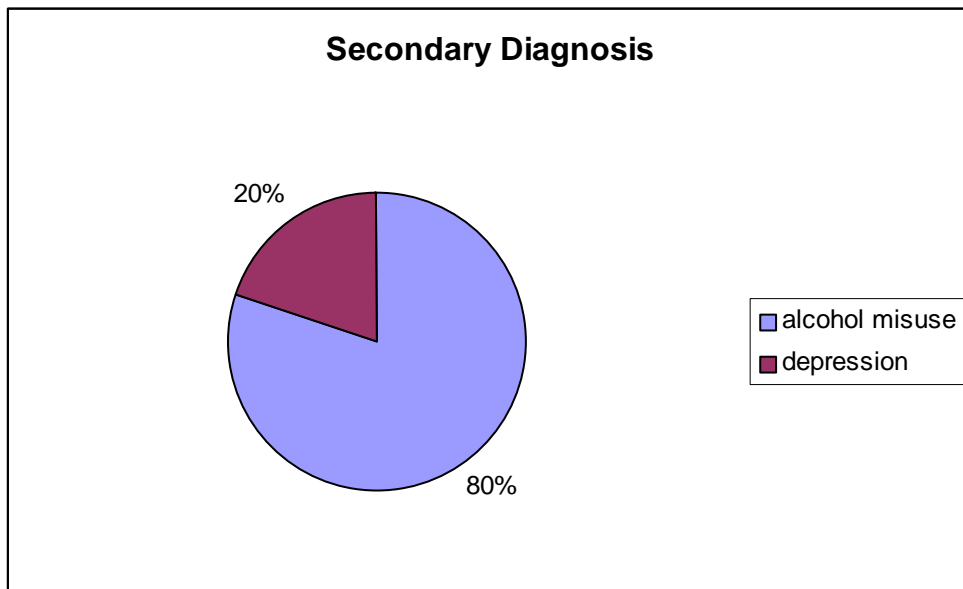
All five patients were known to the Fylde Community Mental Health Team

Figure 4 Primary Diagnosis



Of 5 patients, 2(40%) experience schizophrenia; 1(20%) experiences alcohol misuse; 1(20%) experiences huntington's chorea and 1(20%) experiences depression

Figure 5 Secondary Diagnosis

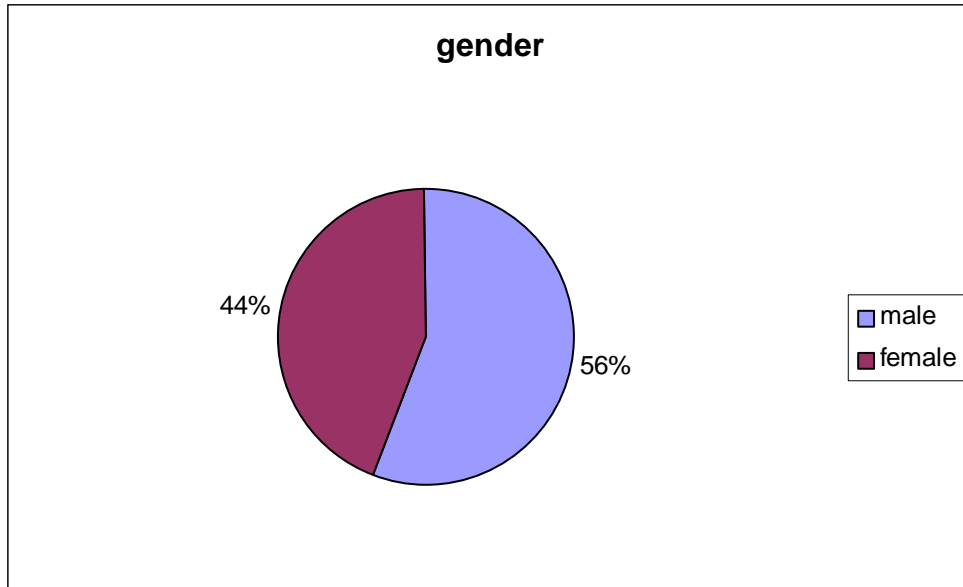


Of five patients, 4(80%) experience depression and one patient (20%) experiences alcohol misuse

All five patients HoNOS score is not known

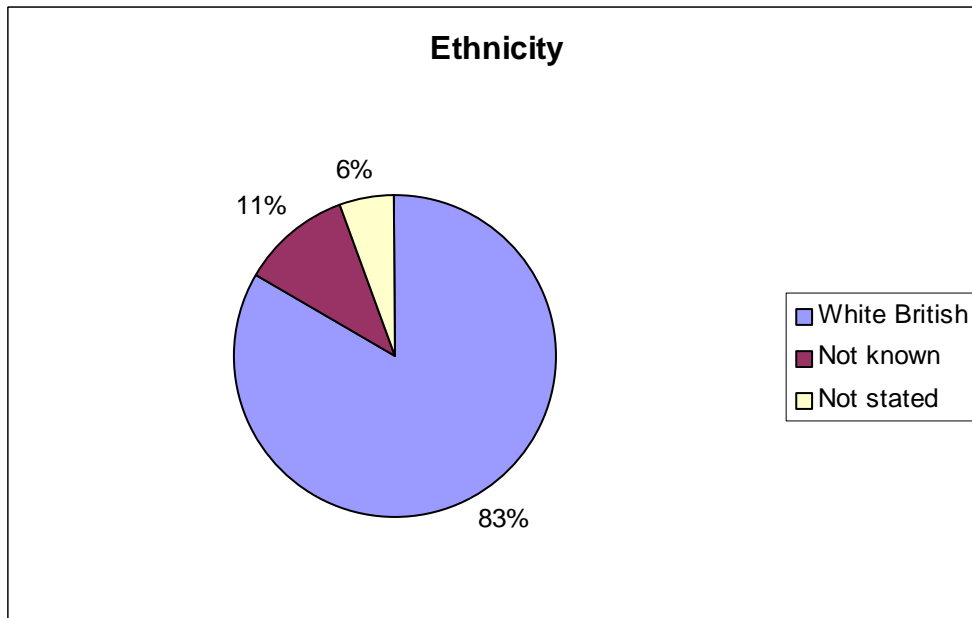
Data from Central Lancashire Primary Care Trust catchment area is presented below. This includes the areas of Preston, Chorley and South Ribble and West Lancashire. 18 patients of the total with dual diagnosis are recorded in the locality

Figure 1 Gender



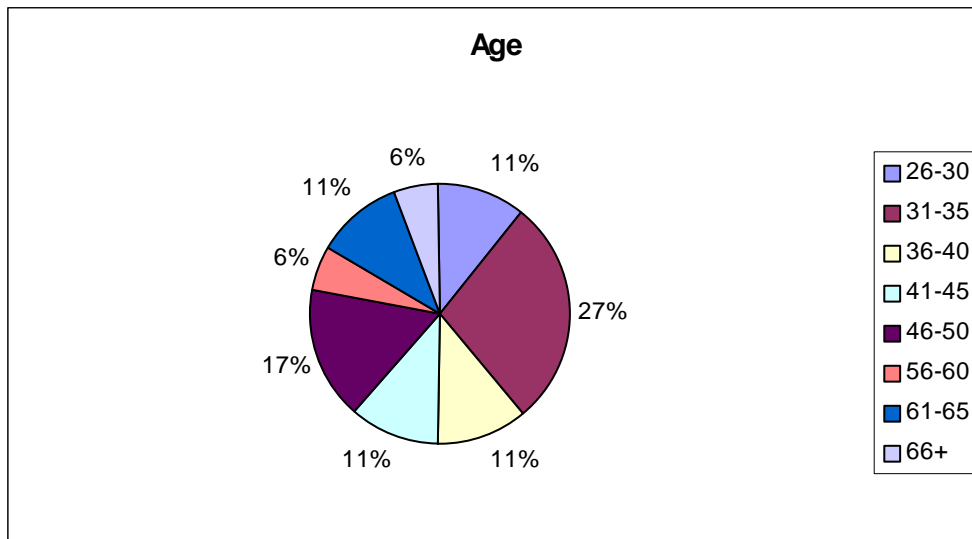
Of 18 patients, 10 (56%) are male and 8 (44%) are female

Figure 2 Ethnicity



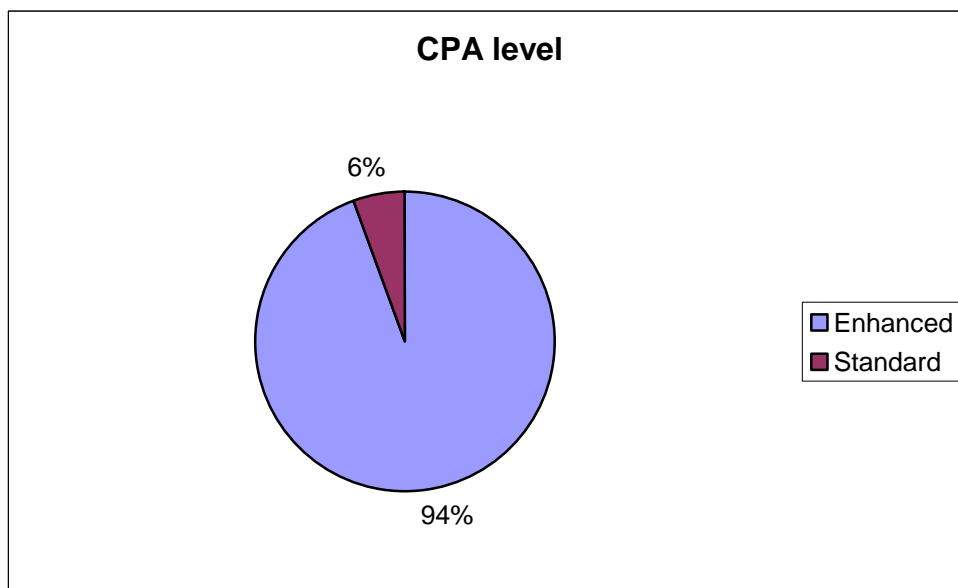
Of 18 patients, 15 (83%) are White British, 2 (11%) ethnicity is not known and 1 patient's ethnicity (6%) is not stated

Figure 3 Age



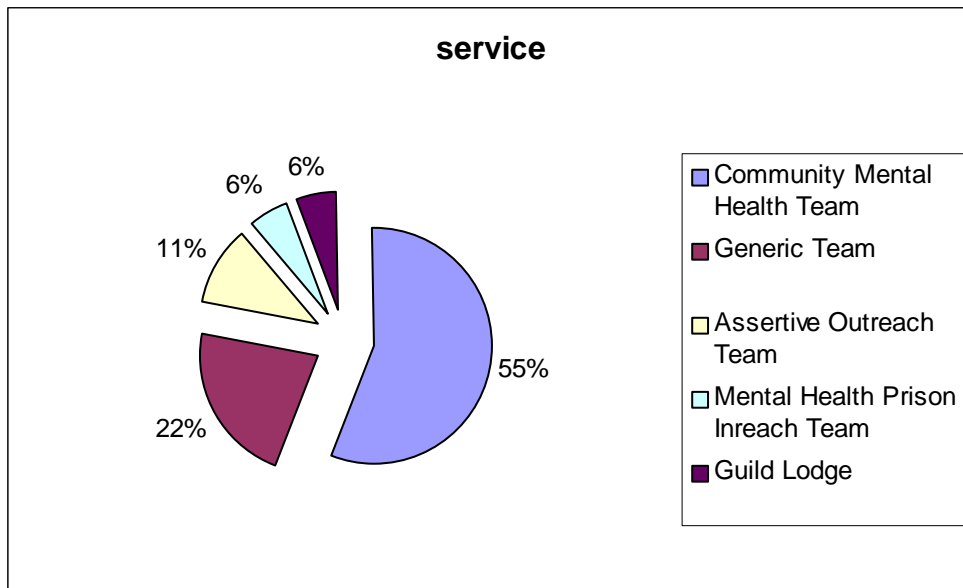
Of 18 patients, 2(11%) are 26-30 years of age; 5(27%) are 31-35; 2(11%) are 36-40; 2(11%) are 41-45; 3(17%) are 46-50; 1(6%) are 56-60; 2(11%) are 61-65 and 1(6%) patient is 66+ years of age

Figure 4 CPA Level



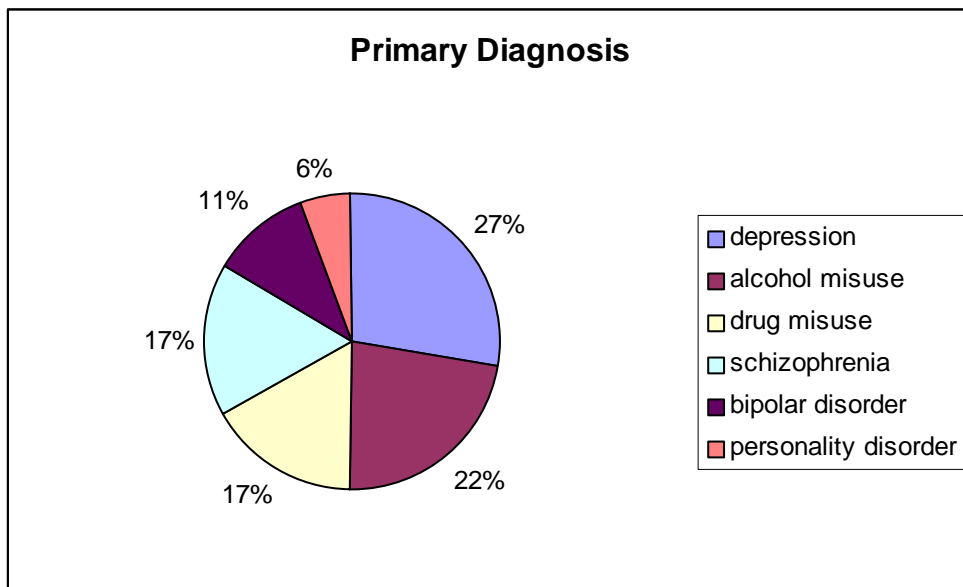
Of 18 patients, 17 (94%) are registered on Enhanced Level CPA and 1 patient (6%) is registered on Standard CPA

Figure 5 Service



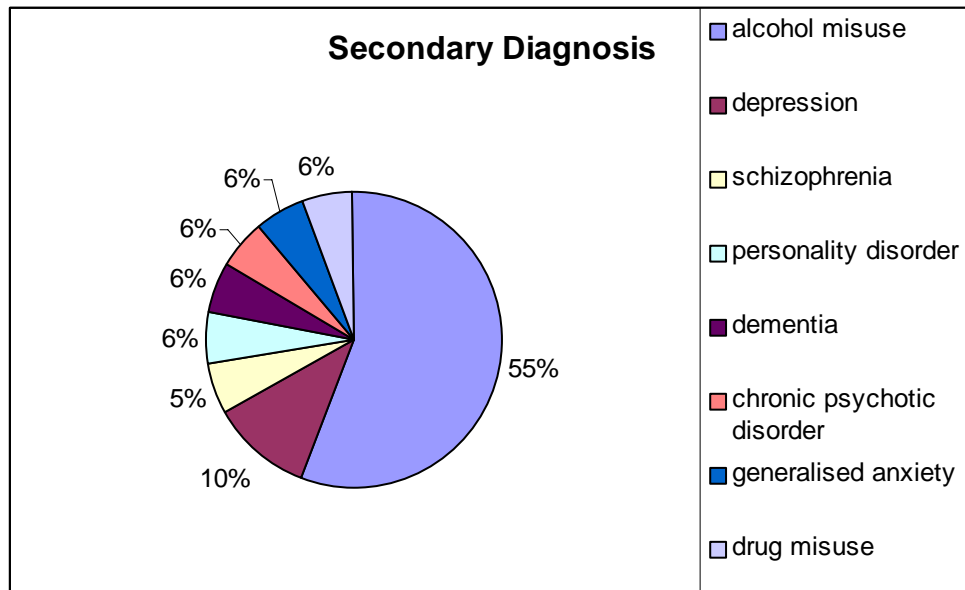
Of 18 patients, 10 (55%) are known to the community mental health team; 4 (22%) are known to the generic team; 2 (11%) are known to the assertive outreach team. One patient (6%) is known to the mental health prison team and one patient (6%) is known to Guild Lodge

Figure 6 Primary Diagnosis



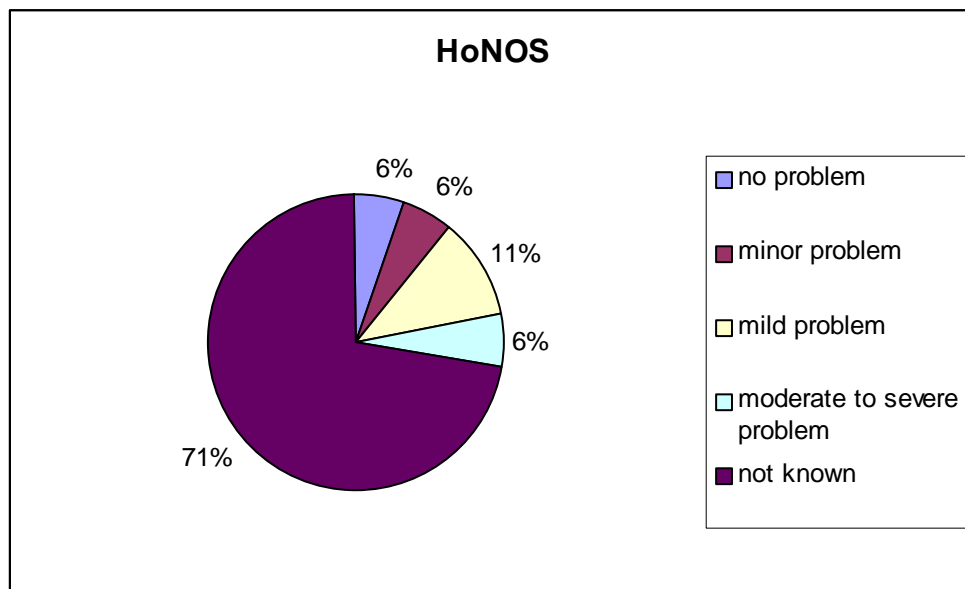
Of 18 patients, 5(27%) experience depression; 4(22%) experience alcohol misuse; 3(17%) experience drug misuse; 3(17%) experience schizophrenia; 2(11%) experience bipolar disorder and 1(6%) experience personality disorder

Figure 7 Secondary Diagnosis



Of 18 patients, 10(55%) experience alcohol misuse; 2(10%) experience depression; 1(5%) experience schizophrenia; 1(6%) experience personality disorder; 1(6%) experience dementia; 1(6%) experience chronic psychotic disorder; 1(6%) experience generalised anxiety and 1(6%) experiences drug misuse

Figure 8 HoNOS



Of 18 patients, 1(6%) has no problem with their substance misuse, 1(6%) has a minor problem; 2(11%) has a mild problem; 1(6%) has a moderate to severe problem and 13(71%) patients HoNOS score is not known

There are several themes emerging from this data. A thematic analysis is presented below:

- **Gender**

For all areas, males experience dual diagnosis at a higher rate than females. This is consistent with national trends and the profile of a person with dual diagnosis. The exception is North Lancashire PCT area. However, as the total number is very small, it may not alter the gender pattern overall

- **Ethnicity**

The data does not significantly present clients from Black and Minority Ethnic Communities. Some reasons for this may include:

- Black and minority ethnicity is not routinely recorded
- Clients from black and minority ethnic backgrounds do not access services
- Clients from black and minority ethnic backgrounds do not have the means to access services
- Services do not actively pursue clients from black and minority ethnic backgrounds.

The Dual Diagnosis Good Practice Policy Implementation Guidelines (2002) recognises that people from black and ethnic minorities have specific needs.

For further guidance, please see:

- Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England Department of Health (2003)
- Community Engagement Report Department of Health (2003)
- Mental Health Policy Implementation Guidance Community Development Workers for Black and Minority Ethnic Communities: Interim Guidance Department of Health (2004)
- Developing Race Equality in Mental Health Care Department of Health (2005)

- **Age**

For the majority of areas, people with dual diagnosis appear to be in their thirties. This is consistent with national trends and the profile of a person with dual diagnosis. The exceptions are East Lancashire Primary Care Trust area who experiences a slightly higher age range – mid forties – but only by 3% of the total number of people recorded with dual diagnosis in this locality. This may be particular to the age profile of the registered population within the general population for the area. North Lancashire Primary Care Trust area is another exception. Of the five patients, known to the locality with dual diagnosis each patient is a different age and there is no pattern to the age distribution. However, the number of total patients is very small and may carry no statistical significance to the overall population for this area.

There is also a noticeable age profile of younger people and this is obviously attributed to the early intervention services, but highlights a crucial factor of

the profile of people with dual diagnosis, a proportion of whom may experience first episode psychosis with substance misuse

- **CPA Level**

For all areas, patients are registered on Enhanced Level CPA. This is consistent with national trends and the profile of a person with dual diagnosis.

- **Service**

For all areas, the majority of people with dual diagnosis are known to the Community Mental Health Teams. This is followed closely by care co-ordination provided by the Assertive Outreach Services. This is consistent with national trends and the profile of a person with dual diagnosis. There is nominal mention of crisis resolution and home treatment teams. We know these services care for people with dual diagnosis. The omission is therefore one of recording on Methincs and not a lack of activity for these services. A noticeable proportion of service users are recorded as known to the 'Generic Team'. This is not an actual team but describes that a patient is awaiting allocation of a care co-ordinator

- **Primary diagnosis**

For the majority of areas, the primary diagnosis is Schizophrenia. This is consistent with national trends for severe and enduring mental illness and the profile of a person with dual diagnosis. The exception is Central Lancashire Primary Care Trust area whose primary diagnosis is recorded as Depression within the area.

- **Secondary diagnosis**

Overall, within the Trust, the secondary diagnosis is alcohol misuse followed closely by drug misuse. However, each locality has presented differently. Within East Lancashire, it is alcohol misuse and then drug misuse. Within Blackburn with Darwen, the secondary diagnosis is drug misuse followed by alcohol misuse. Within Blackpool, the secondary diagnosis is drug misuse. North Lancashire's total number recorded with dual diagnosis is very small and there is no pattern to the secondary diagnosis. Within Central Lancashire the secondary diagnosis is alcohol.

The overall impression of mental health presentation is Schizophrenia and Alcohol Misuse. This is also the presentation within East Lancashire and to an extent within North Lancashire. In Blackburn with Darwen and Blackpool areas, it is schizophrenia and drug misuse. This may imply drug induced psychosis. In Central Lancashire, the mental health presentation is depression and alcohol which implies a causal relationship.

- **HoNOS**

There are a significant proportion of HoNOS ratings that have been recorded as no problem with drink or drug taking or not known. This may contribute to unmet needs, indicate a training issue for practitioners, may suggest that at the time of recording the status was not known or not considered to be a problem. This could be measured again at formal review.

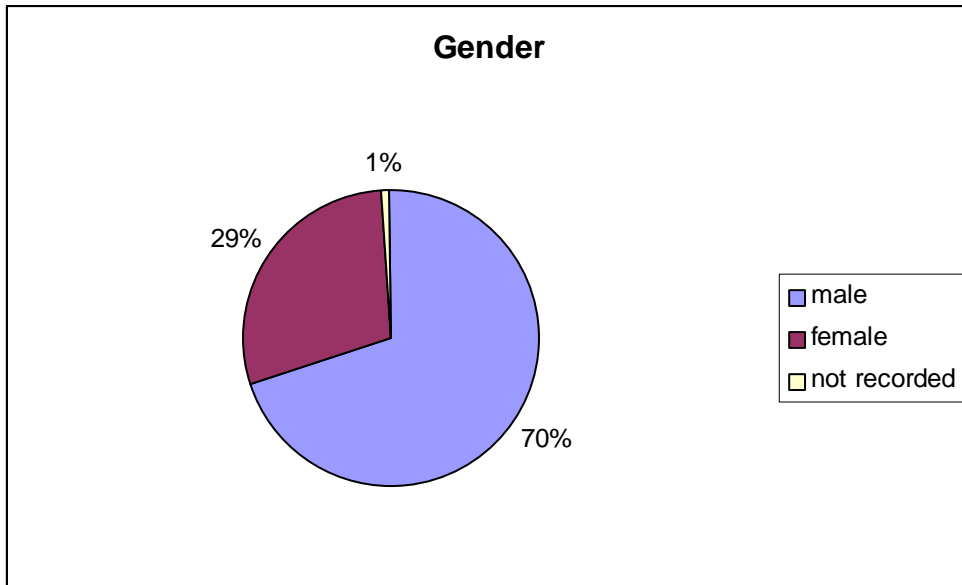
There are several cautionary notes to be advised when interpreting this data.

- It must be noted, that Methincs is a live system and therefore there will be fluctuations in performance reporting.
- The data does not accurately reflect the dual diagnosis activity of the Trust as we know, anecdotally, there are more than 222 patients with dual diagnosis. For example, is it grossly inaccurate that there are only five patients with dual diagnosis within Blackpool Primary Care Trust area
- East Lancashire has been a 'pilot site' for the roll out of Methincs and as such services have refined their ways of working within this system
- Mental Health Services in East Lancashire have benefited from the presence of the dual diagnosis strategy in Blackburn with Darwen. This will have raised awareness of dual diagnosis issues within the locality
- Activity for the North Lancashire area is grossly inaccurate as it does not include Morecambe and Lancaster
- The data does not significantly specify numbers of people with dual diagnosis currently in Prison, who may require care co-ordination upon release. This may have implications for the integrated care pathway for offenders
- The data does not significantly specify numbers of people with dual diagnosis known to Inpatient Services, or secure services that may require care co-ordination upon discharge. This may contribute to delayed discharges
- The data does not specify the numbers of people with dual diagnosis known to primary care mental health services. This has implications for service demand for people with common mental health problems who may also experience substance misuse issues and their interface with secondary mental health services.

Data from the Substance Misuse Network is presented below. An overall impression of the prevalence of dual diagnosis is presented first and then the data is broken down into the Drug and Alcohol Action Team areas.

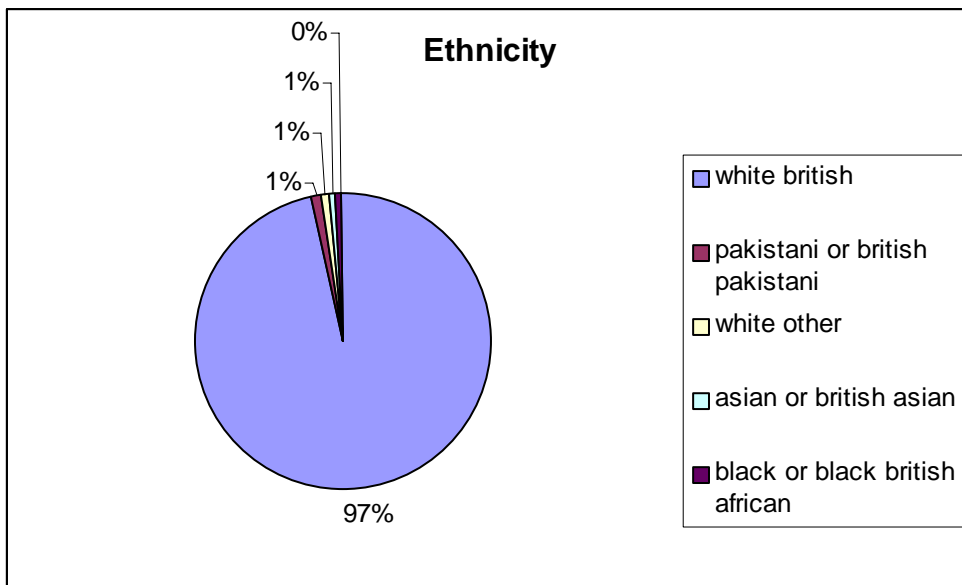
A total of 234 clients presenting to the substance misuse services are considered to experience dual diagnosis issues. This data is presented below:

Figure 1: Gender



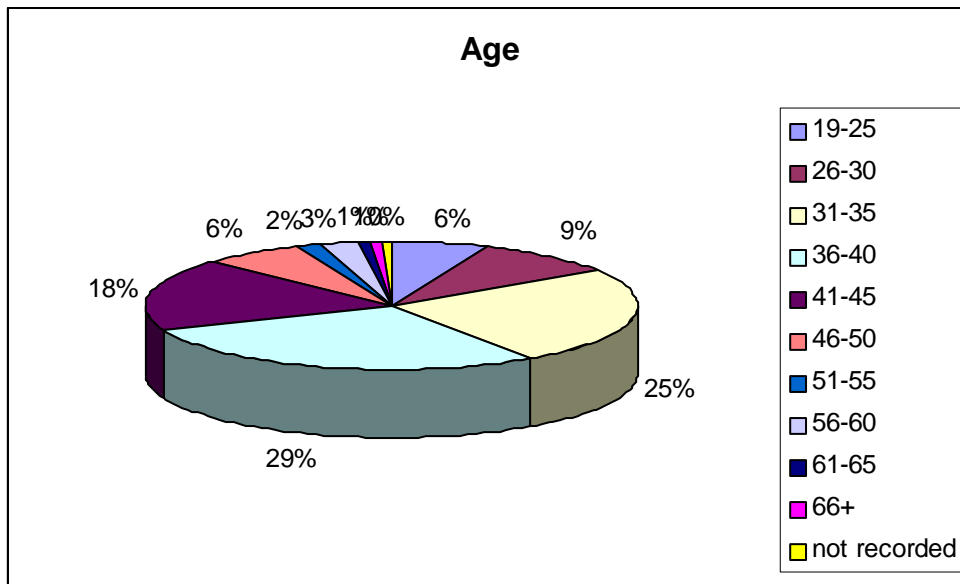
Of 234 clients, 163(70%) are male; 69(29%) are female and 2(1%) clients gender is not recorded

Figure 2: Ethnicity



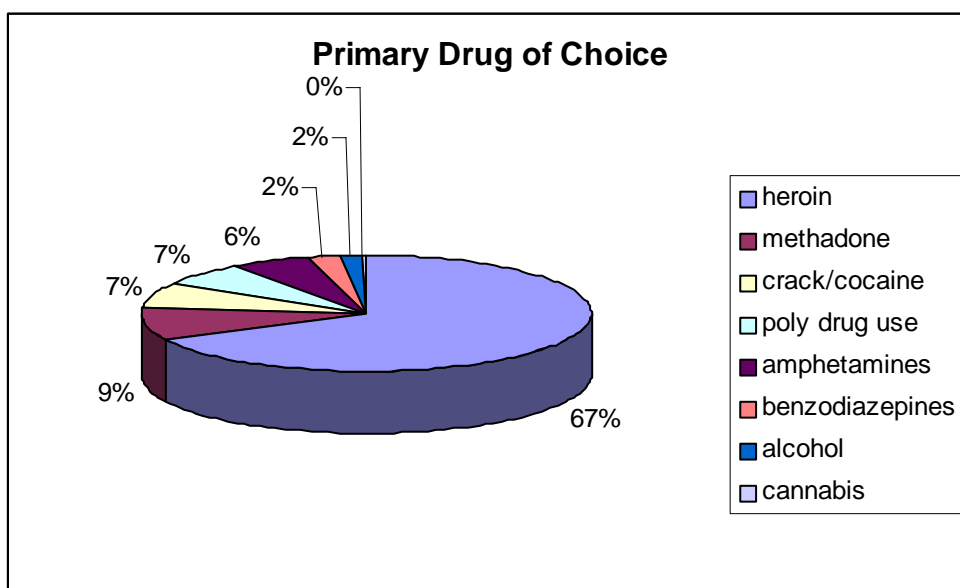
Of 234 clients, 226 (97%) are White British; 3(1%) are Pakistani or British Pakistani; 2(1%) are White Other; 2(1%) are Asian or British Asian and 1(0%) client is Black or Black British African

Figure 3: Age



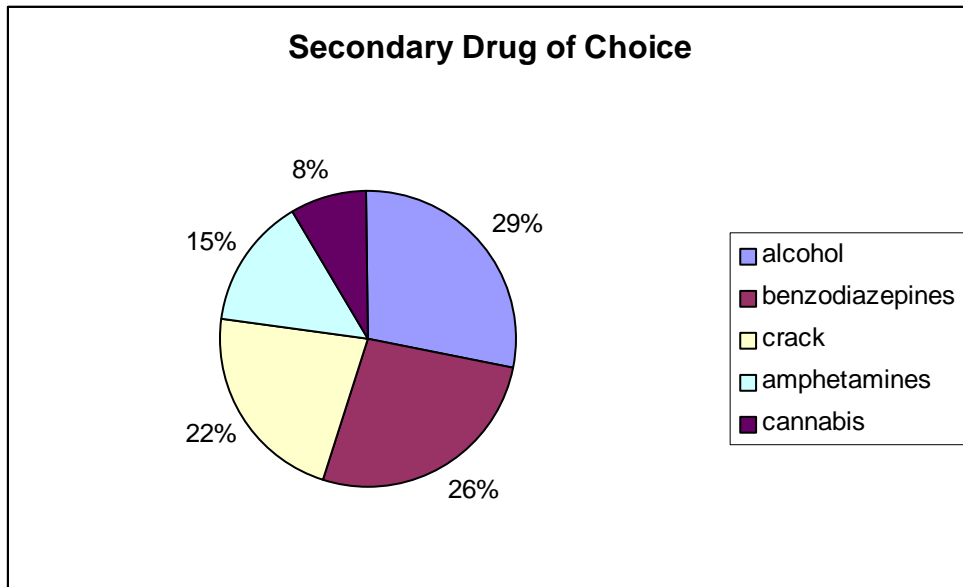
Of 234 clients, 15(6%) are aged 19-25; 22(9%) are 26-30; 58(25%) are 31-35; 66(29%) are 36-40; 43(18%) are 41-45; 15(6%) are 46-50; 4(2%) are 51-55; 6(3%) are 56-60; 2(1%) are 61-65; 2(1%) are 66+ and 1(0%) clients age is not recorded

Figure 4: Primary Drug of Choice



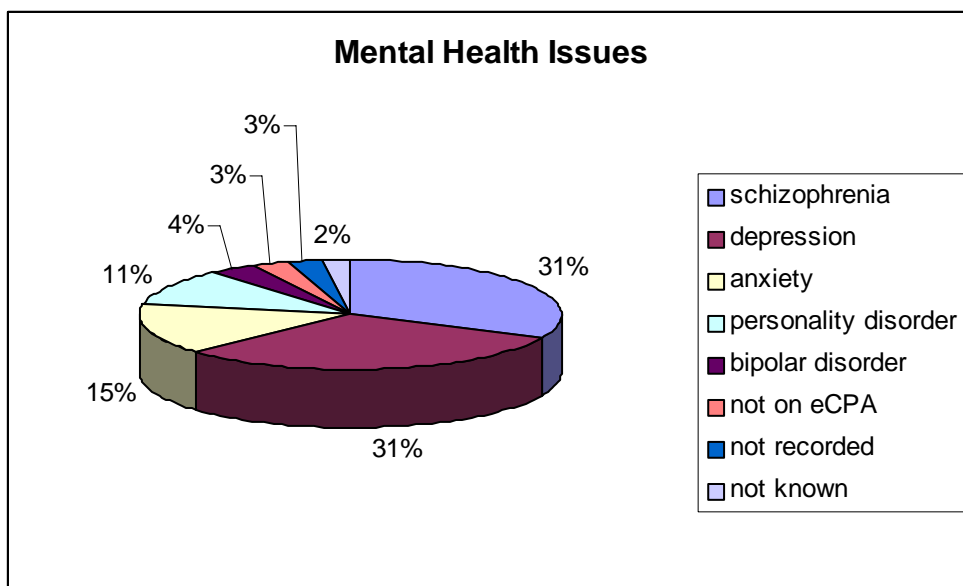
Of 234 clients, 164 (67%) use heroin; 22(9%) use methadone; 17(7%) use crack/cocaine; 16(7%) are poly drug users; 14(6%) use amphetamines; 5(2%) use benzodiazepines; 4(2%) use alcohol and 1(0%) client uses cannabis

Figure 5: Secondary Drug of Choice



Of 234 clients, 27(29%) use alcohol; 25(26%) use benzodiazepines; 21(22%) use crack; 14(15%) use amphetamines and 8(8%) use cannabis

Figure 6: Mental Health Issues

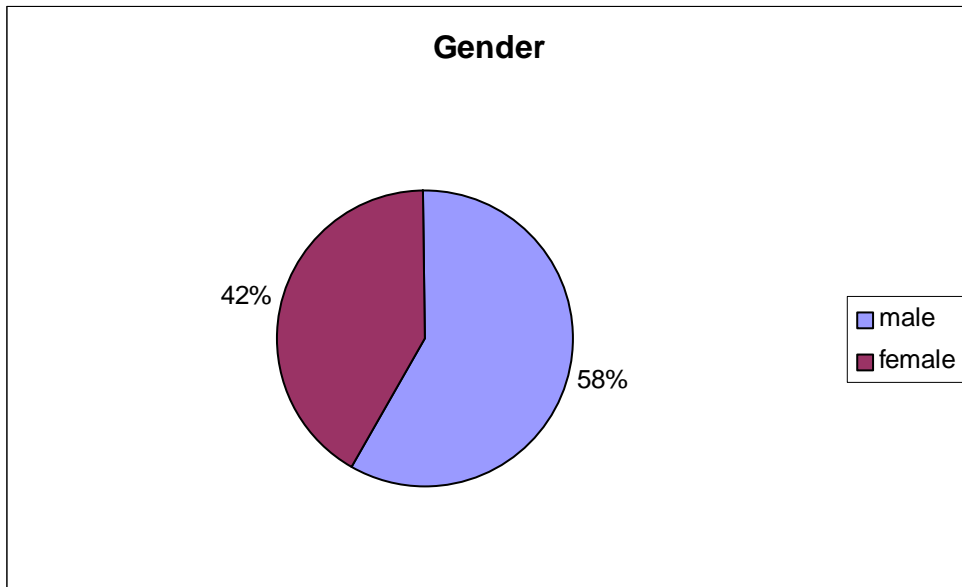


Of 234 clients, 76(31%) experience schizophrenia; 74(31%) experience depression; 35(15%) experience anxiety; 26(11%) experience personality disorder; 9(4%) experience bipolar disorder; 7(3%) clients are considered

to have mental health issues but are not registered no CPA; 6(3%) of clients mental health status is not recorded and 5(2%) of clients mental health status is not known

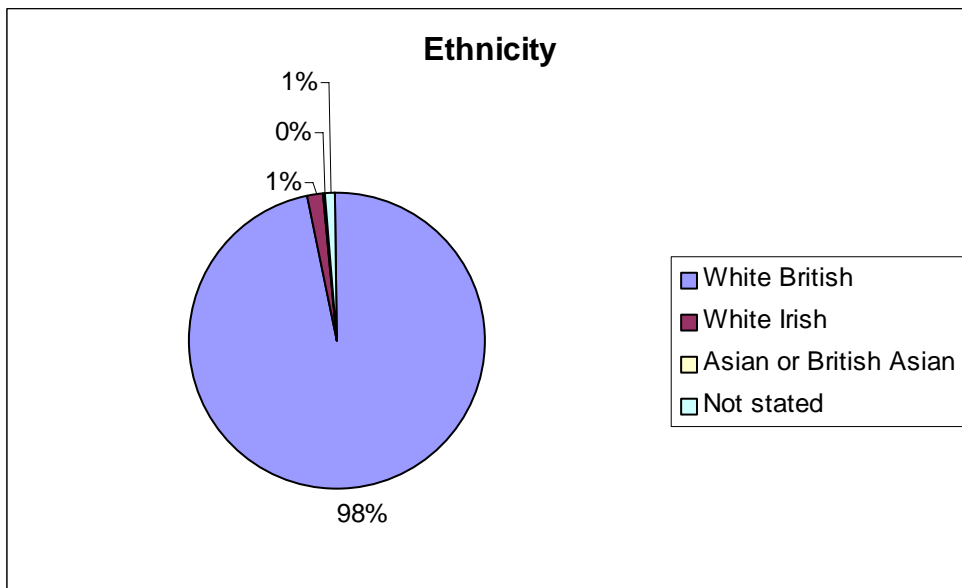
An overall impression of prevalence rates from alcohol services is presented below:

Figure 1: Gender



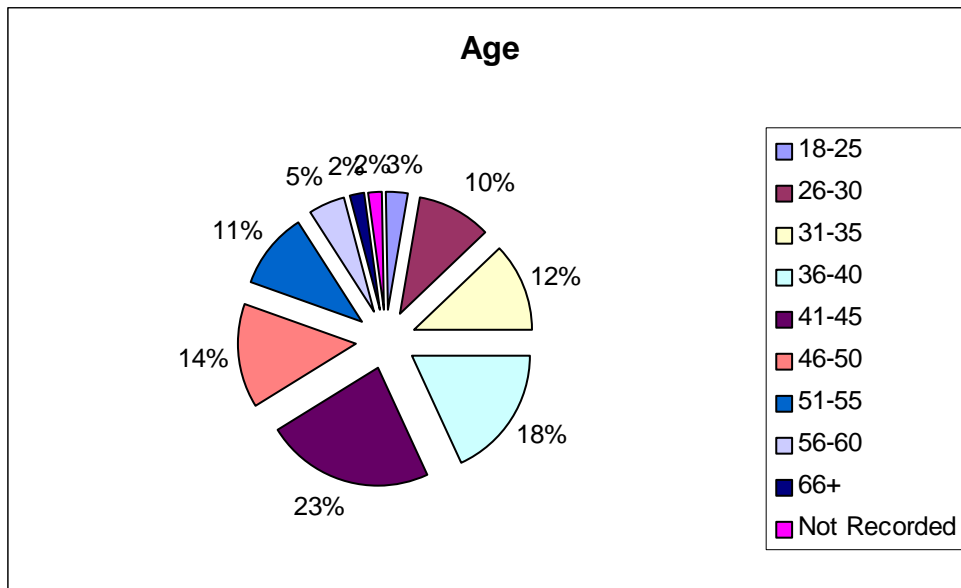
Of 202 patients, 117 (58%) are male and 85 (42%) are female

Figure 2: Ethnicity



Of 202 patients, 196(98%) are White British; 3(1%) are White Irish; 1(0%) patient is Asian or British Asian and 2(1%) patients ethnicity is not stated

Figure 3: Age

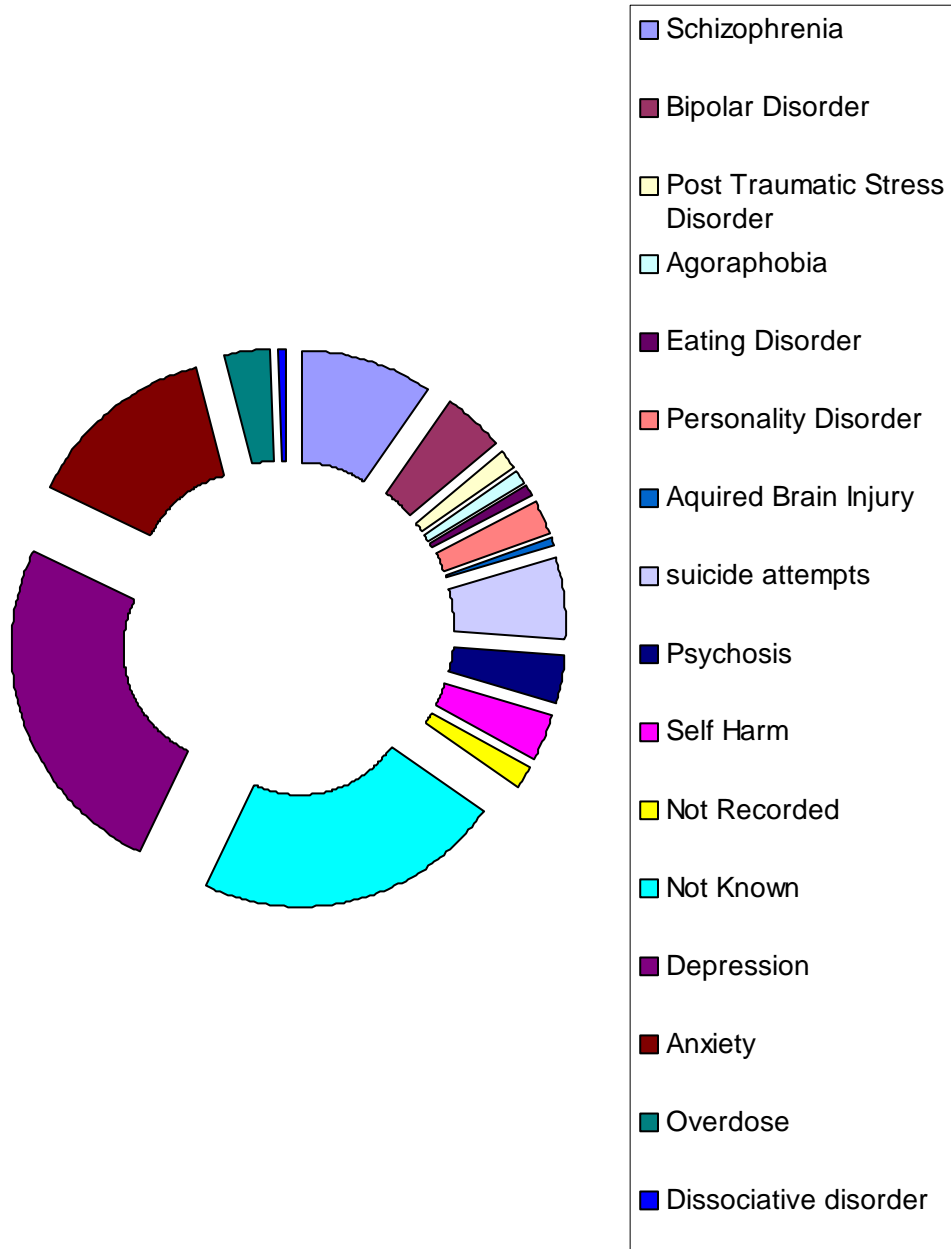


Of 202 patients, 6(3%) are aged 18-25; 21(10%) are 26-30; 24(12%) are 31-35; 36(18%) are 36-40; 46(23%) are 41-45; 29(14%) are 46-50; 22(11%) are 51-55; 10(5%) are 56-60; 4(2%) are 66+ and 4(3%) patients age is not recorded

Figure 4: Mental Health Issues

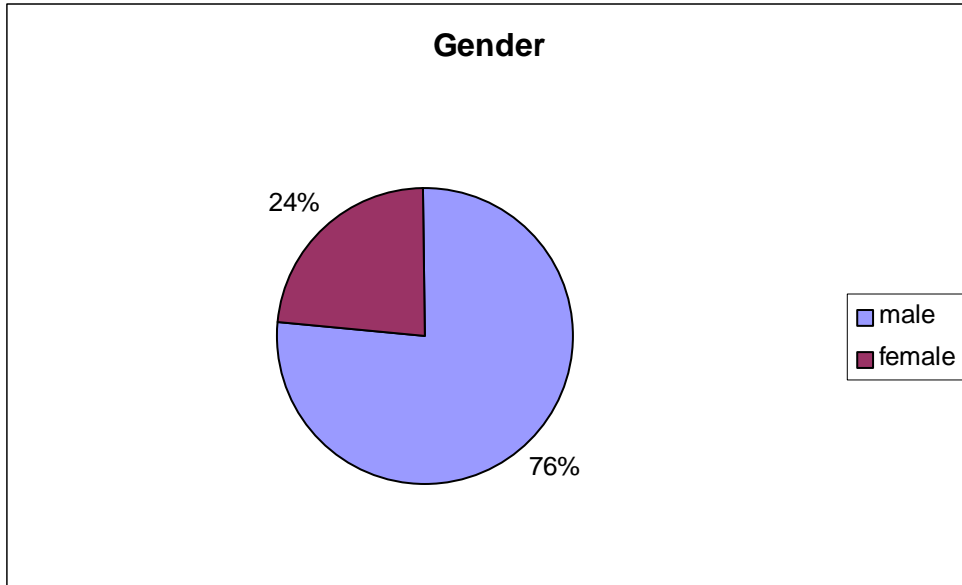
Mental health issues are presented below. Of 202 patients, 19(10%) experience Schizophrenia; 9(4%) experience Bipolar Disorder; 3(1%) experience Post Traumatic Stress Disorder; 2(1%) experience Agoraphobia; 2(1%) experience Eating Disorder; 5(2%) experience Personality Disorder; 1(0%) has Aquired Brain Injury; 12(7%) experience suicide attempts; 7(3%) experience Psychosis; 7(3%) experience Self Harm; 3(1%) patients mental health issue is not recorded; 45(23%) patients mental health issue is not known; 51(26%) experience depression; 28(15%) experience Anxiety; 7(3%) experience Overdose and 1(0%) experience Dissociative Disorder

Mental Health Issues



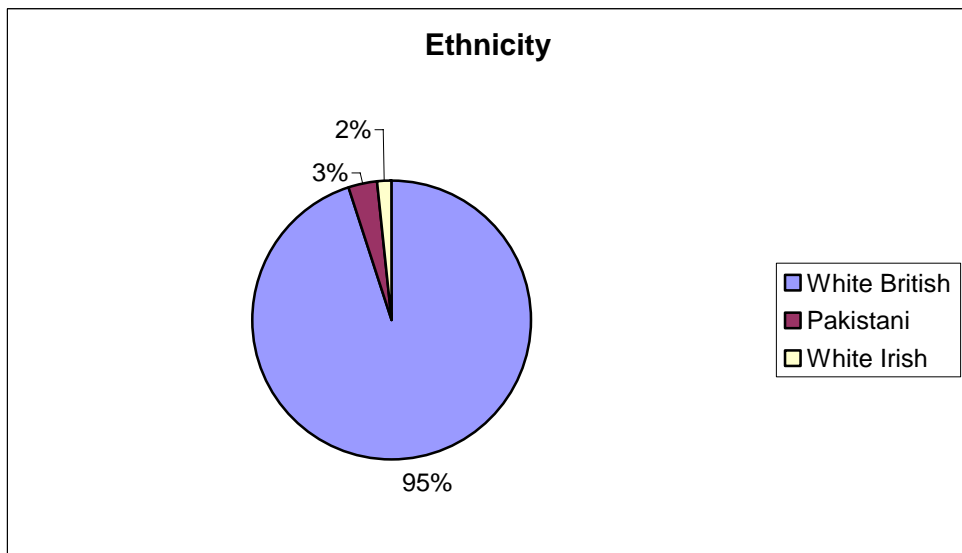
Data from Blackburn with Darwen Drug and Alcohol Action Team catchment area is presented below. A total of 59 clients presenting with substance misuse issues are considered to have dual diagnosis

Figure 1: Gender



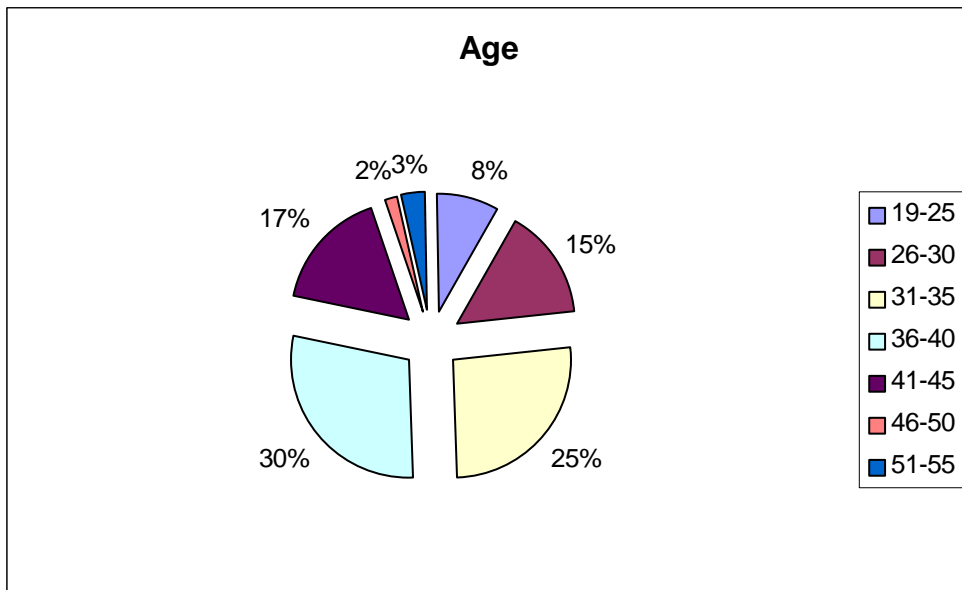
Of 59 clients, 45 (76%) are male and 14 (24%) are female.

Figure 2: Ethnicity



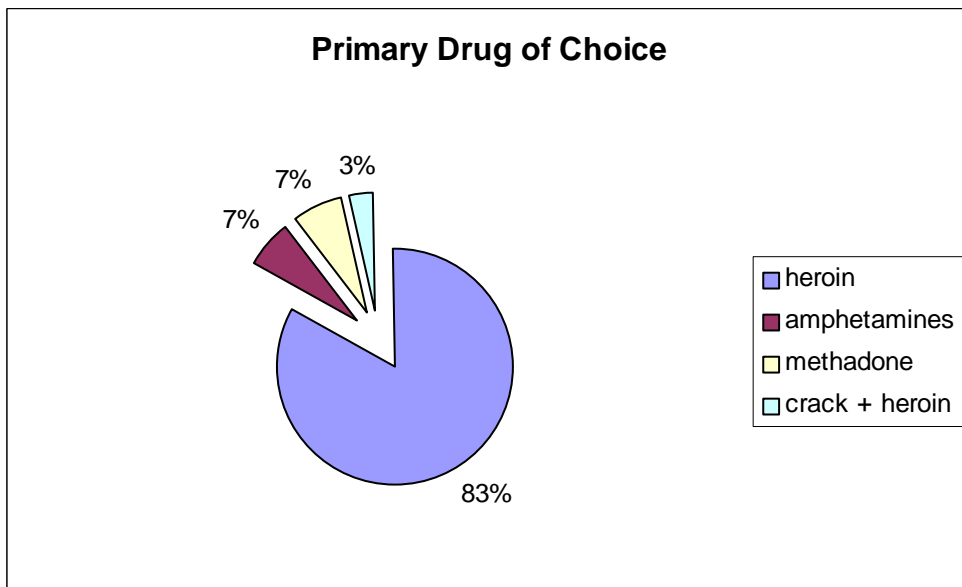
Of 59 clients, 56 (95%) are White British, 2 (3%) are Pakistani and 1 (2%) client is White Irish

Figure 3: Age



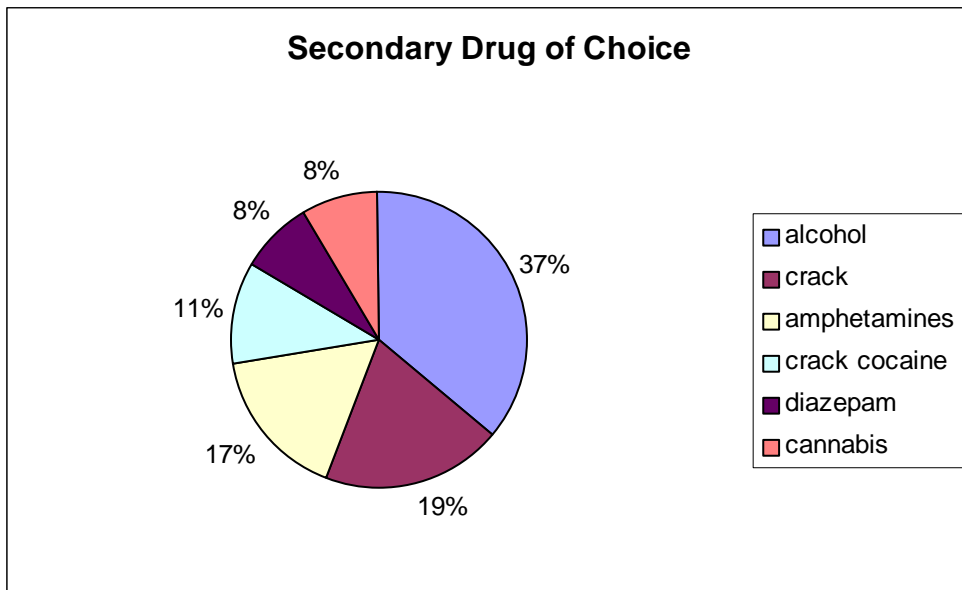
Of 59 clients, 5(8%) are 19-25; 9(15%) are 26-30; 15(25%) are 31-35; 17(30%) are 36-40; 10(17%) are 41-45; 1(2%) are 46-50 and 2 clients (3%) are aged 51-55 years.

Figure 4: Primary Drug of Choice



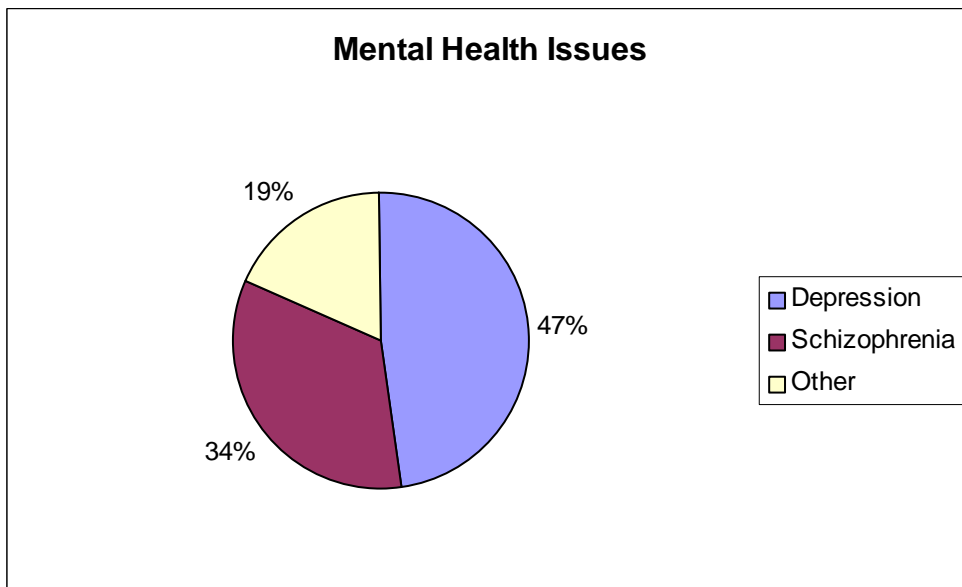
Of 59 clients, 49 (83%) use heroin as their primary drug of choice; 4 clients (7%) use amphetamines; 4 (7%) use methadone and 2 clients (3%) use crack and heroin

Table 5: Secondary Drug of Choice



Of 59 clients, 13 (37%) use alcohol as a secondary drug of choice; 7 (19%) use crack; 6 (17%) use amphetamines; 4 (11%) use crack cocaine; 3 (8%) use diazepam and 3 (8%) use cannabis

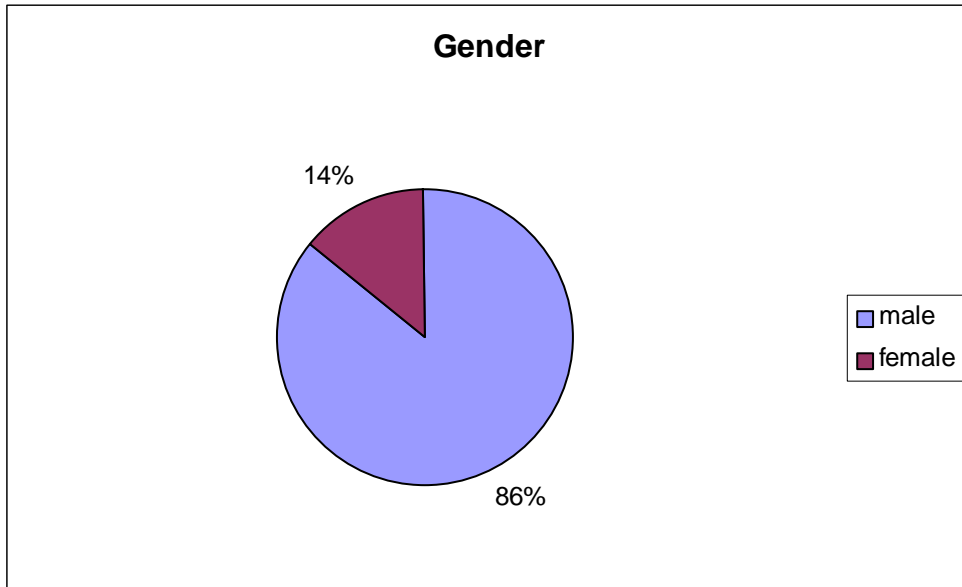
Figure 6: Mental Health Issues



Of 59 clients, 28 (47%) experience depression; 20 (34%) experience schizophrenia and 11 (19%) experience other mental health issues.

Seven clients presenting with alcohol issues, within the catchment area are considered to have dual diagnosis issues

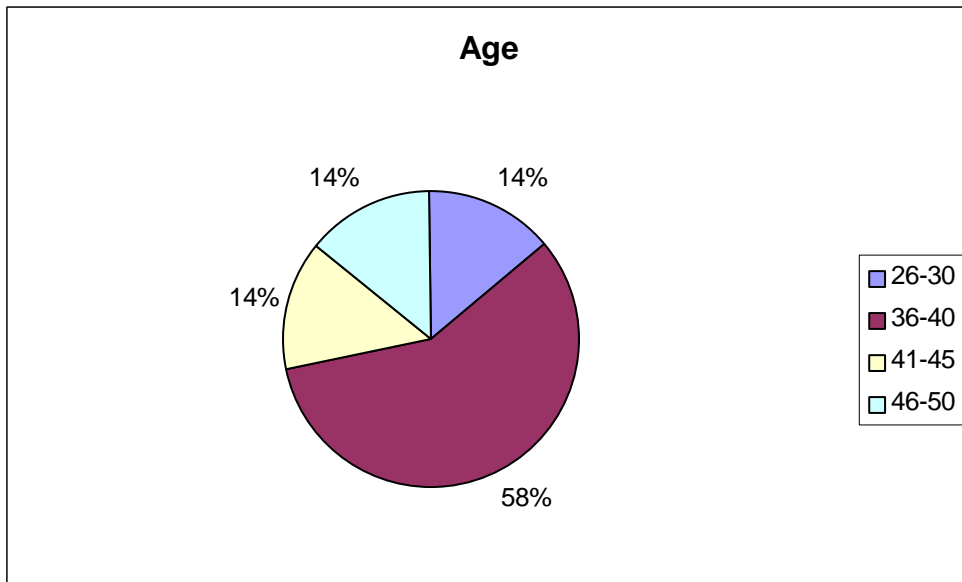
Figure 1 Gender



Of 7 clients, 6 (86%) are male and 1(14%) is female

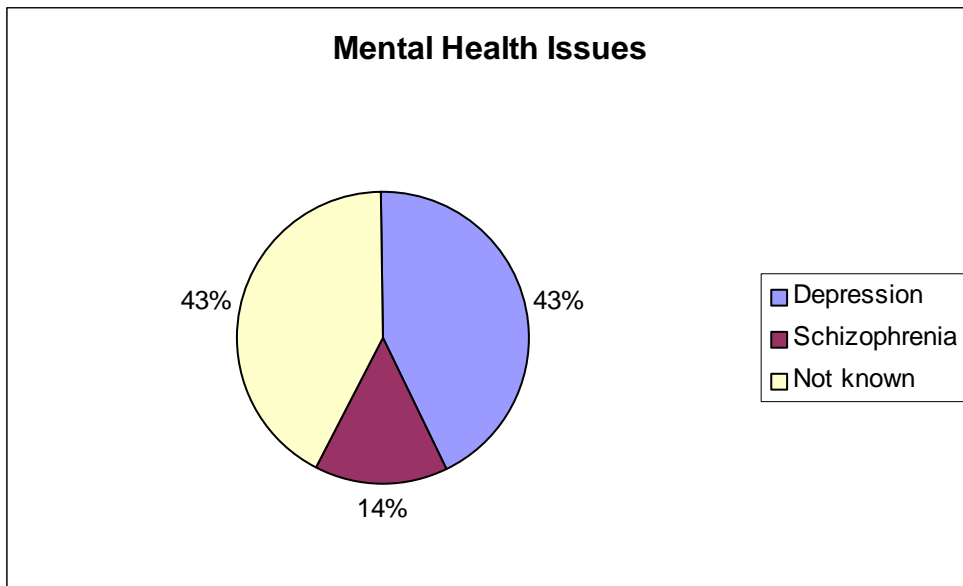
All 7 clients ethnicity is recorded as White British

Figure 2: Age



Of 7 clients, 1(14%) is aged 26-30; 4(58%) are 36-40; 1(14%) is aged 41-45 and 1(14%) client is 46-50.

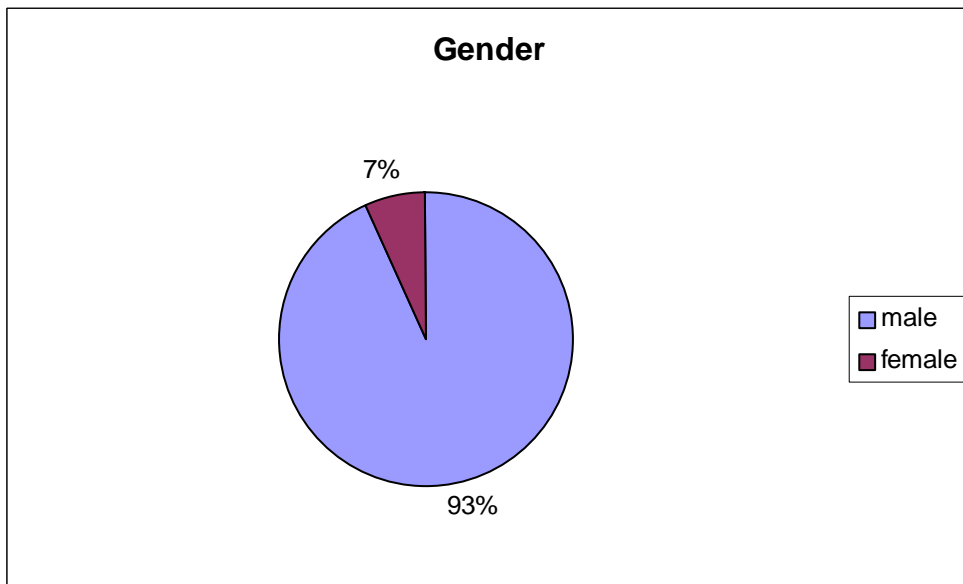
Figure 3: Mental Health Issues



Of 7 clients, 3(43%) experience depression; 1(14%) experience schizophrenia and 3(43%) clients mental health issues are not known

Fifteen clients known to the Drug Intervention Programme are considered to have dual diagnosis issues.

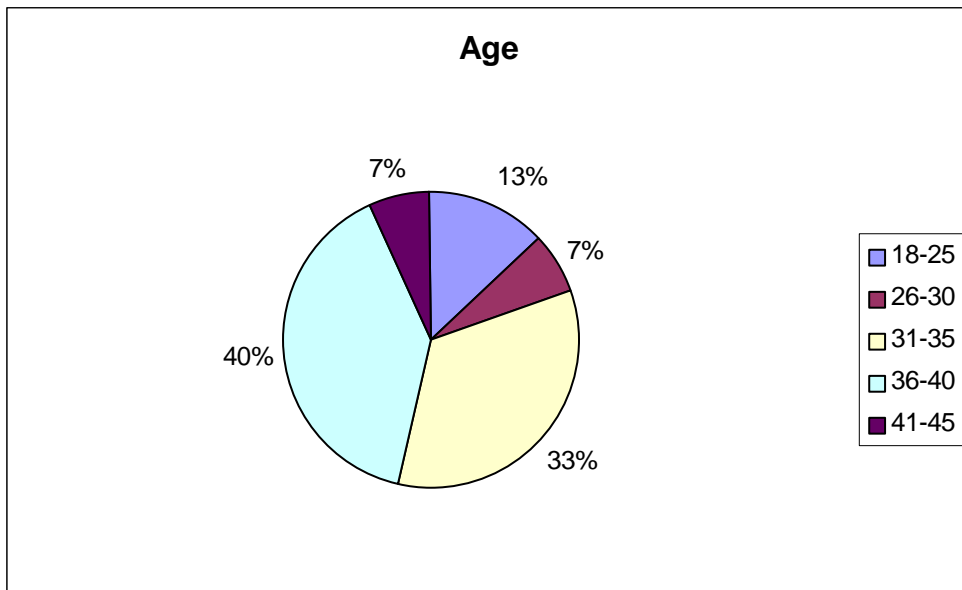
Figure 1: Gender



Of 15 clients, 14(93%) are male and 1(7%) is female

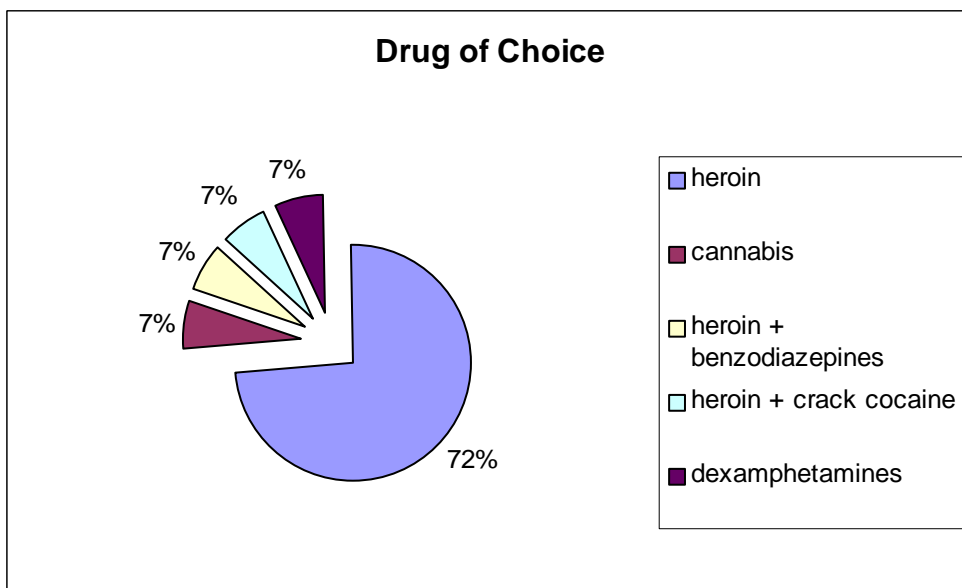
All fifteen clients ethnicity is recorded as White British

Figure 2: Age



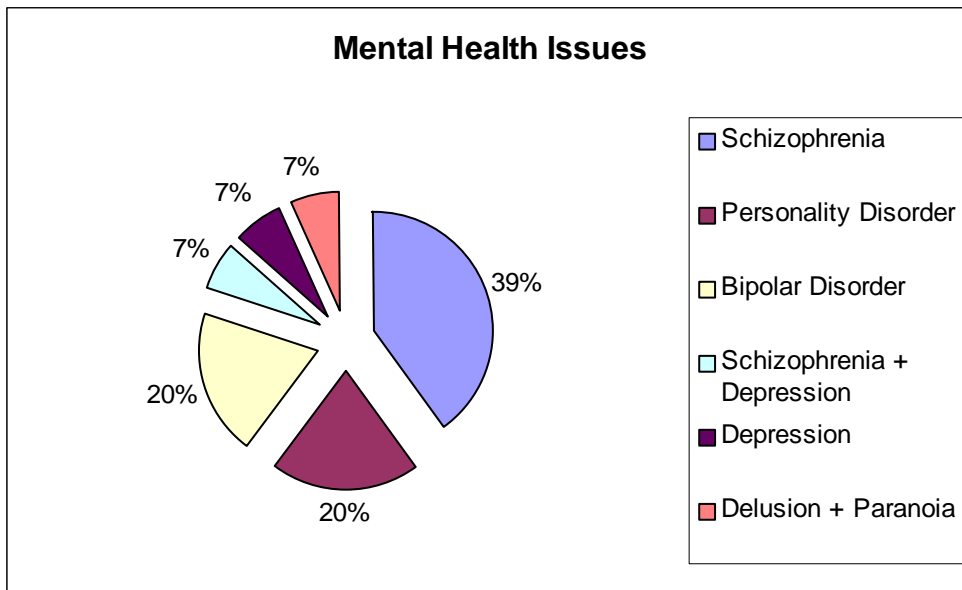
Of 15 clients, 2(13%) are aged 18-25; 1(7%) is 26-30; 5(33%) are 31-35; 6(40%) are 36-40 and 1 (7%) is 41-45

Figure 3: Drug of Choice



Of 15 clients, 11(72%) use heroin; 1(7%) uses cannabis; 1(7%) uses heroin and benzodiazepines and 1(7%) uses heroin and crack cocaine and 1(7%) uses dexamphetamines

Figure 4: Mental Health Issues

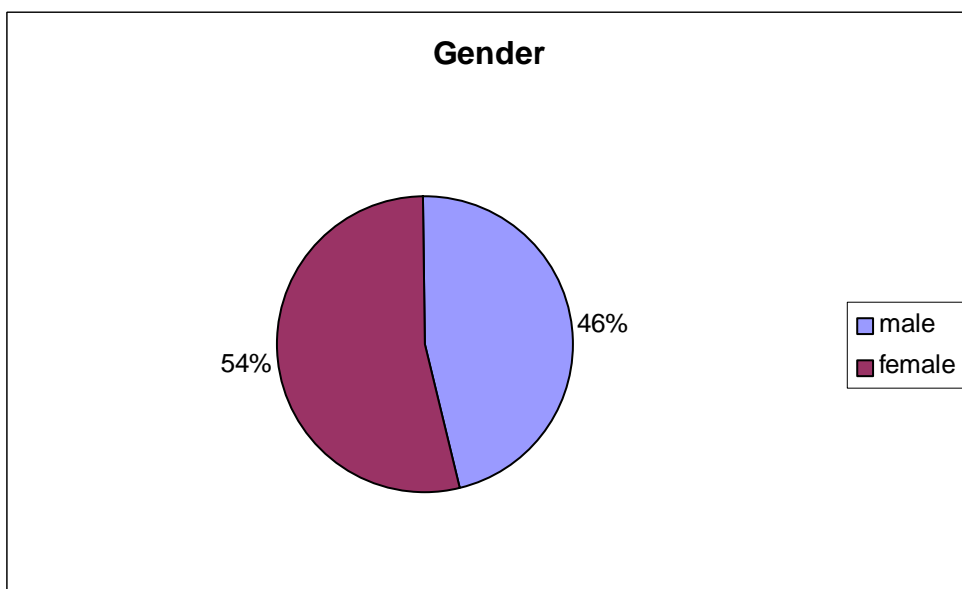


Of 15 clients, 6(39%) experience schizophrenia; 3(20%) experience personality disorder; 3(20%) experience bipolar disorder; 1(7%) experiences schizophrenia and depression; 1(7%) experiences depression and 1 client (7%) experiences delusion and paranoia.

Data from Blackpool Drug and Alcohol Action Team catchment area is presented below:

A total of 13 clients presenting with substance misuse issues are considered to have dual diagnosis issues

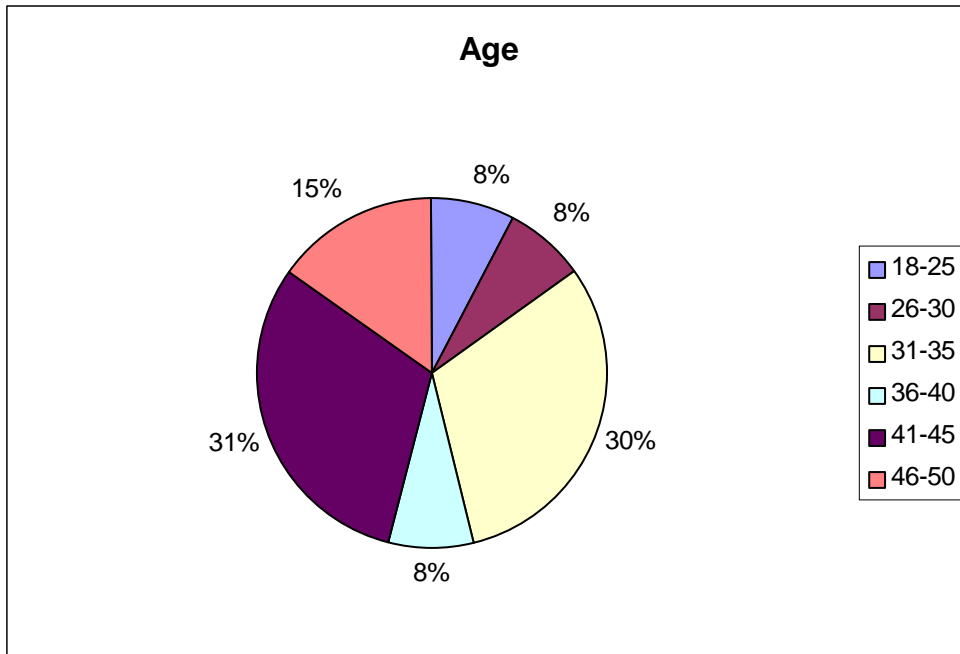
Figure 1: Gender



Of 13 clients, 6(46%) are male and 7(54%) are female

All 13 clients ethnicity is recorded as White British

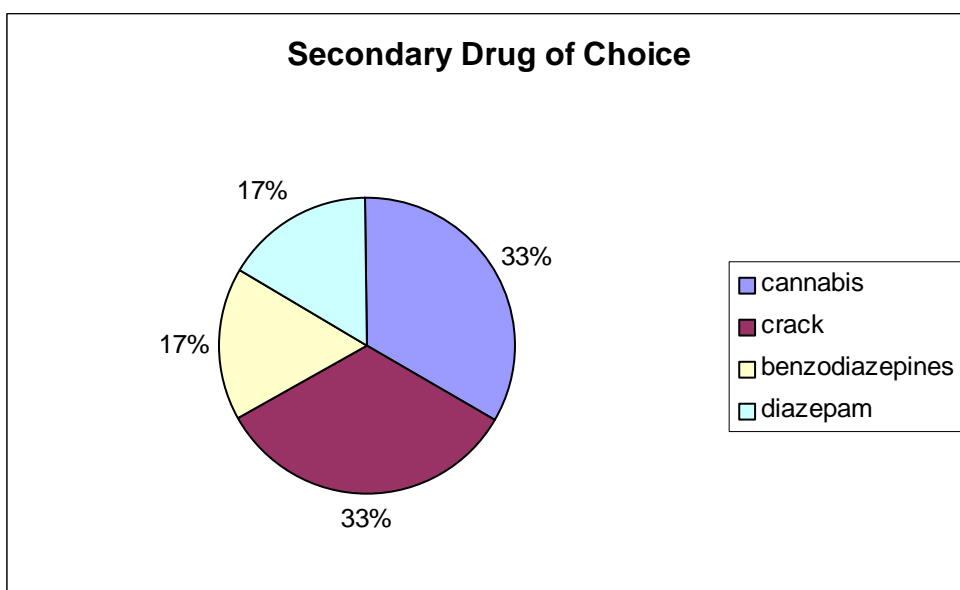
Figure 2: Age



Of 13 clients, 1(8%) is aged 18-25; 1(8%) is 26-30; 4(30%) are 31-35; 1(8%) is 36-40; 4(31%) are 41-45 and 2(15%) are 46-50

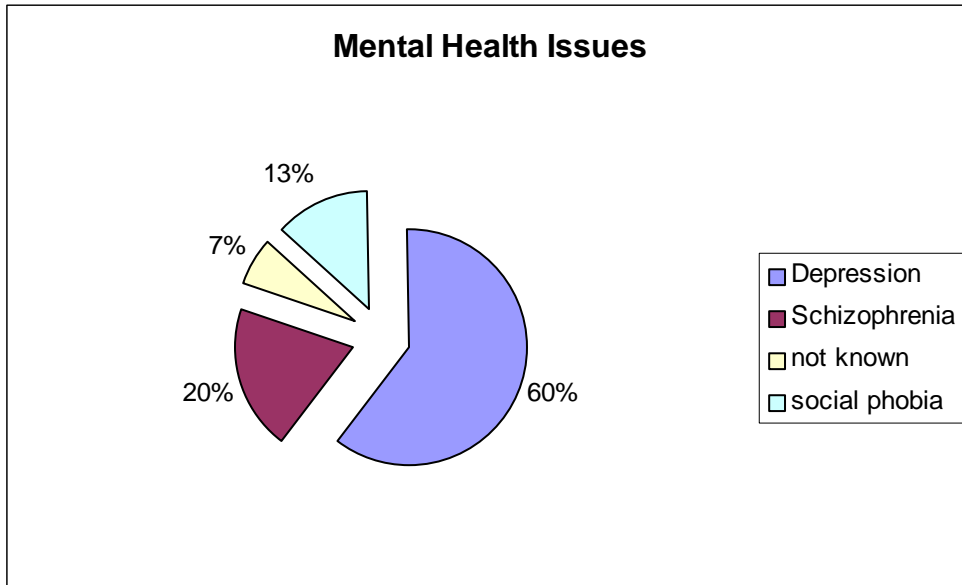
All 13 clients primary drug of choice is heroin

Figure 3: Secondary Drug of Choice



Of 13 clients, 2(33%) use cannabis; 2(33%) use crack; 1(17%) uses benzodiazepines and 1(17%) uses diazepam

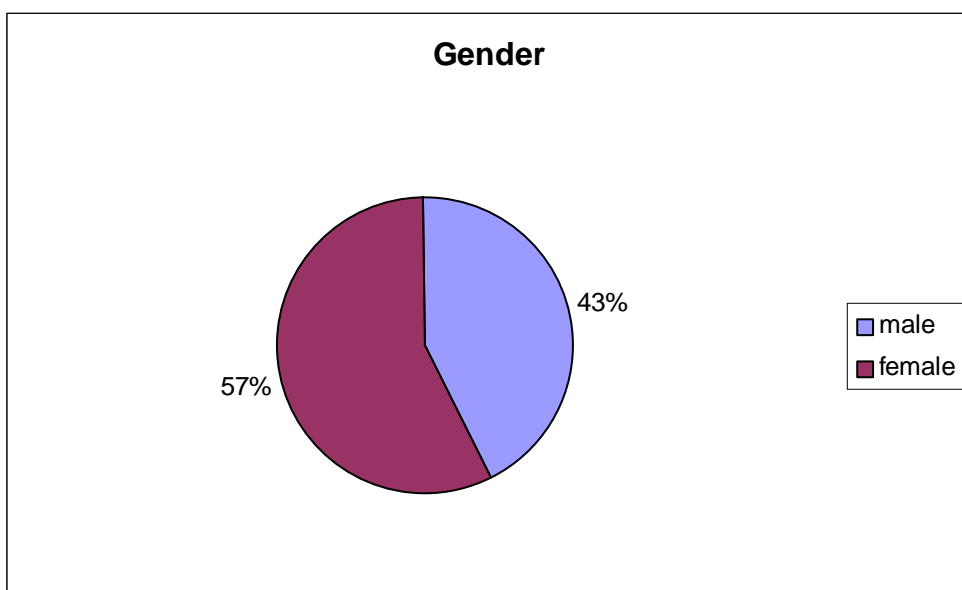
Figure 4: Mental Health Issues



Of 13 clients, 9(60%) experience depression; 3(20%) experience schizophrenia; 1 client's mental health issue is not known and 2(13%) experience social phobia

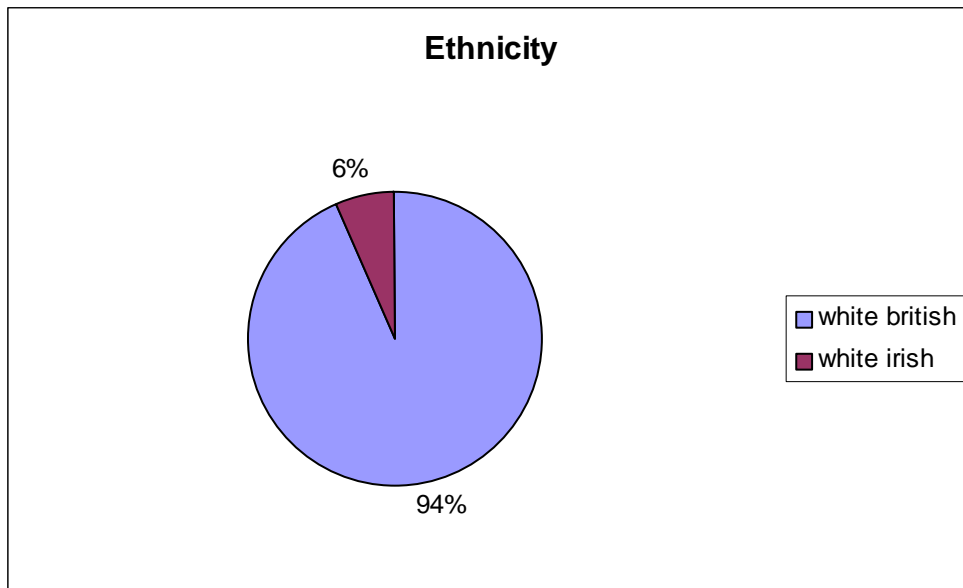
A total of forty seven clients presenting to the community alcohol service are considered to have dual diagnosis issues. The data is presented below:

Figure 1: Gender



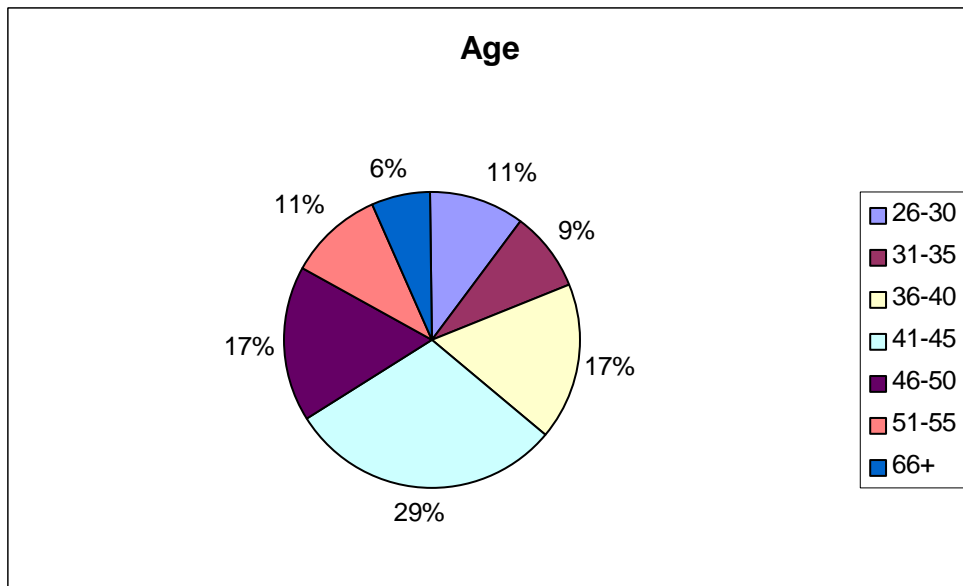
Of 47 clients, 20 (43%) are male and 27 (57%) are female

Figure 2: Ethnicity



Of 47 clients, 44(94%) are White British and 3(6%) are White Irish

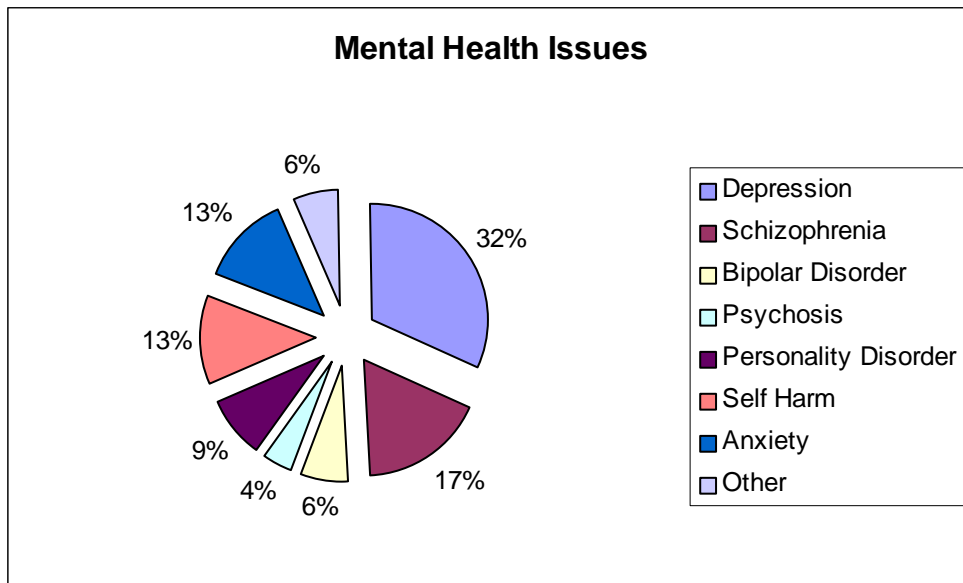
Figure 3: Age



Of 47 clients, 5(11%) are aged 26-30; 4(9%) are 31-35; 8(17%) are 36-40; 14(29%) are 41-45; 8(17%) are 46-50; 5(11%) are 51-55 and 3(6%) are 66+

The primary drug of choice of all clients is alcohol

Figure 4: Mental Health Issues

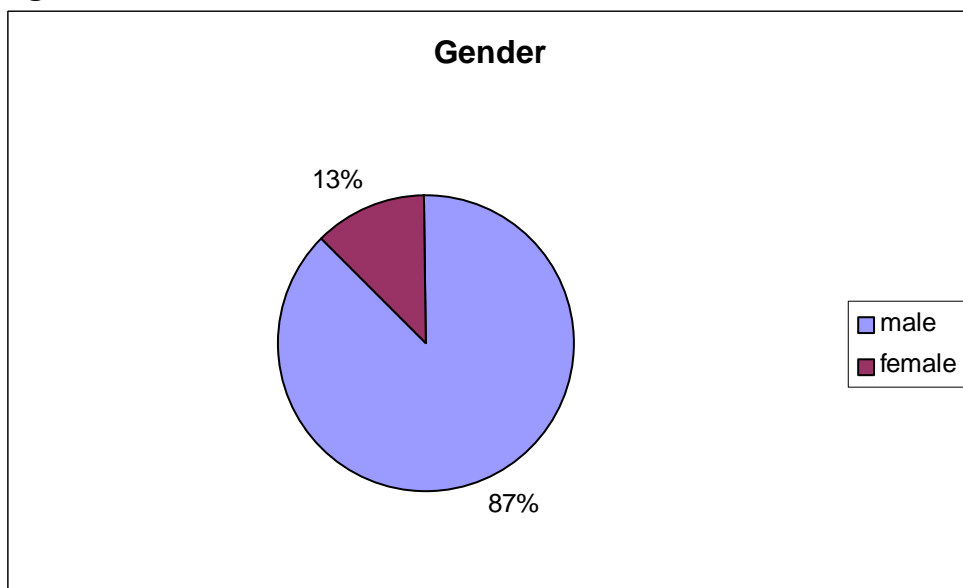


Of 47 clients, 15(32%) experience depression; 8(17%) experience schizophrenia; 3(6%) experience bipolar disorder; 2(4%) experience psychosis; 4(9%) experience personality disorder; 6(13%) experience self harm; 6(13%) experience anxiety and 3(6%) experience other mental health issues

Data from Lancashire Drug and Alcohol Action Team catchment area is presented below:

A total of 24 clients presenting with substance misuse in the Hyndburn and Ribble Valley area are considered to have dual diagnosis issues

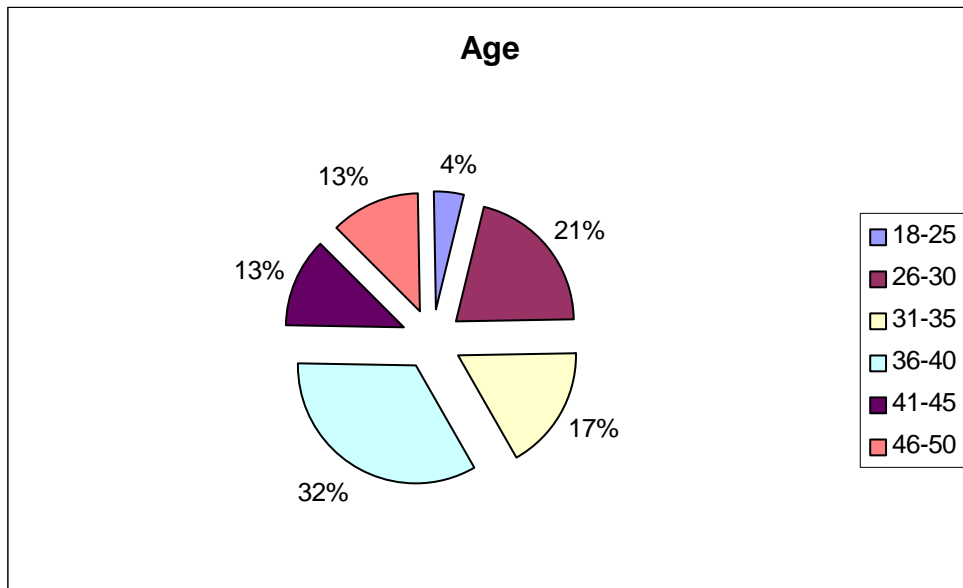
Figure 1: Gender



Of 24 clients, 21(87%) are male and 3(13%) are female

All 24 clients ethnicity is recorded as White British

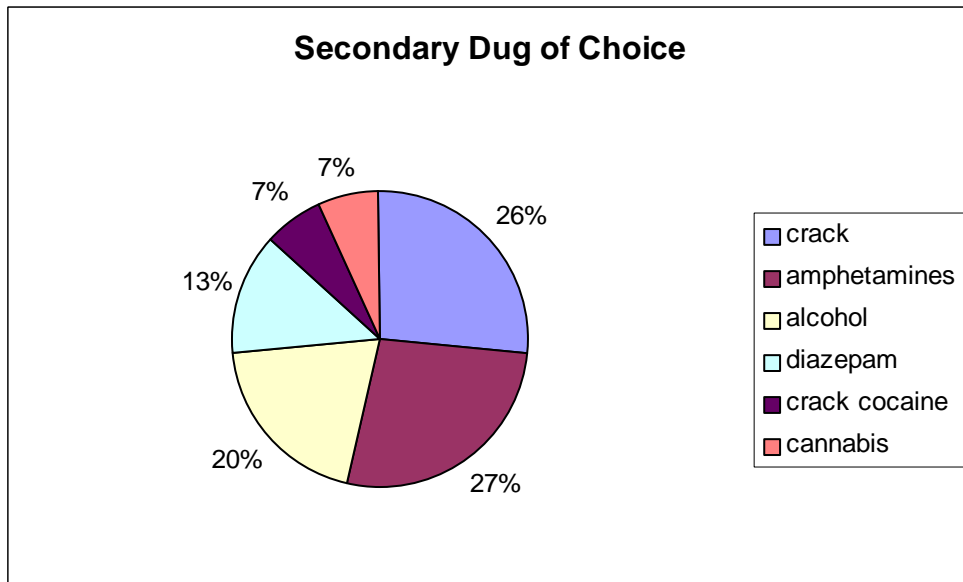
Figure 2: Age



Of 24 clients, 1(4%) is aged 18-25; 5(21%) are 26-30; 4(17%) are 31-35; 8(32%) are 36-40; 3(13%) are 41-45 and 3(13%) clients are aged 46-50 years

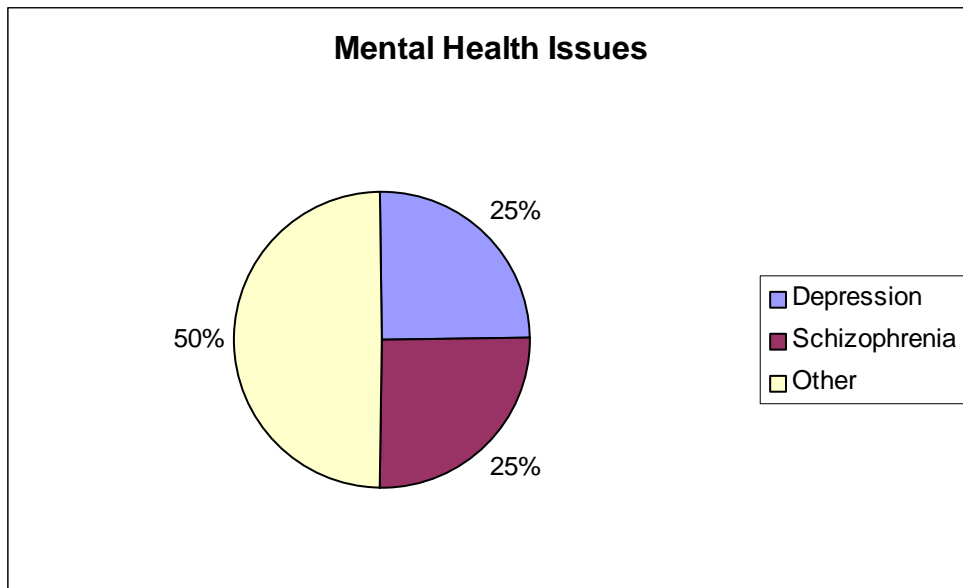
All 24 clients primary drug of choice is heroin

Figure 3: Secondary Drug of Choice



Of 24 clients, 4(26%) use crack; 4(27%) use amphetamines; 3(20%) use alcohol; 2(13%) use diazepam; 1(7%) uses crack cocaine and 1(7%) client uses cannabis

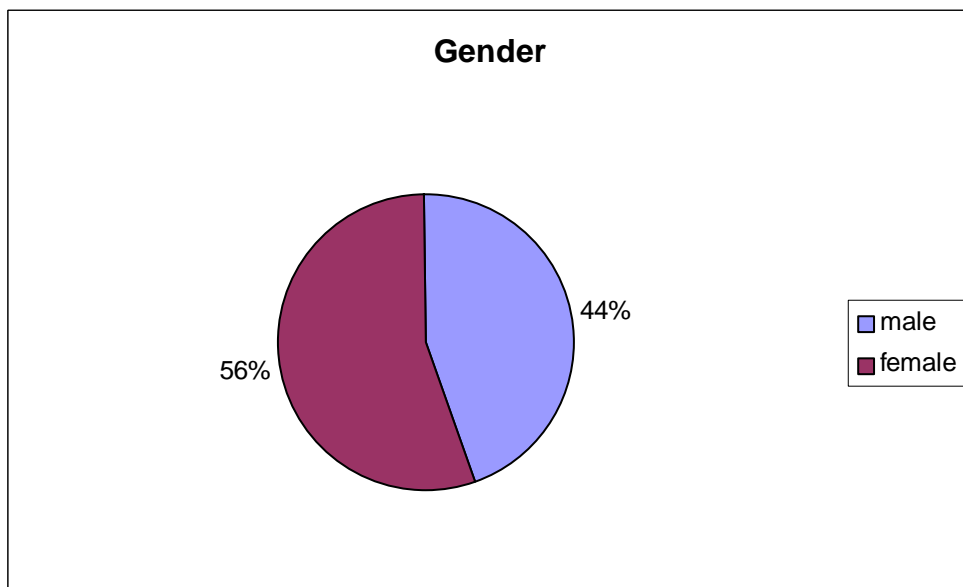
Figure 4: Mental Health Issues



Of 24 clients, 6(25%) experience depression; 6(25%) experience schizophrenia and 12 clients (50%) experience other mental health issues

A total of 9 clients presenting with alcohol issues within the Hyndburn and Ribble Valley areas are considered to have dual diagnosis issues

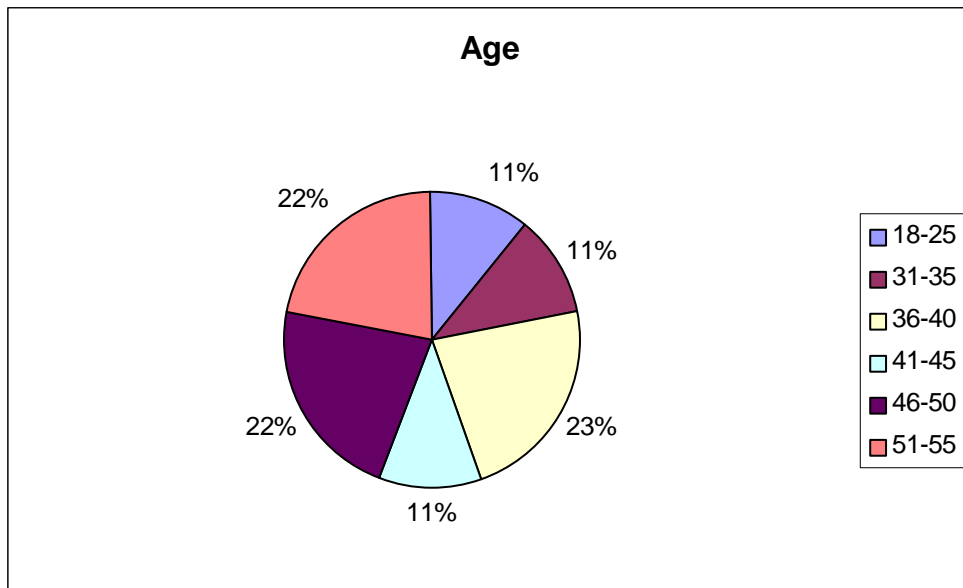
Figure 1: Gender



Of 9 clients, 4(44%) are male and 5(56%) are female

All 9 clients ethnicity is recorded as White British

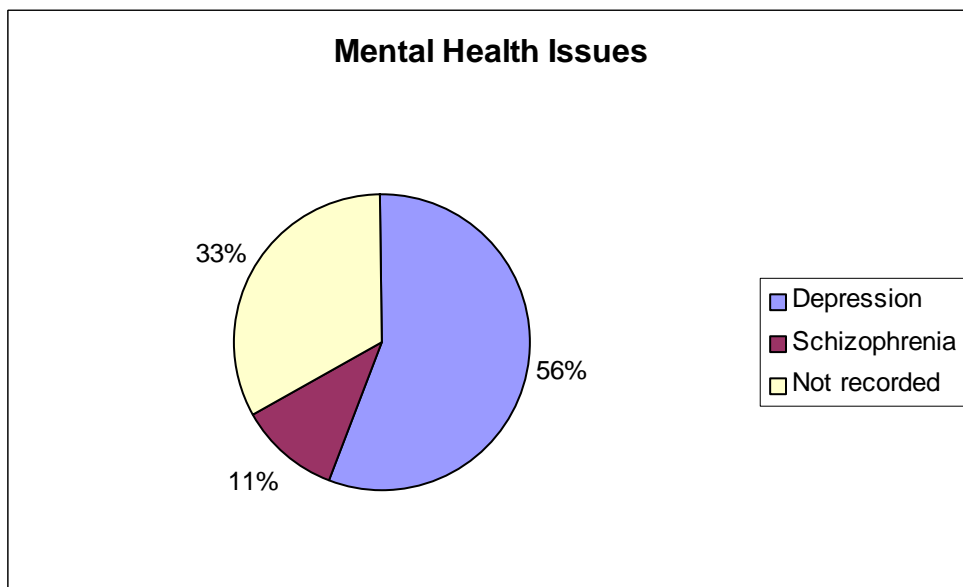
Figure 2: Age



Of 9 clients, 1(11%) is aged 18-25; 1(11%) is 31-35; 2(23%) are 36-40; 1(11%) are 41-45; 2(22%) are 46-50 and 2(22%) are 51-55 years

All 9 clients primary drug of choice is alcohol and secondary drug of choice is amphetamine

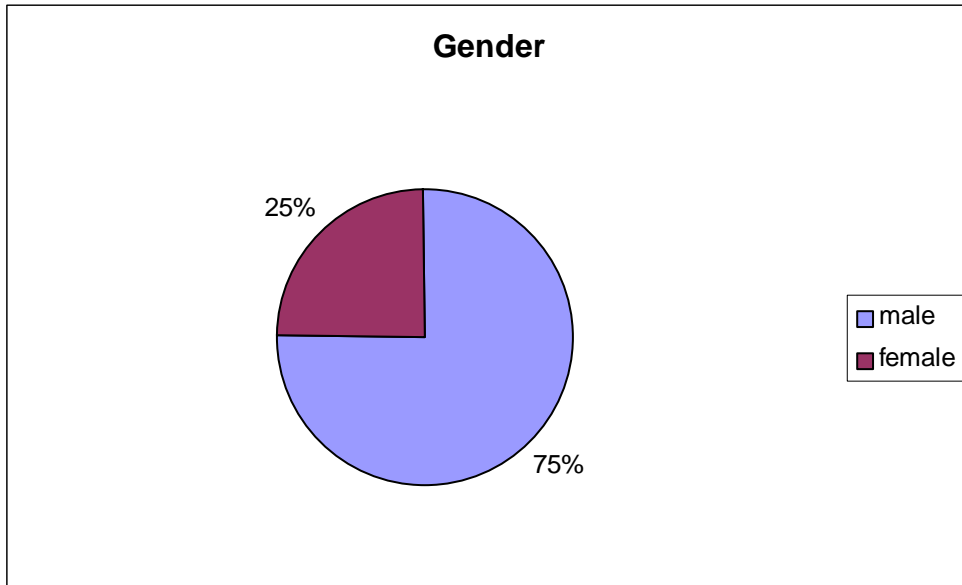
Figure 3: Mental Health Issues



Of 9 clients, 5(56%) experience depression; 1(11%) experiences schizophrenia and 3(33%) clients mental health issues are not recorded

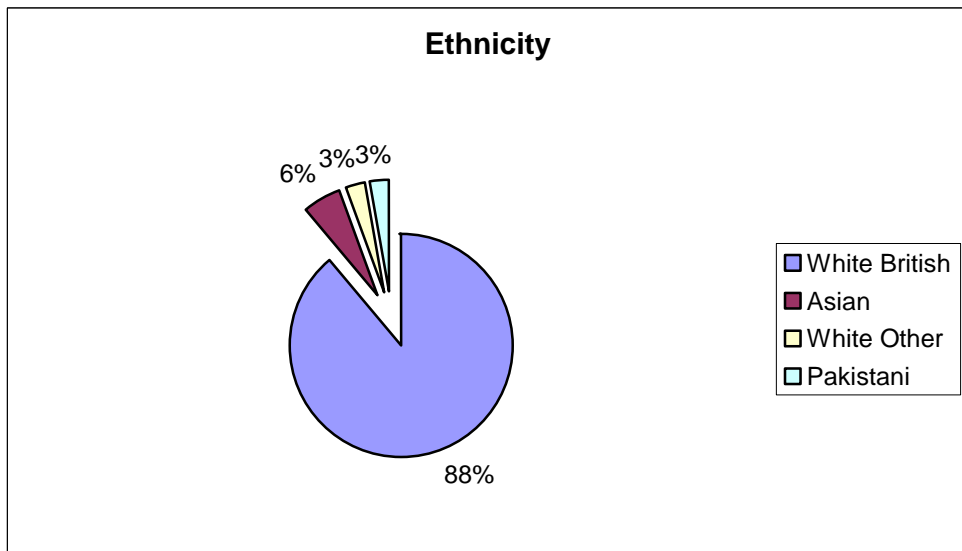
A total of 36 clients presenting at Burnley Pendle and Rossendale substance misuse service are considered to have dual diagnosis issues

Figure 1: Gender



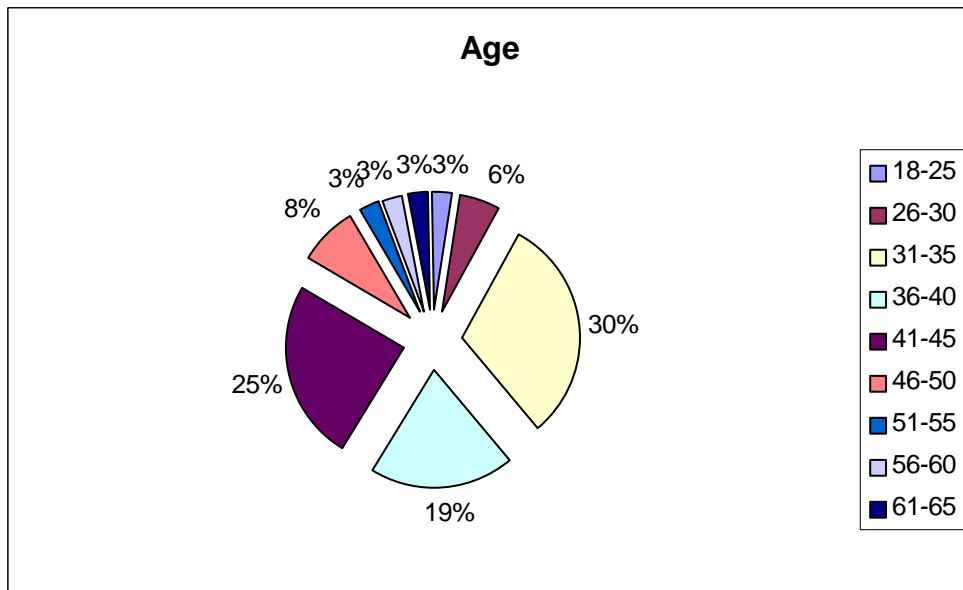
Of 36 clients, 27(75%) are male and 9(25%) are female

Figure 2: Ethnicity



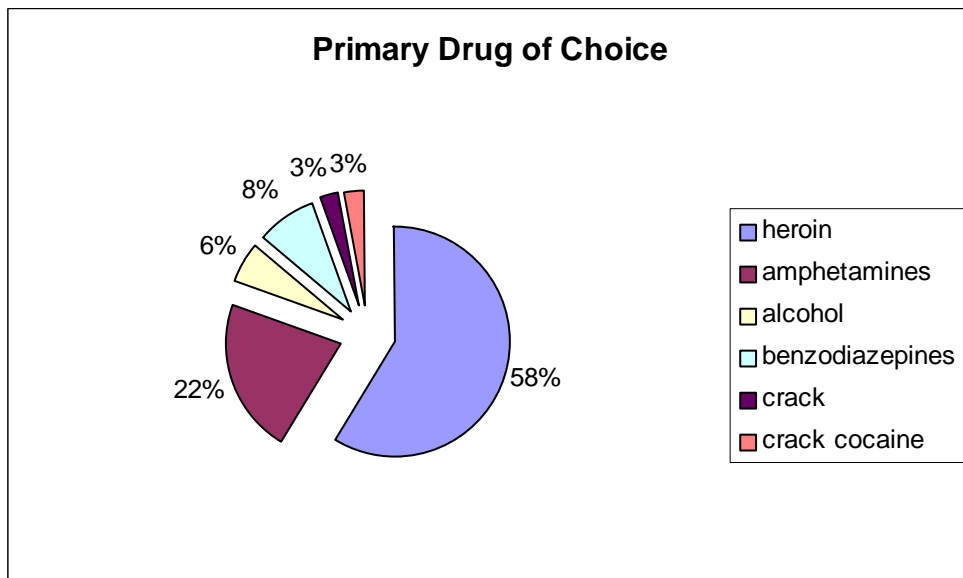
Of 36 clients, 32(88%) are White British; 2(6%) are Asian; 1(3%) is White Other and 1(3%) client is Pakistani

Figure 3: Age



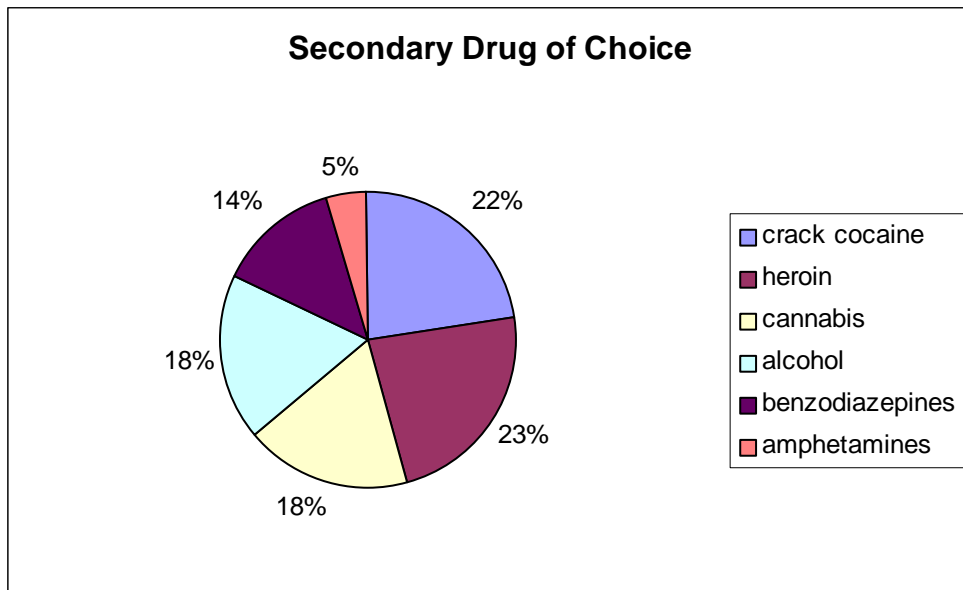
Of 36 clients, 1(3%) is aged 18-25; 2(6%) are 26-30; 11(30%) are 31-35; 7(19%) are 36-40; 9(25%) are 41-45; 3(8%) are 46-50; 1(3%) is 51-55; 1(3%) is 56-60 and 1(3%) client is 61-65 years of age

Figure 4: Primary Drug of Choice



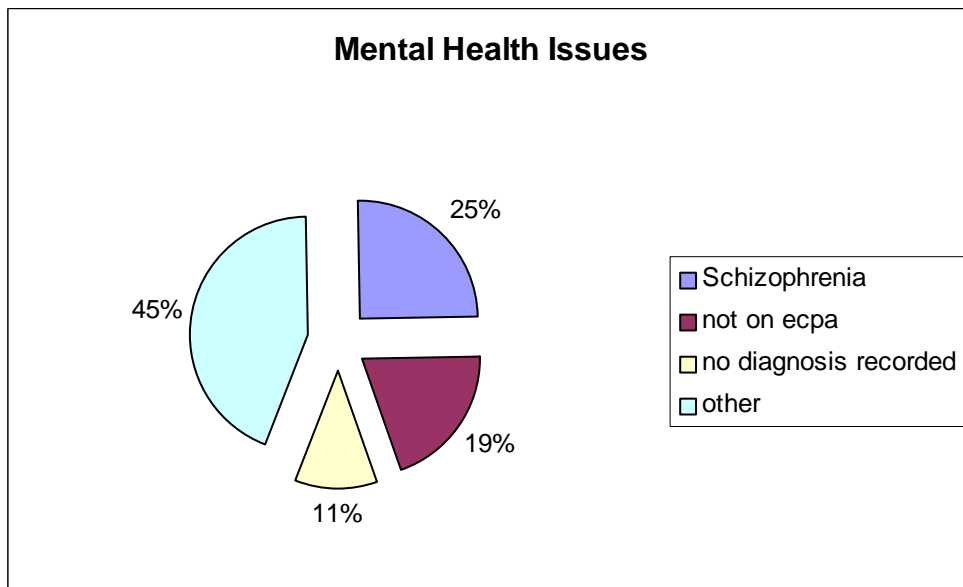
Of 36 clients, 21(58%) use heroin; 8(22%) use amphetamines; 2(6%) use alcohol; 3(8%) use benzodiazepines; 1(3%) uses crack and 1(3%) uses crack cocaine

Figure 5: Secondary Drug of Choice



Of 36 clients, 5(22%) use crack cocaine; 5(23%) use heroin; 4 (18%) use cannabis; 4(18%) use alcohol; 3(14%) use benzodiazepines and 1(5%) client uses amphetamines

Figure 6: Mental Health Issues

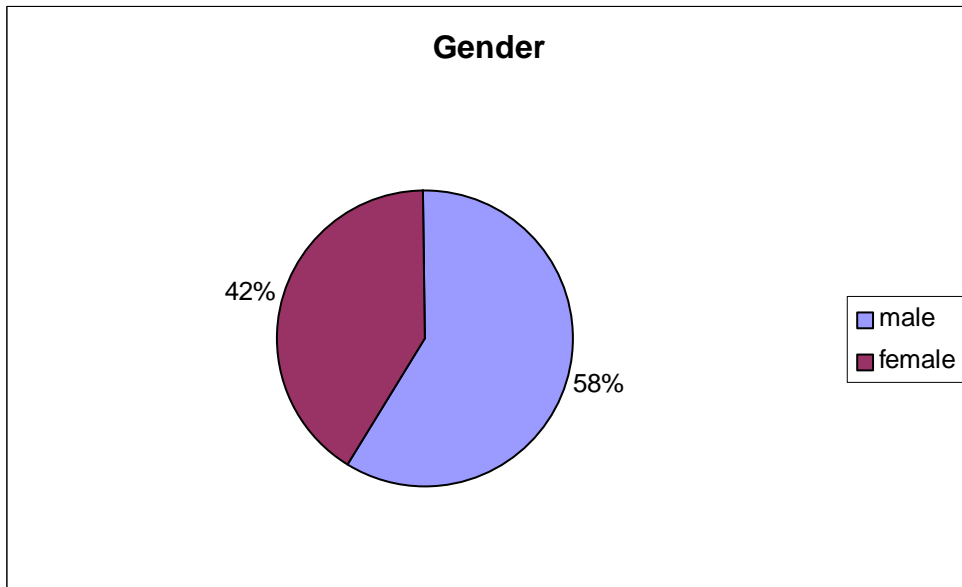


Of 36 clients, 9(25%) experience schizophrenia; 7(19%) of clients are considered to have a mental health issue, but are not on eCPA; 4(11%) of clients have no diagnosis recorded and 16(45%) of clients experience other mental health issues

Within the South Lancashire Locality, comprising Preston, Chorley and South Ribble and West Lancashire, the following dual diagnosis issues are presented.

Twelve clients presenting at the Preston service are considered to have dual diagnosis issues

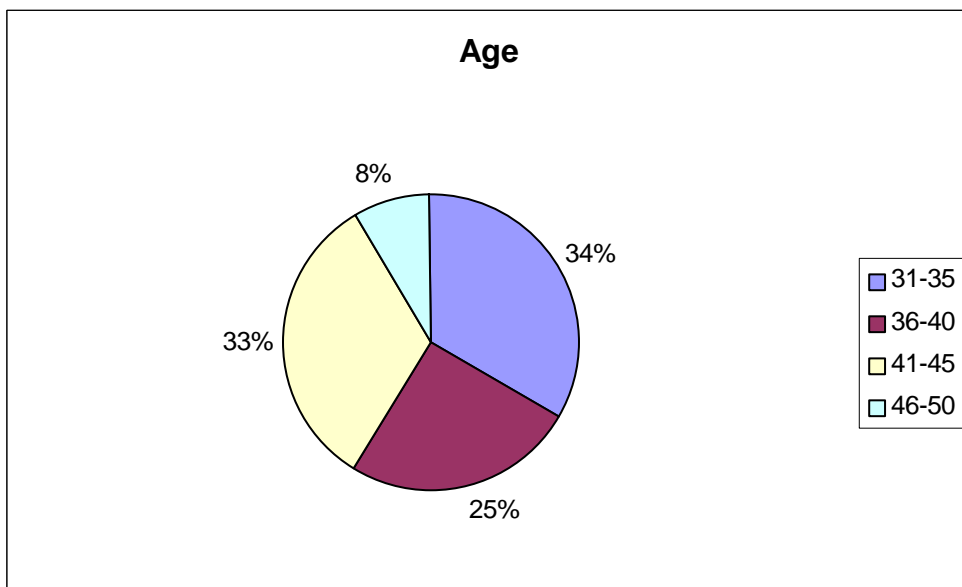
Figure 1: Gender



7(58%) are male and 5(42%) are female

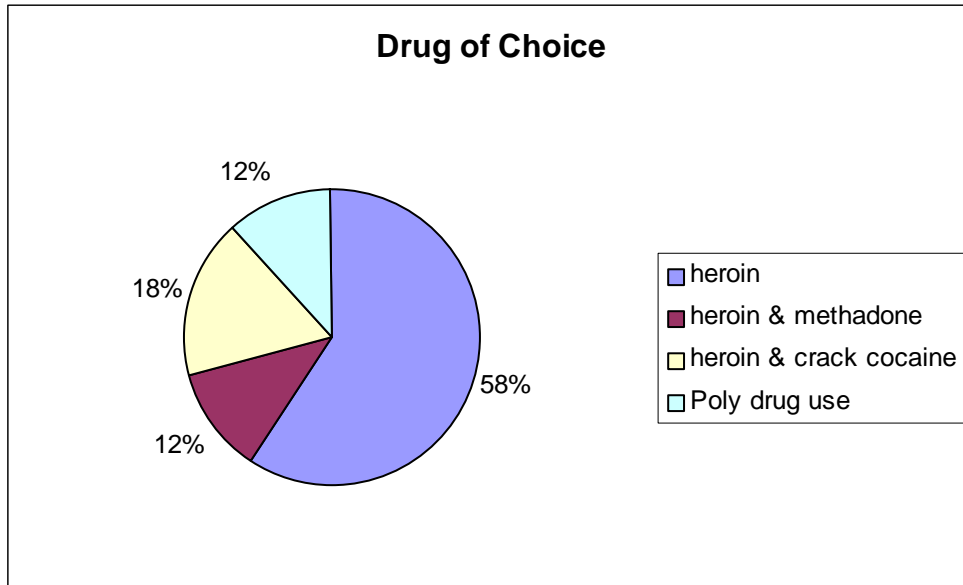
All twelve clients ethnicity is recorded as White British

Figure 3:Age



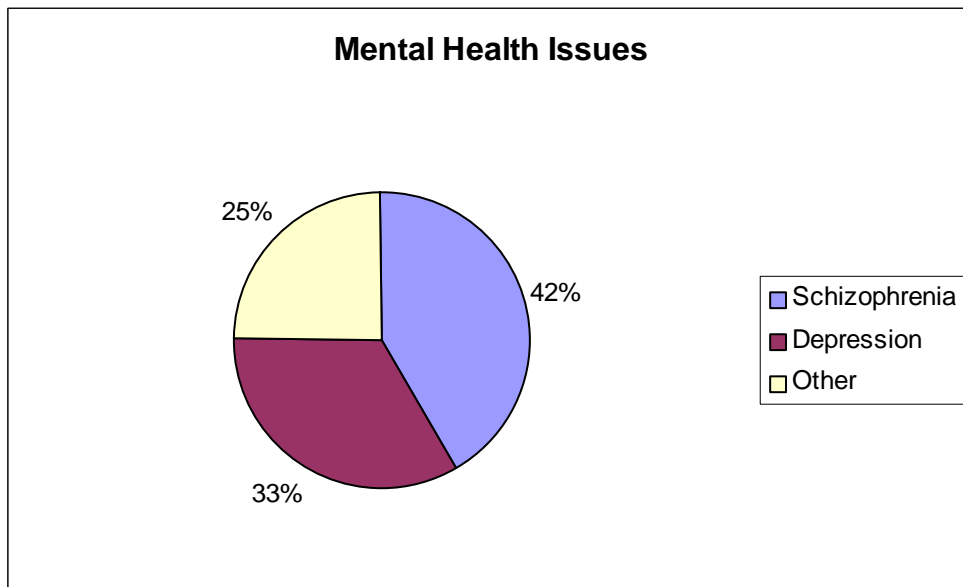
Of twelve clients, 4(34%) are aged 31-35; 3(25%) are 36-40; 4(33%) are 41-45; 1(8%) client is 46-50 years of age

Figure 4: Drug of Choice



Of twelve clients, 10(58%) use heroin; 2(12%) use heroin and methadone; 3(18%) use heroin and crack cocaine and 2(12%) clients are poly drug users

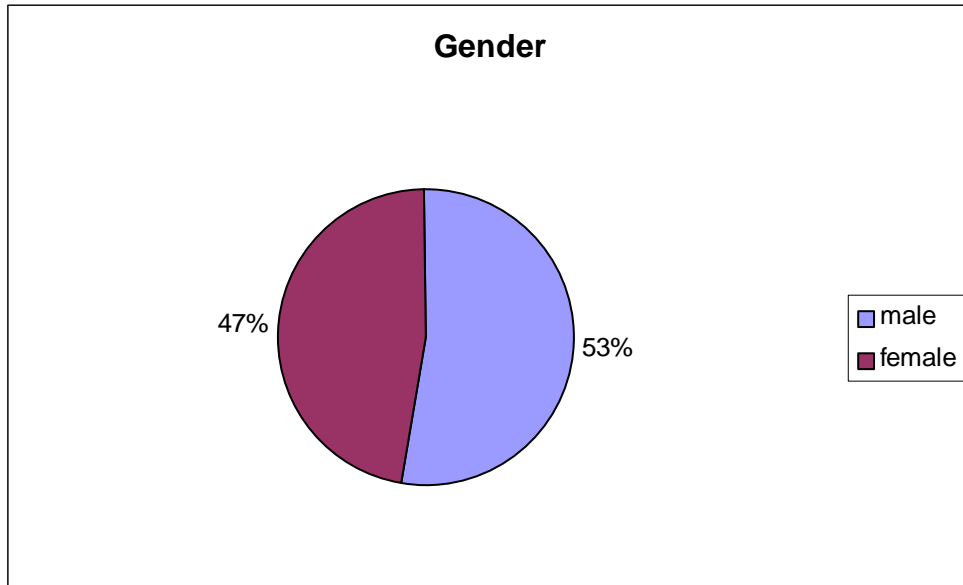
Figure 5: Mental Health Issues



Of twelve clients, 5(42%) experience schizophrenia; 4(33%) experience depression and 3(25%) experience other mental health issues

Nineteen clients presenting at the West Lancashire service are considered to have dual diagnosis issues

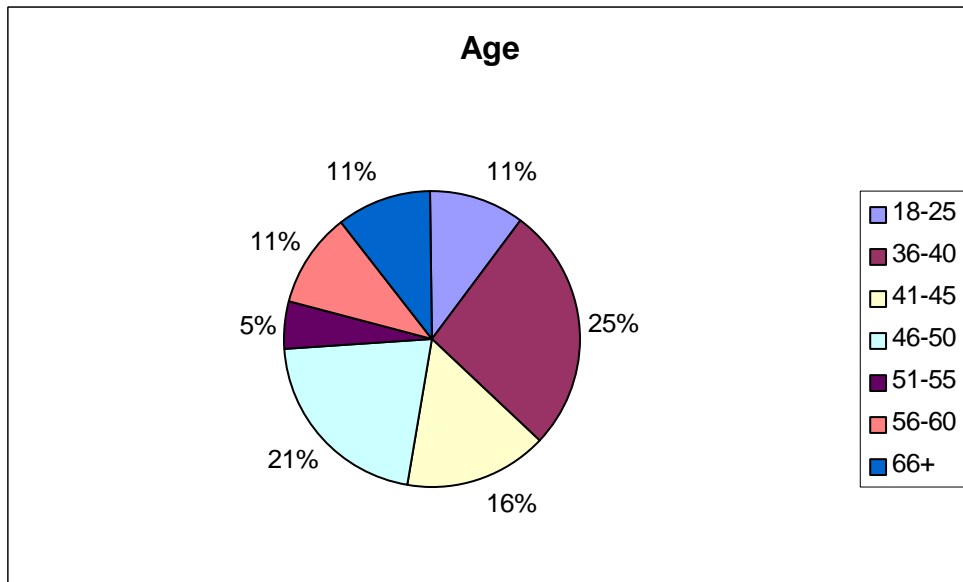
Figure 1: Gender



Of nineteen clients, 10(53%) are male and 9(47%) are female

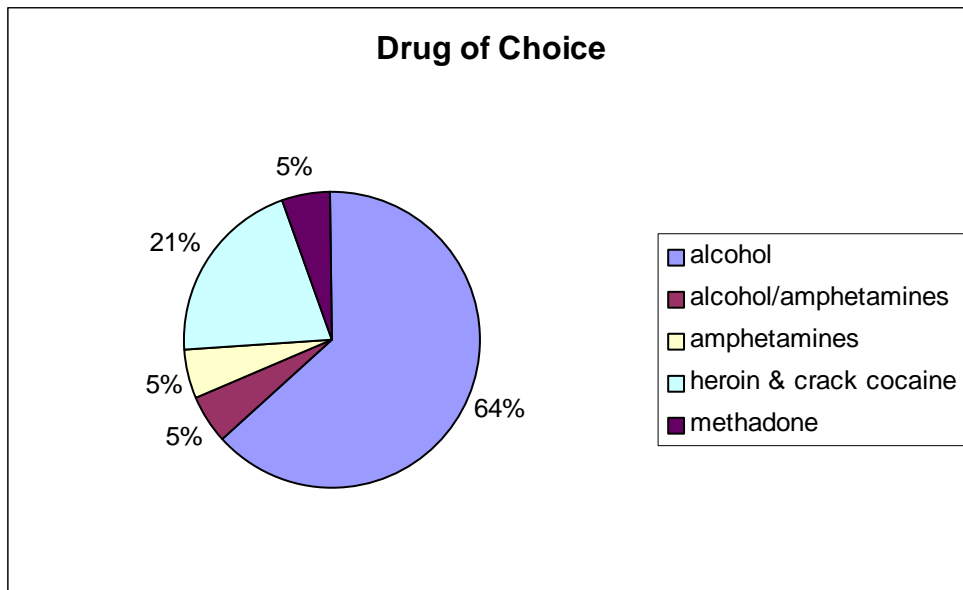
All nineteen clients ethnicity is recorded as White British

Figure 2: Age



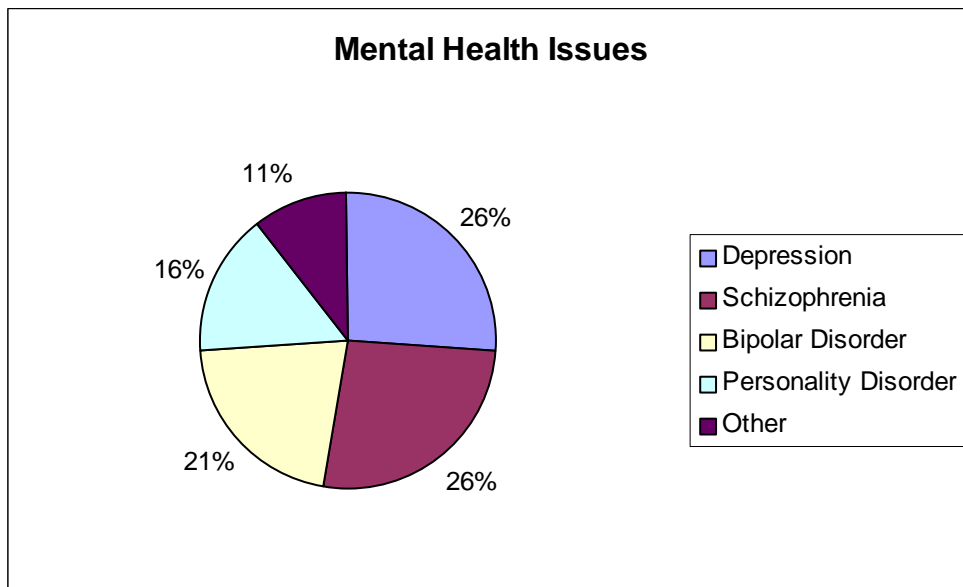
Of nineteen clients, 2(11%) are aged 18-25; 5(25%) are 36-40; 3(16%) are 41-45; 4(21%) are 46-50; 1(5%) is 51-55; 2(11%) are 56-60 and 2 clients (11%) are aged 66+

Figure 3: Drug of Choice



Of 19 clients, 12(64%) use alcohol; 1(5%) uses alcohol and amphetamines; 1(5%) uses amphetamines; 4(21%) use heroin and crack cocaine and 1(5%) uses methadone

Figure 4: Mental Health Issues

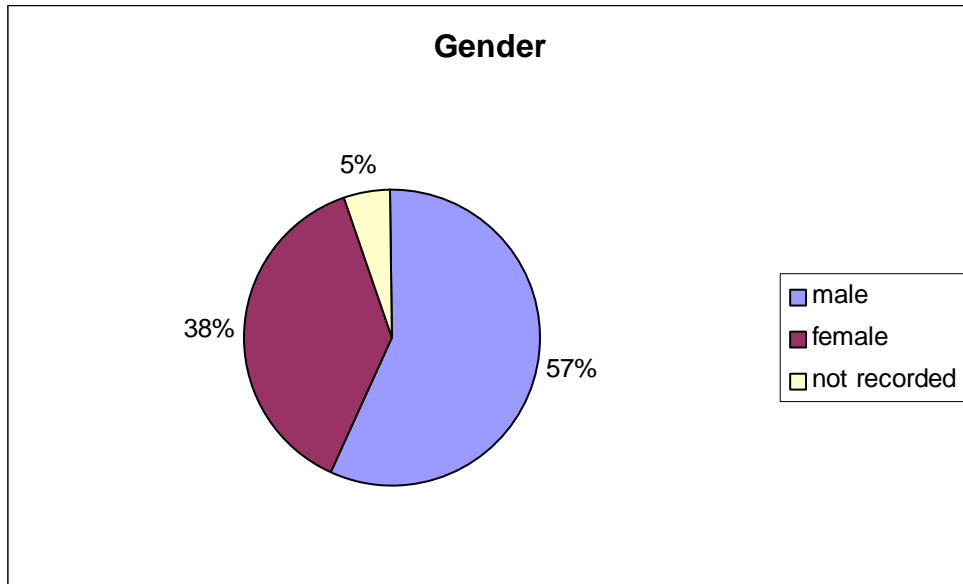


Of 19 clients, 5(26%) experience depression; 5(26%) experience schizophrenia; 4(21%) experience bipolar disorder; 3(16%) experience personality disorder and 2(11%) clients experience other mental health issues

Data from the North Locality are presented below. This comprises Wyre and Fylde and Lancaster and Morecambe areas.

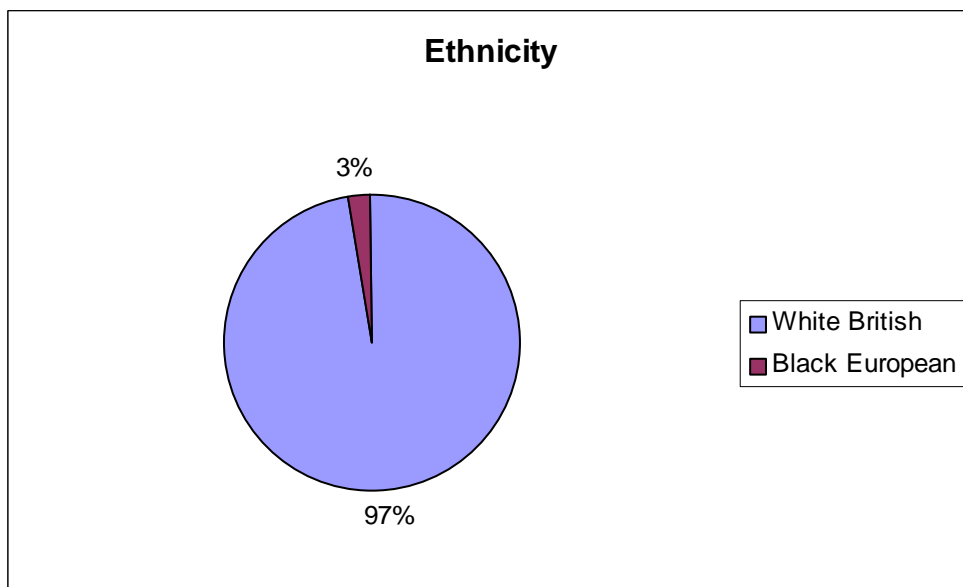
A total of 39 clients presenting to Wyre and Fylde services are considered to have dual diagnosis.

Figure 1: Gender



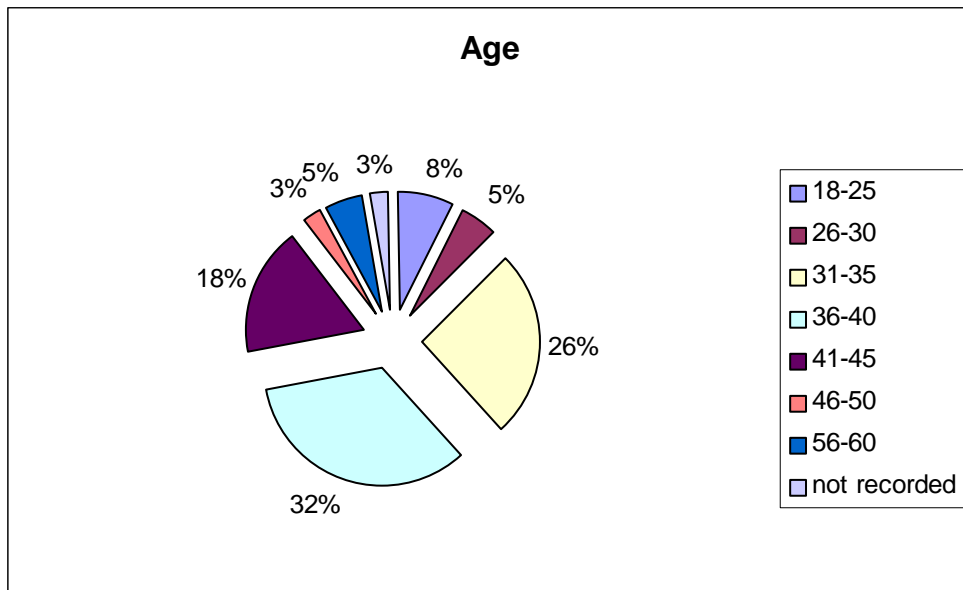
Of 39 clients, 22(57%) are male; 15(38%) are female and 2(5%) clients gender is not recorded

Figure 2: Ethnicity



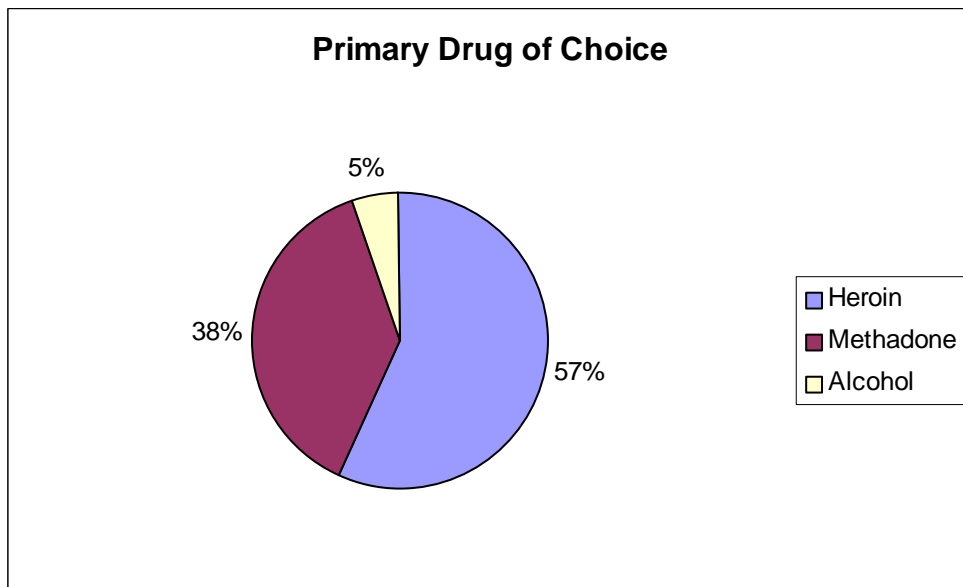
Of 39 clients, 38(97%) are White British and 1(3%) is Black European

Figure 3: Age



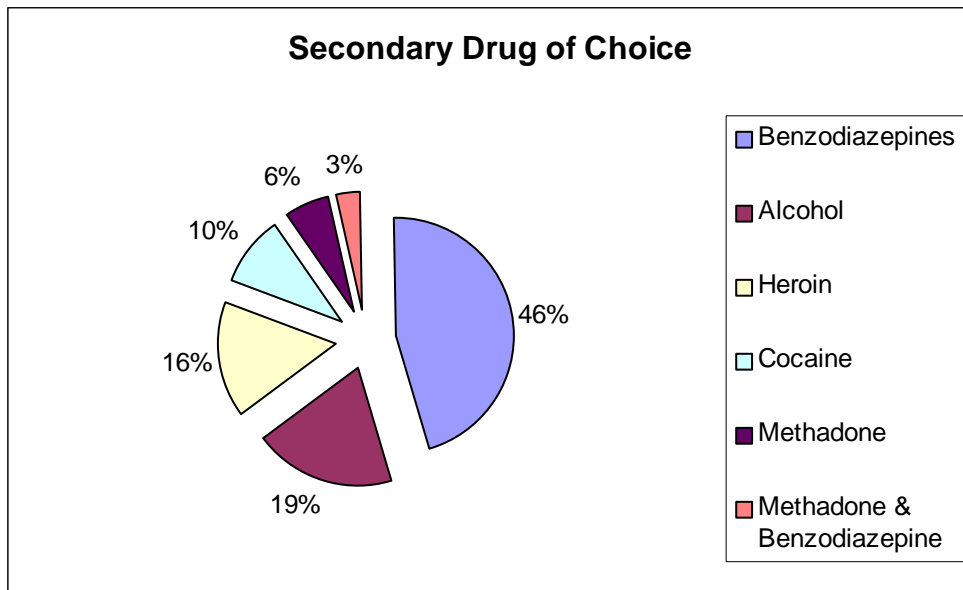
Of 39 clients, 3(8%) are aged 18-25; 2(5%) are 26-30; 10(26%) are 31-35; 13(32%) are 36-40; 7(18%) are 41-45; 1(3%) is 46-50; 2(5%) are 56-60 and 1(3%) client's age is not recorded

Figure 4: Primary Drug of Choice



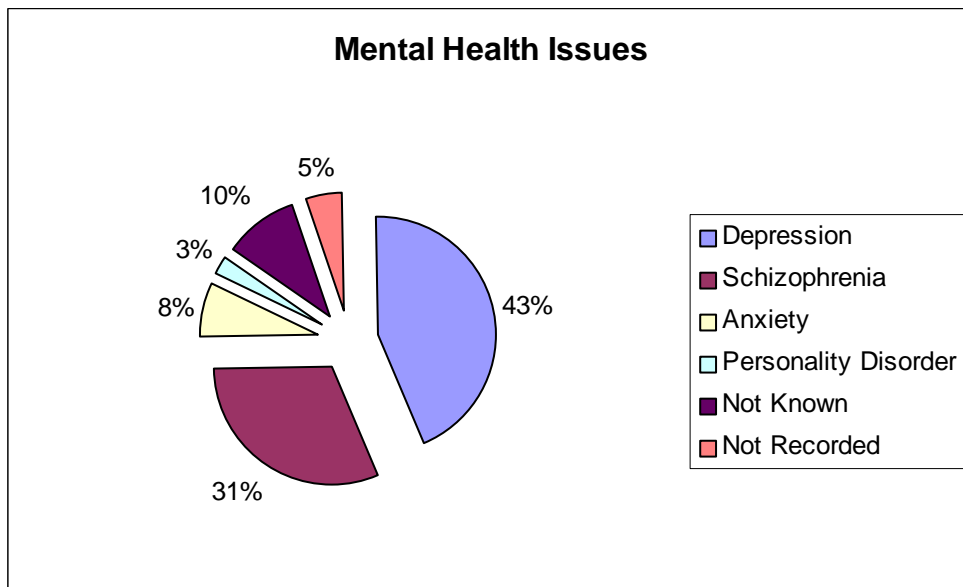
Of 39 clients, 22(57%) use heroin; 15(38%) use methadone; and 2(5%) use alcohol

Figure 5: Secondary Drug of Choice



Of 39 clients, 14(46%) use benzodiazepines; 6(19%) use alcohol; 5(16%) use heroin; 3(10%) use cocaine; 2(6%) use methadone and 1(3%) client uses methadone and benzodiazepines

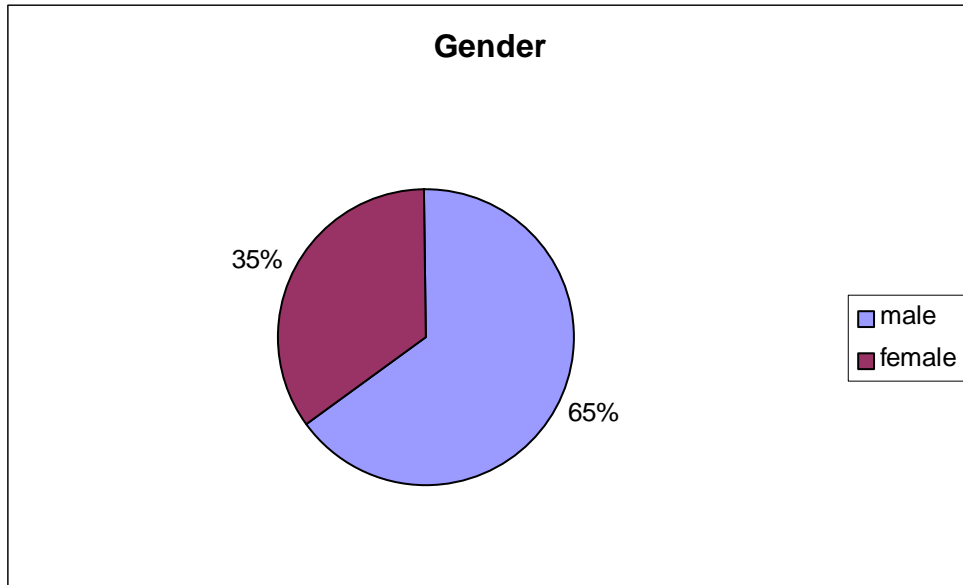
Figure 6: Mental Health Issues



Of 39 clients, 17(43%) experience depression; 12(31%) experience schizophrenia; 3(8%) experience anxiety; 1(3%) experience personality disorder; 4(10%) clients mental health issues are not known and 2(5%) clients mental health issues are not recorded

A total of 17 clients presenting to the Lancaster and Morecambe substance misuse service are considered to have dual diagnosis issues

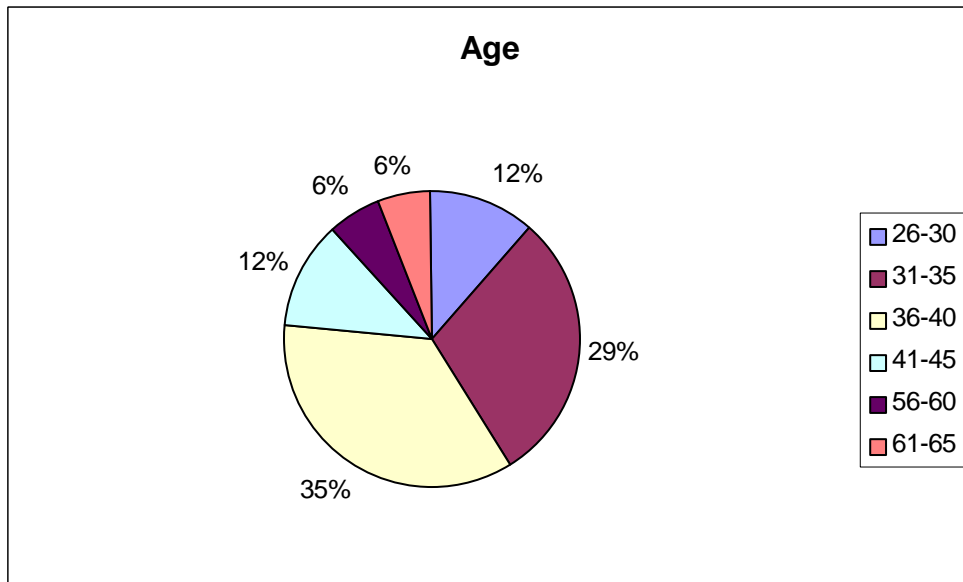
Figure 1: Gender



Of 17 clients, 11(65%) are male and 6(35%) are female

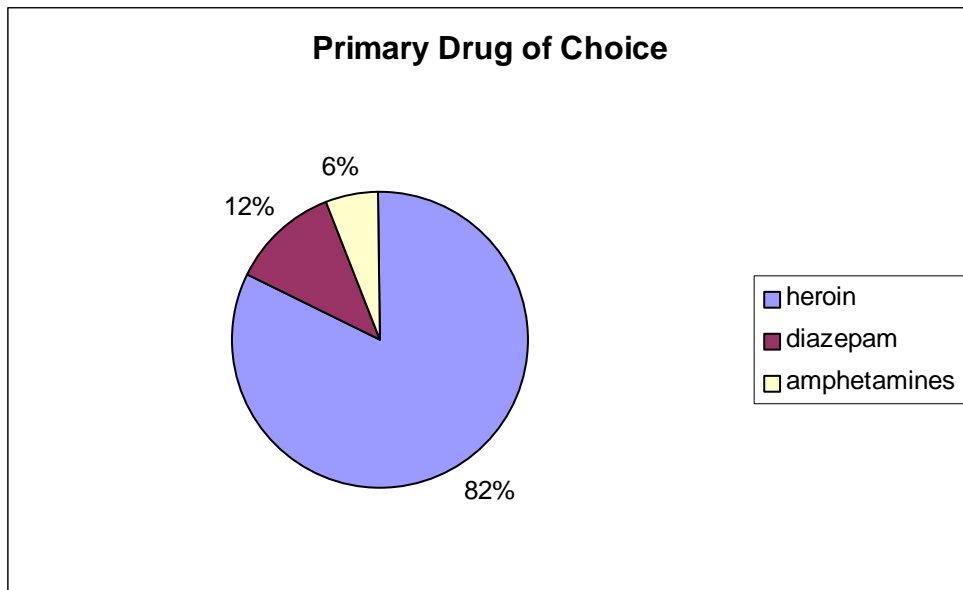
All 17 clients ethnicity is recorded as White British

Figure 2: Age



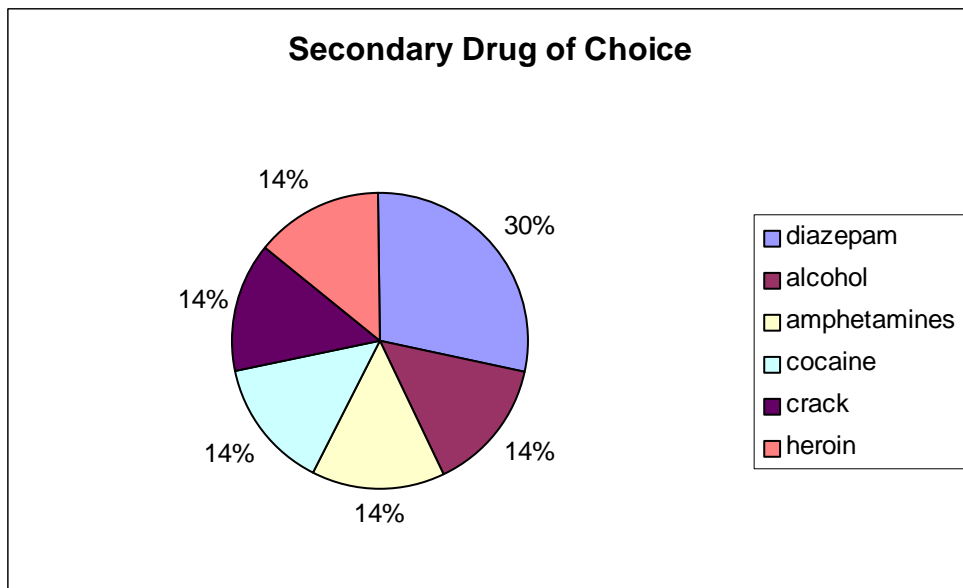
Of 17 clients, 2(12%) are aged 26-30; 5(29%) are 31-35; 6(35%) are 36-40; 2(12%) are 41-45; 1(6%) is 56-60 and 1(6%) client is 61-65 years of age

Figure 3: Primary Drug of Choice



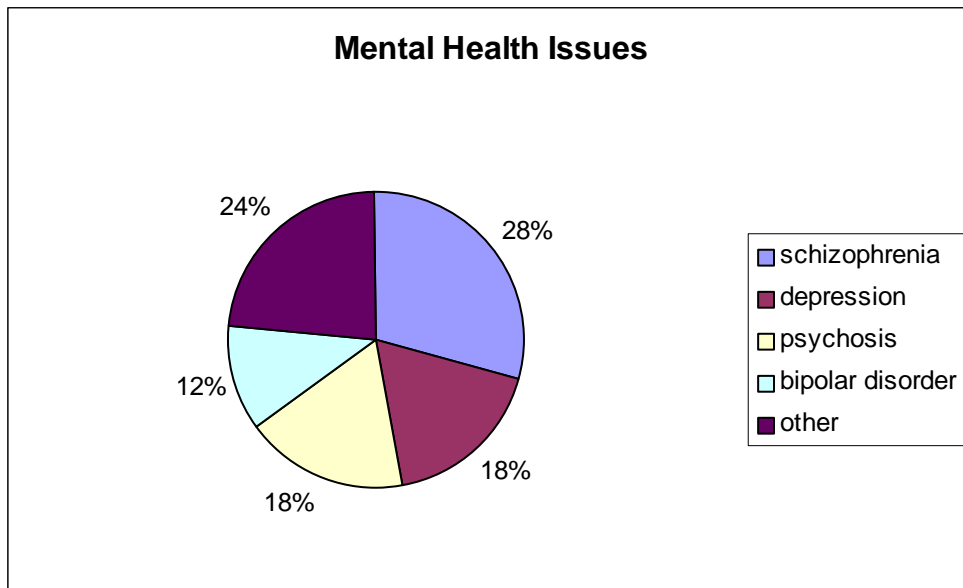
Of 17 clients, 14(82%) use heroin; 2(12%) use diazepam and 1(6%) client uses amphetamines

Figure 4: Secondary Drug of Choice



Of 17 clients, 2(30%) use diazepam; 1(14%) uses alcohol; 1(14%) uses amphetamines; 1(14%) uses cocaine; 1(14%) uses crack and 1(14%) uses heroin

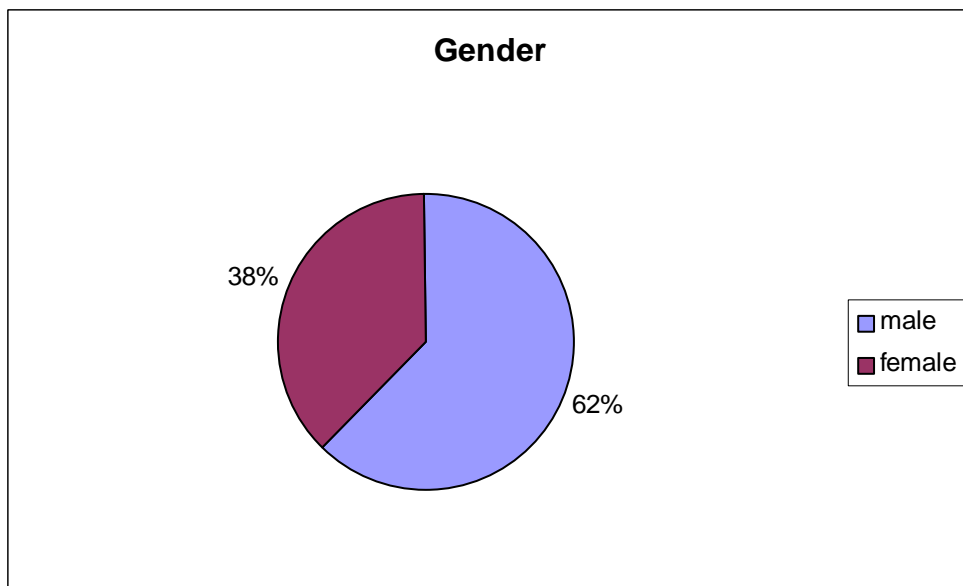
Figure 5: Mental Health Issues



Of 17 clients, 5(28%) experience schizophrenia; 3(18%) experience depression; 3(18%) experience psychosis; 2(12%) experience bipolar disorder and 4(24%) clients experience other mental health issues

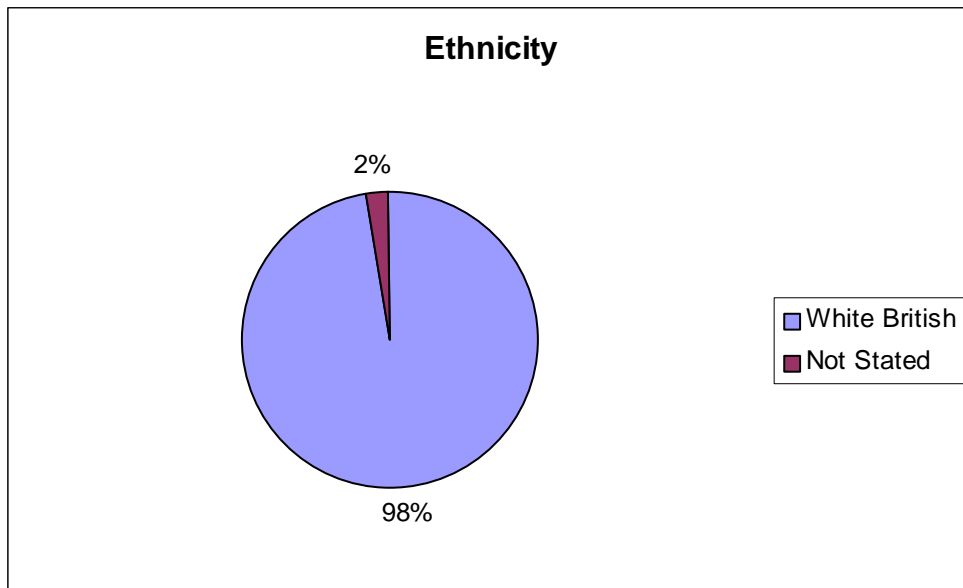
Data from Lancaster & Morecambe alcohol services is presented below. A total of forty two clients presenting to the service are considered to have dual diagnosis.

Figure 1: Gender



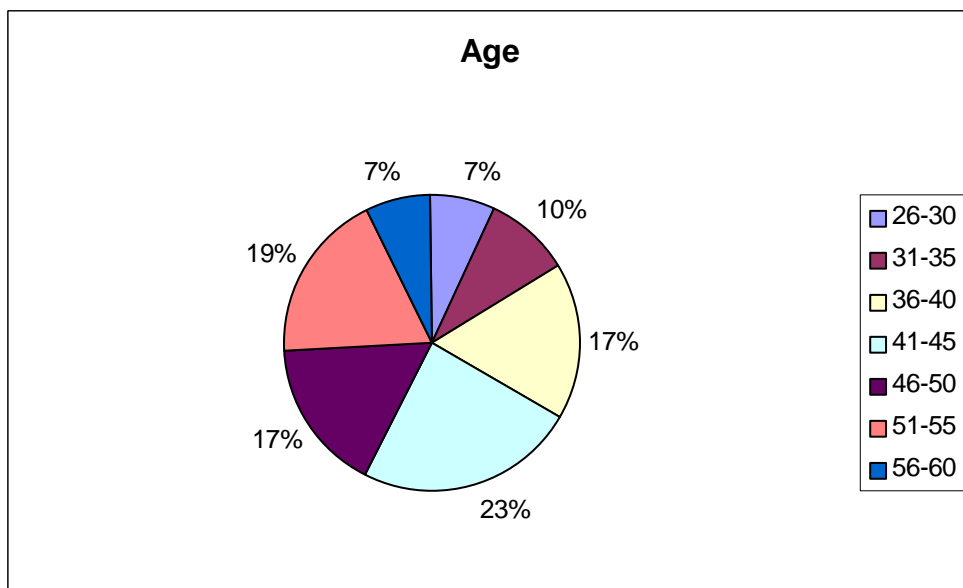
Of forty two clients, 26(62%) are male and 16(38%) are female

Figure 2: Ethnicity



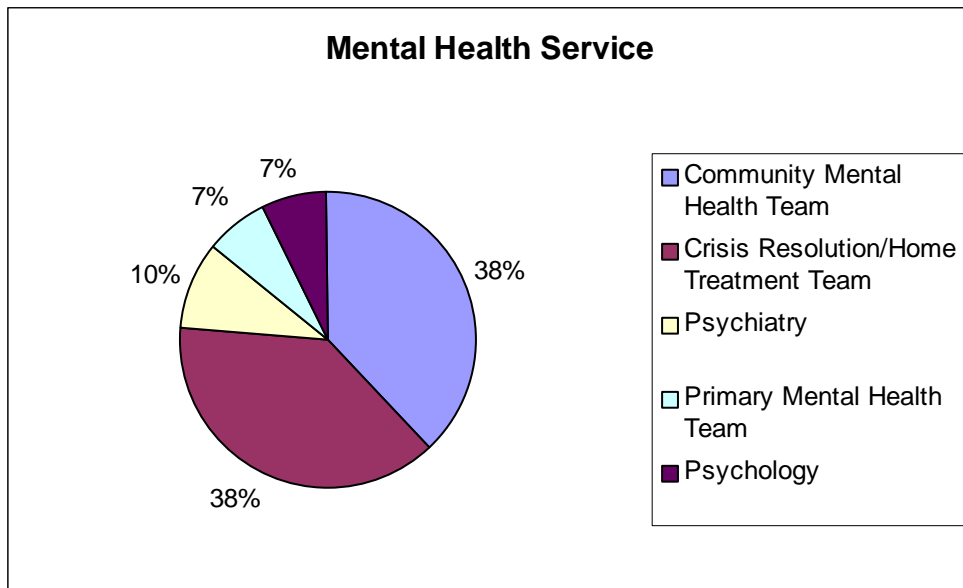
Of forty two clients, 41(98%) are White British and 1(2%) clients ethnicity is not stated

Figure 3: Age



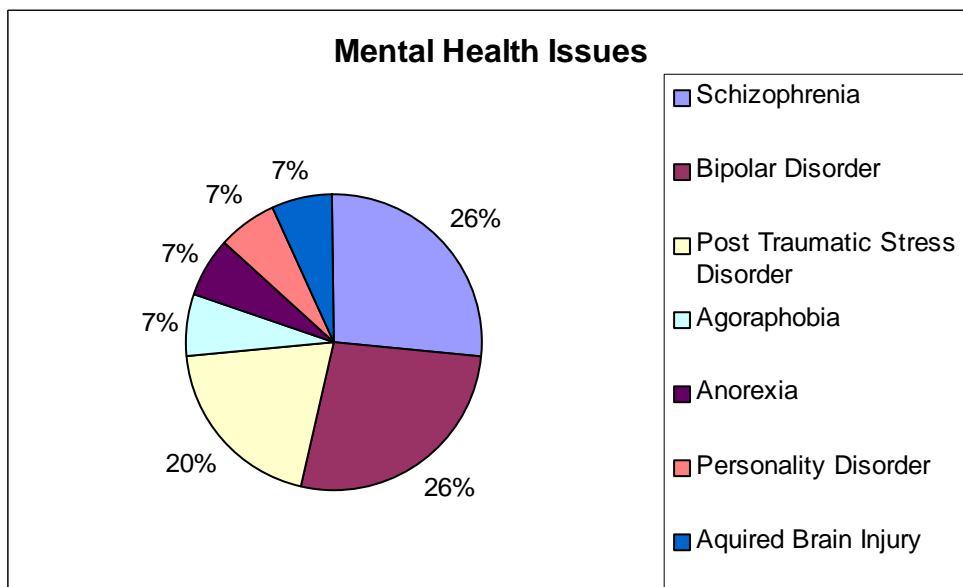
Of forty two clients, 3(7%) are aged 26-30 years; 4(10%) are aged 31-35; 7 (17%) are 36-40; 10 (23%) are 41-45; 7(17%) are 46-50; 8(19%) are 51-55 and 3(7%) are aged 56-60 years

Figure 4: Mental Health Service



Of forty two clients, 16(38%) are known to the Community Mental Health Team; 16(38%) are known to the Crisis Resolution/Home Treatment Team; 4(10%) are known to Psychiatry; 3(7%) are known to the Primary Mental Health Team and 3(7%) are known to Psychology services

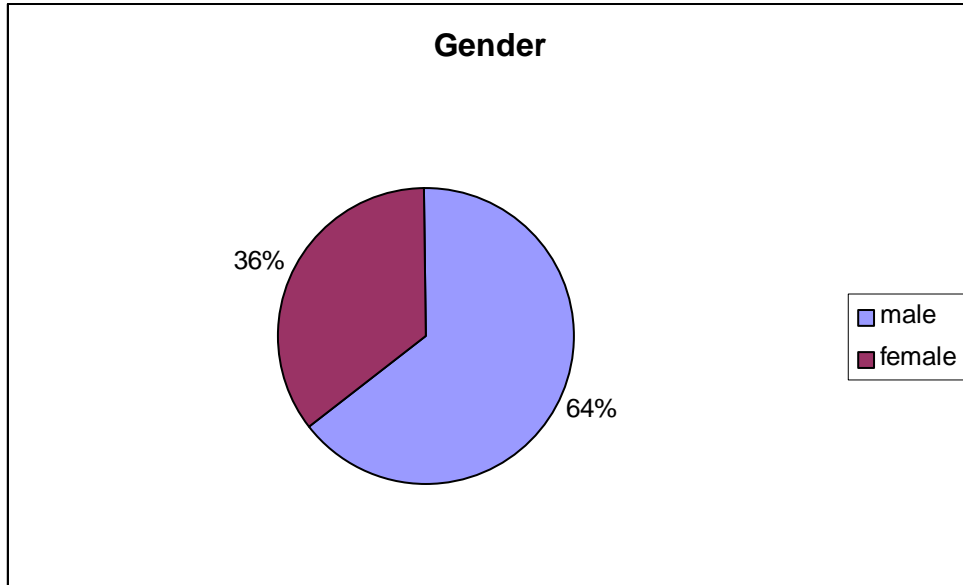
Figure 5: Mental Health Issues



Of forty two clients, 4(26%) experience Schizophrenia; 4(26%) experience Bipolar Disorder; 3(20%) experience Post Traumatic Stress Disorder; 1(7%) experience Agoraphobia; 1(7%) experience Anorexia; 1(7%) experience Personality Disorder and 1(7%) have Acquired Brain Injury

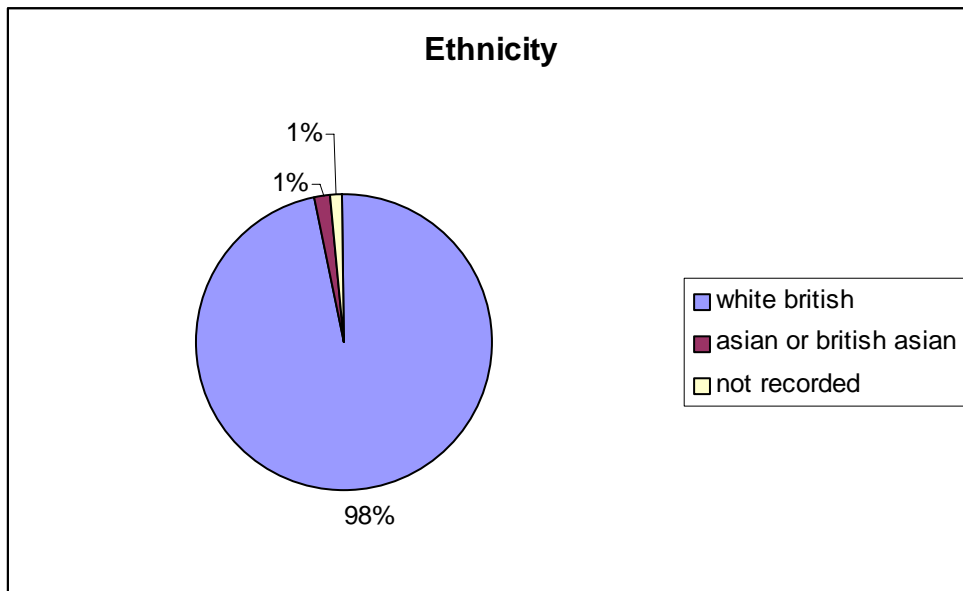
Data from Harvey House, inpatient alcohol detoxification unit is presented below. A total of sixty seven clients with dual diagnosis presented to the service.

Figure 1: Gender



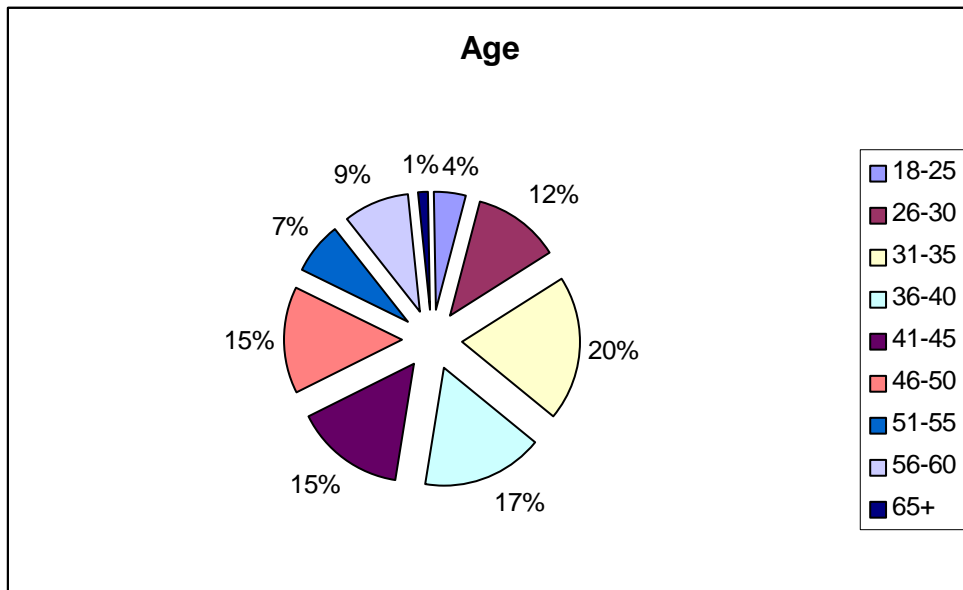
Of sixty seven clients, 43(64%) are male and 24(36%) are female

Figure 2: Ethnicity



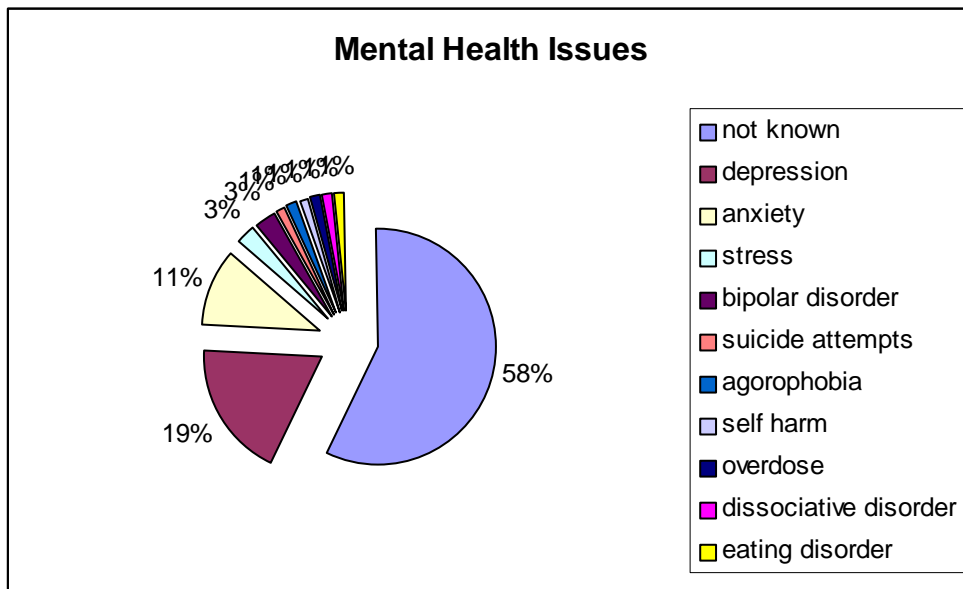
Of sixty seven clients, 65(98%) are White British; 1(1%) client is Asian or British Asian and 1(1%) client's ethnicity is not recorded

Figure 3: Age



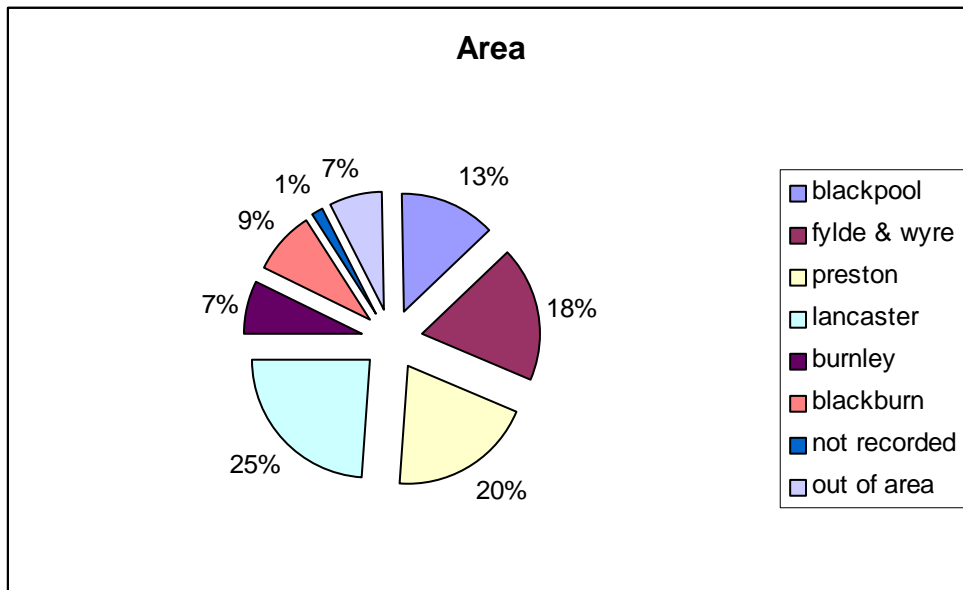
Of sixty seven clients, 3(4%) are aged 18-25; 8(12%) are 26-30; 13(20%) are 31-35; 11(17%) are 36-40; 10(15%) are 41-45; 10(15%) are 46-50; 5(7%) are 51-55; 6(9%) are 56-60 and 1(1%) client is aged 65+ years

Figure 4: Mental Health Issues



Of sixty seven clients, 42(58%) mental health issue is not known; 14(19%) are considered to experience depression; 8(11%) experience anxiety; 2(3%) experience stress; 2(3%) experience bipolar disorder; 1(1%) experience suicide attempts; 1(1%) experience agoraphobia; 1(1%) experience self harm; 1(1%) experience overdose; 1(1%) experience dissociative disorder and 1(1%) client experiences eating disorder

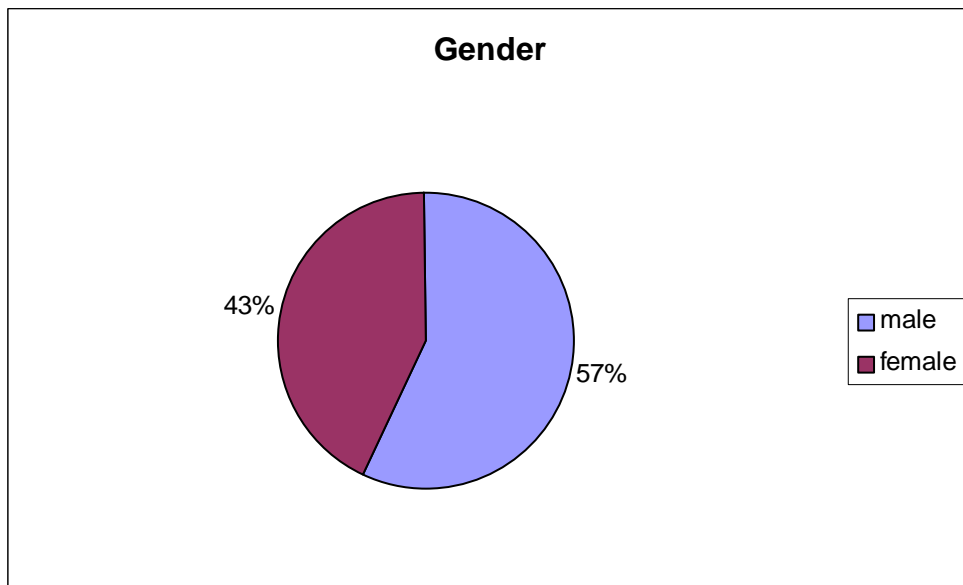
Figure 5: Area



Of sixty seven clients, 9(13%) clients are from Blackpool; 12(18%) are from Fylde & Wyre; 13(20%) are from Preston; 16(25%) are from Lancaster; 5(7%) are from Burnley; 6(9%) are from Blackburn; 1(1%) clients area is not recorded and 5(7%) clients are out of area

A total of 113 clients with substance misuse issues presenting to Chorley and South Ribble Services are considered to have dual diagnosis issues.

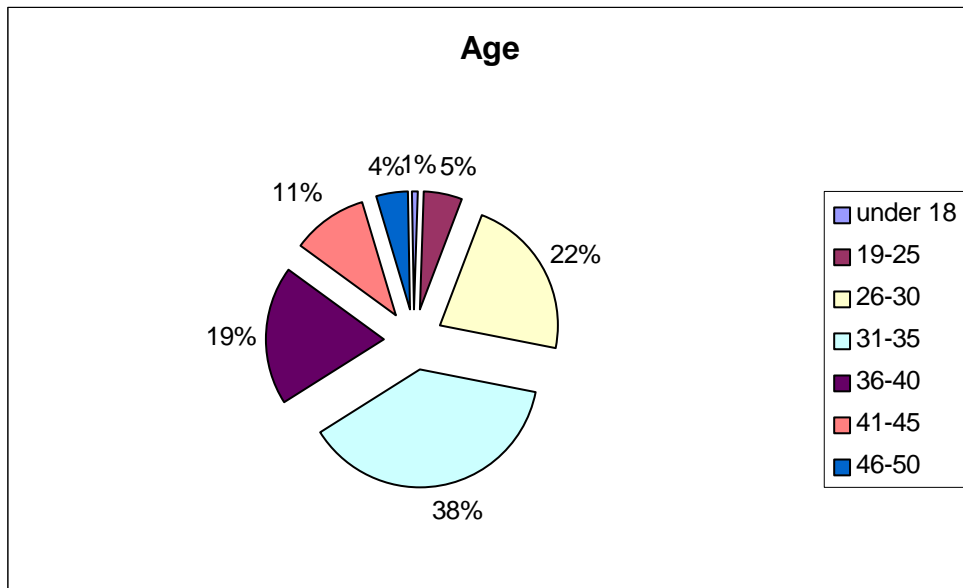
Figure 1: Gender



Of 113 clients, 64(57%) are male and 49(43%) are female

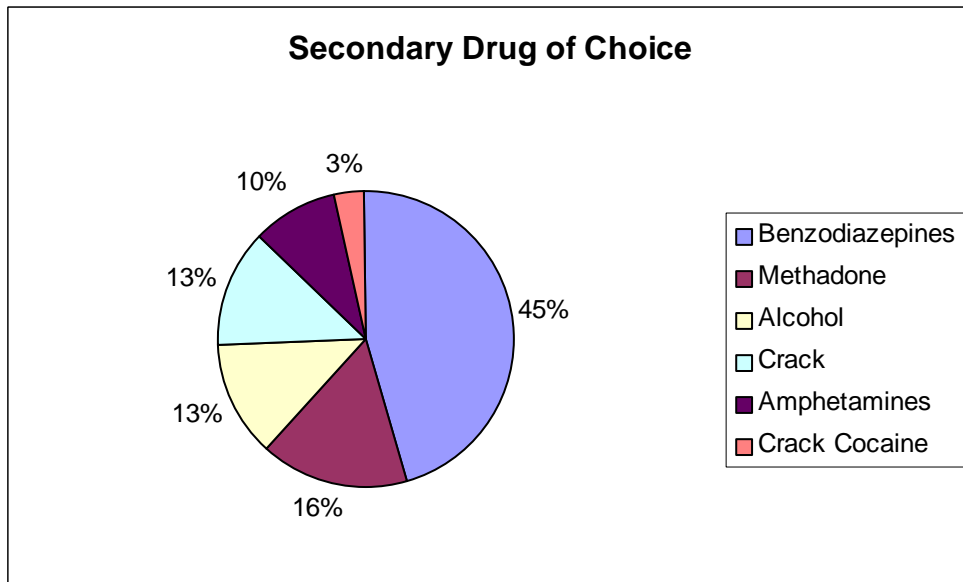
All 113 clients ethnicity is recorded as White British

Figure 2: Age



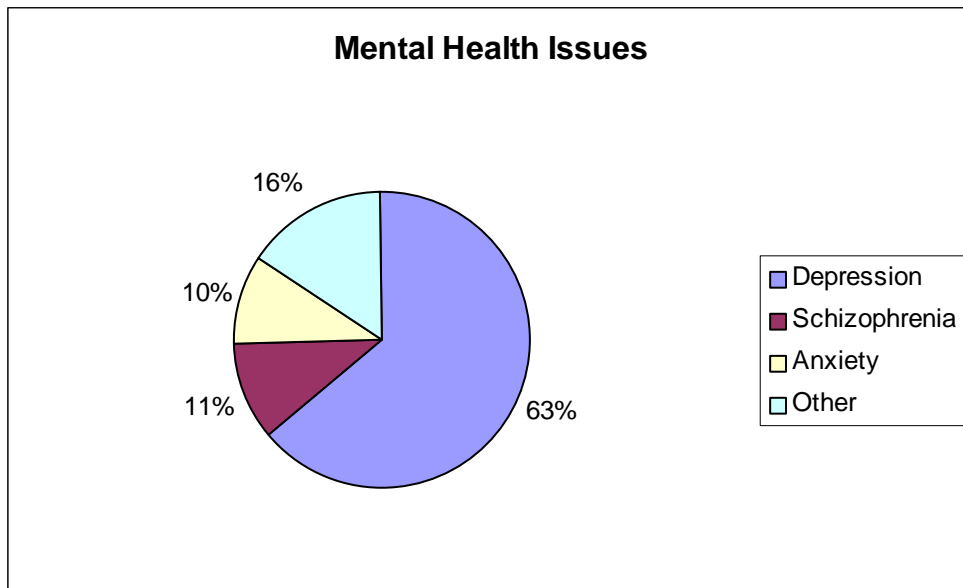
Of 113 clients, 1(1%) client is under 18 years of age; 6(5%) are 19-25; 25(22%) are 26-30; 42(38%) are 31-35; 22(19%) are 36-40; 12(11%) are 41-45 and 5(4%) clients are 46-50 years of age
All 113 clients primary drug of choice is heroin

Figure 3: Secondary Drug of Choice



Of 113 clients, 14(45%) use benzodiazepines; 5(16%) use methadone; 4(13%) use alcohol; 4(13%) use crack; 3(10%) use amphetamines and 1(3%) client uses benzodiazepines

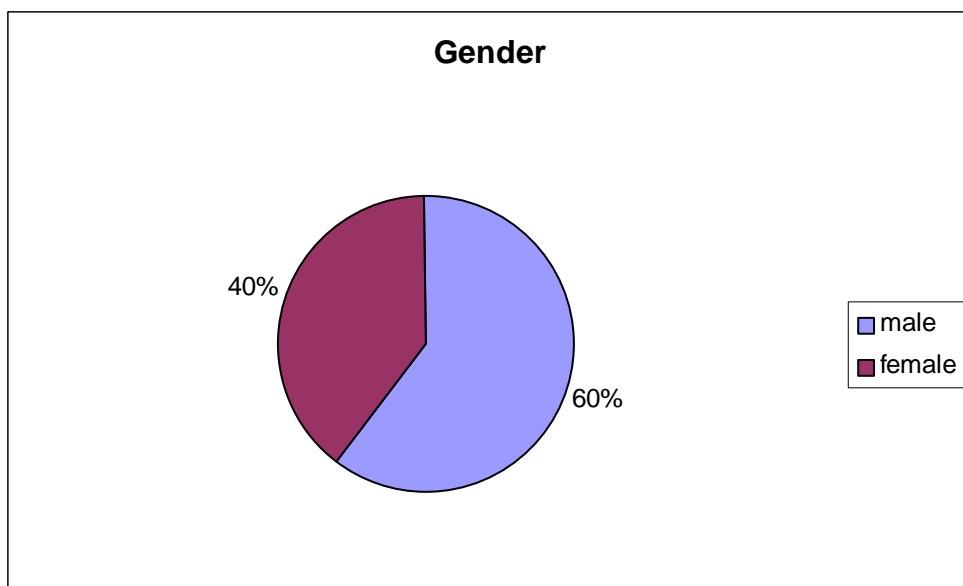
Figure 4: Mental Health Issues



Of 113 clients, 72(63%) experience depression; 12(11%) experience schizophrenia; 11(10%) experience anxiety and 18(16%) experience other mental health issues

A total of 30 clients, presenting predominately with alcohol issues at Chorley and South Ribble Service, are considered to have dual diagnosis issues

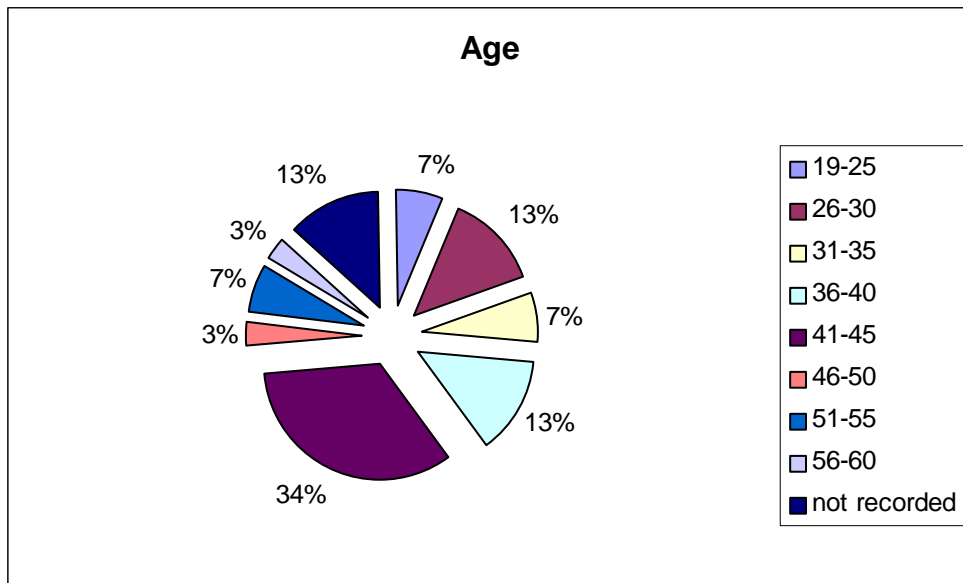
Figure 1: Gender



Of 30 clients, 18(60%) are male and 12(40%) are female

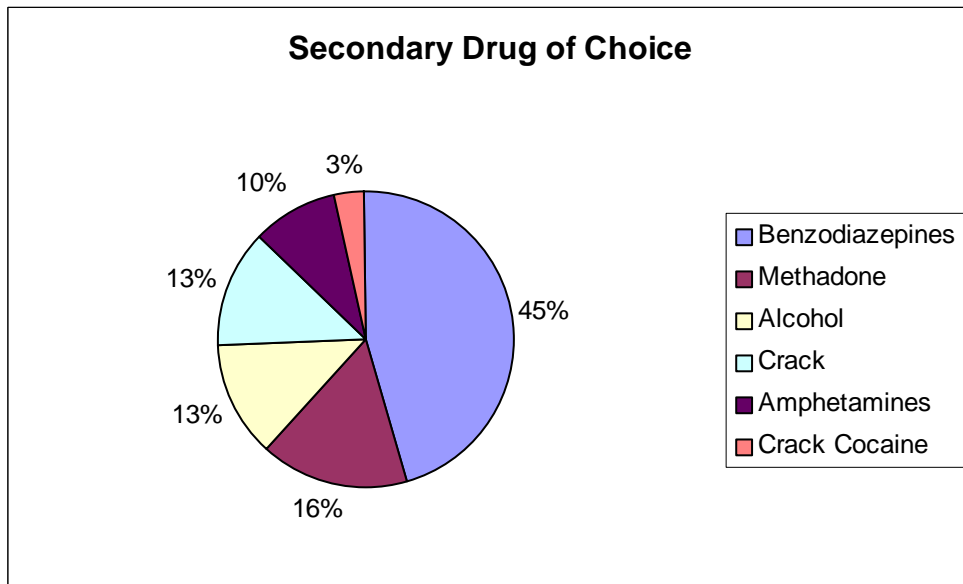
All 30 clients ethnicity is recorded as White British

Figure 2: Age



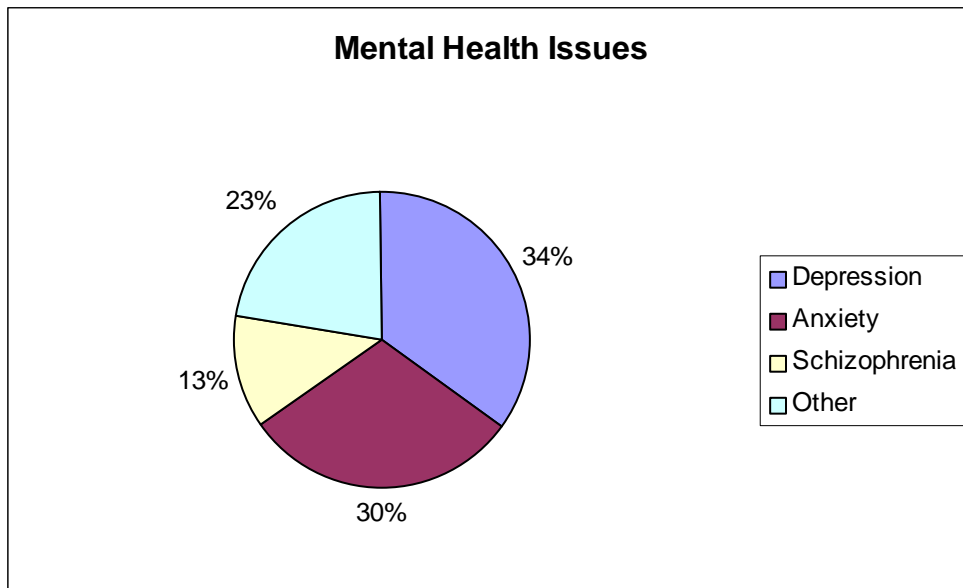
Of 30 clients, 2(7%) are aged 19-25; 4(13%) are 26-30; 2(7%) are 31-35; 4(7%) are 36-40; 10(34%) are 41-45; 1(3%) are 46-50; 2(7%) are 51-55; 1(13%) are 56-60 and 4 (13%) clients age is not recorded
 All 30 clients primary drug of choice is alcohol

Figure 3: Secondary Drug of Choice



Of 30 clients, 14(45%) use benzodiazepines; 5(16%) use methadone; 4(13%) use alcohol; 4(13%) use crack; 3(10%) use amphetamines and 1(3%) client uses crack cocaine

Figure 4: Mental Health Issues



Of 30 clients, 14 (34%) experience depression; 12(30%) experience anxiety; 5(13%) experience schizophrenia and 9(23%) experience other mental health issues

A thematic review of the data is presented below:

- **Gender**

For most areas, males experience dual diagnosis at a higher rate than females. The exceptions are Blackpool and Hyndburn and Ribble Valley areas where females slightly exceed males. However, this is consistent with national trends and the profile of a person with dual diagnosis

- **Ethnicity**

The data does not significantly present clients from Black and Minority Ethnic Communities. Some reasons for this may include:

- Black and minority ethnicity is not routinely recorded
- Clients from black and minority ethnic backgrounds do not access services
- Clients from black and minority ethnic backgrounds do not have the means to access services
- Services do not consistently and actively pursue clients from black and minority ethnic backgrounds

- **Age**

For the majority of areas, people with dual diagnosis appear to be in their thirties. The exception is in Blackpool where 29% of clients are in their forties. However, overall, this is consistent with national trends and the profile of a person with dual diagnosis

- **Primary Drug of Choice**
The primary drug of choice is heroin. This is consistent with national trends and the profile of a person with dual diagnosis
- **Secondary Drug of Choice**
The secondary drug of choice is alcohol. This is consistent with national trends and the profile of a person with dual diagnosis
- **Mental Health Issues**
Patients present with a range of issues, most notably Schizophrenia and Depression. This data is consistent with national trends and the profile of a person with dual diagnosis.

This data is consistent with national trends and the profile of a person with dual diagnosis. There are several cautionary notes to be advised when interpreting this data:

- Services within the substance misuse network do not routinely capture dual diagnosis statistics as they have not previously been requested to do so by commissioners. This is not unusual, as nationally, substance misuse services have not been required to collate this data.
- There is no database system to record all of the variables needed, so the data presented may be inaccurate and therefore limited in what it shows
- Substance misuse services have developed at a faster rate than alcohol services within the Network. This is due to local and national priorities regarding the alcohol agenda
- Several services are working on an informal diagnosis of a mental health issue. This is evident from case notes. This suggests a greater need for a focused assessment for mental health issues; a further need to establish integrated care pathways and joint working protocols with primary care mental health teams and specialist mental health services.
- Several clients from Lancaster and Morecambe Alcohol Services were previously known to Crisis Resolution/ Home Treatment Services. This suggests a need to co-ordinate joined up working between services for those clients who may present in crisis and have additional support needs.

We can assume from these sets of data that there will be a constant demand for services and that people with dual diagnosis will require services at various parts of their treatment journey. This will be reliant on joined up working and effective liaison arrangements to monitor changes to clinical presentation. We can also forecast patterns of drug and alcohol use and their effects on mental health.

- **Lancashire Care Trust informal study**

In 2003 an informal study conducted by the Professional Lead for substance misuse in conjunction with Clinical Governance found that of 129 serious and untoward incidents, drugs and alcohol were implicated in 51 of these.

Themes highlighted:

- High incidence of violence

- Chaotic lifestyles
- Poly drug use
- Self medication
- Non compliance with medications
- Exacerbation of psychotic illnesses.

In addition this study also drew attention to the fact that staff were working in isolation and there was a need for improved communication between services. Clients were also found to be unwilling to go to substance misuse services when referred and often disengaged in the early stages of treatment and therefore were not afforded follow up.

- A later study conducted in the Substance Misuse Network early in 2005 indicated the following:
 - Between 10 and 25% of clients currently in treatment were considered as dually diagnosed.
 - However, between 20 and 90% of clients in treatment at the time of the study were accessing mental health services.
 - None of the then seven substance misuse services had a clear understanding or definition of dual diagnosis.

- **Suicide Audit and Thematic Review of Serious and Untoward Incidents**

Lancashire Care Trust is committed to the recommendations outlined in An Organisation with a Memory (2000) and Safety First (2001). The Trust actively seeks to explore incidents with a view to learning lessons and developing 'patient safety solutions' to help improve the overall safety and quality of care and services. The report lists care and service delivery problems and where possible contributory factors. These are arranged in line with the National Patient Safety Agency's classification system (Taxonomy) for contributory factors:-

- Patient Factors
- Individual Factors
- Task Factors
- Communication Factors
- Team Factors
- Education and Training Factors
- Work Environment Factors
- Organisational Factors

The Trusts Clinical Governance Network undertook a thematic review of serious and untoward incidents from April 2005 to March 2006 and a suicide prevention audit 2006 - 2007. Whilst not exclusive to dual diagnosis, the majority of findings highlighted particular issues relating to care of service users from this vulnerable group. The key headlines were as follows:-

- Dual Diagnosis
- Physical Health Problems
- Communications External & Internal
- Record Keeping
- CPA
- Child Protection
- Clinical Risk Assessment and Management
- Training
- Staffing levels
- Lack of particular services

Some examples and specific details in relation to each headline, as they relate to dual diagnosis are:

Dual Diagnosis

The most obvious theme to emerge from the incident review data was the 'dual diagnosis theme', which is consistent with the Avoidable Deaths report by The University of Manchester. This stated "Dual diagnosis – the occurrence together of mental health and substance misuse – is one of the central problems facing mental health services " in addition, "One thousand six hundred and fifty-nine (27%) suicides and 72 (36%) homicides in their report were dual diagnosis cases". (Avoidable Deaths 2006).

Examples cited from incident reports:-

- The extent to which alcohol influenced mental state is probably significant
- Alcohol & drug use were complicating factors in the management of clients care, especially risk level with input from drug and alcohol services
- Constant use of alcohol without any sustained period of absence can make assessment difficult
- Increased alcohol use evident in recent years and on day of last contact with service
- The need to develop direct links with specialist substance misuse and alcohol services so that in-patients with substance misuse and alcohol problems can access support during their in-patient stay

Written and Verbal Internal Communication

The following are the list of internal communication factors that have been mentioned as problematic or contributory in the context of LCT's incidents.

Team to Team

Examples cited from incident reports:-

- There had been a lack of communication between all teams in relation to communication
- Communication between ward staff and medical staff was poor
- The homeless team have no designated link person within the substance misuse team which is felt hinders communication

- Communication between the In-patient team and the alcohol and drug service could be improved, to ensure that transfer of care arrangements is seamless
- There was no information received to and from services regarding client therefore staff were not aware of clients history
- The standard care plan was not shared with other professionals

Record Keeping

Examples cited from incident reports:-

- It is unclear from the notes what advice was given to client in relation to the risks associated with reduction in tolerance
- There are no entries in the drug team notes in relation to either client induction onto Naltrexone or subsequent compliance with medication
- Screening documentation must be completed in full to enable a clear audit of the decision making process
- Assessment documentation was not dated or signed
- Record keeping from a CMHT perspective was to a poor quality

Task Factor Themes

Task factors typically describe the following:-

- Guidelines, policies and procedures
- Decision-making aids
- Procedural or task design

The most prominent theme to emerge from the incident review data was the 'Care Programme Approach' (CPA). This is consistent with the Avoidable Death Report (December 2006) University of Manchester, "... the most striking illustrations of the under use of CPA in people at high risk".

CPA

Examples cited from incident reports:-

- Absence of formal CPA review meetings
- CPA process not followed in relation to 7 day follow up
- Staff not attending CPA review meetings
- All notes should contain full CPA documentation
- Required assessment documentation not completed as per CPA Policy
- Non compliance with the CPA Policy
- Client discharged in their absence with no arrangement for follow up

Clinical Risk Assessment and Management

This is a theme within CPA but is prominent enough to merit individual focus.

Examples cited from incident reports:-

- Risk assessment highlighted several risks, which may not have been taken into account
- Sections of risk documentation left blank, making it unclear if information had been covered

- No information had been gathered on clients history of alcohol and drug use
- Unclear in notes what advice had been given in relation to risks associated with reduction in tolerance
- Lack of regular training in risk assessment and management
- Not all relevant risk information gained from other resources

Education & Training Factor Themes

These factors focus on the following:-

- Competence
- Supervision
- Availability and accessibility
- Appropriateness

Within LCT the identified training factors themes follow on from task factors with the most prevalent issue being CPA, risk assessment and risk management.

Training

Examples cited from incident reports:-

- The incident draws attention to the importance of regular training in risk assessment and management
- Lack of formal clinical risk management training programme within LCT
- Importance of ensuring all practitioners are provided with education and training in clinical risk management on a regular basis
- The need for CPA induction for all new and agency staff
- All mental health practitioners will undertake a programme of training focusing on the assessment and management of risk in a community setting
- Staff supervision arrangements should be reviewed to ensure all team members are receiving regular supervision
- Practice supervision for the care co-ordinator, to identify training necessary for a full understanding of the CPA process
- The need for training around the problems presented by individuals that present with deliberate self-harm
- Improved access to training for in-patient staff in substance misuse and alcohol harm reduction strategies

To ensure continuity and follow through and action on lessons learned, the 10 key issues/themes raised from the findings of this report and the thematic review of incidents will be identified by the SUI (Serious and Untoward Incidents) Advisory group in July 2007 and a plan developed to address these issues/themes. Monitoring of the plan will be via the SUI Advisory group.

However, these findings and experiences are not unusual. Nationally, a number of external inquiries, and internally, some involving incidents of violence to others and some resulting in deaths to patients/clients and carers

have highlighted the same issues and the need to develop and improve services and systems for those with dual diagnosis.

Throughout Lancashire Care Trust the service for dual diagnosis is currently patchy and where good practice does exist it is often reliant on good will working relationships rather than strategically planned and organised service delivery.

This local data now creates a very real opportunity to inform strategy development and the modernisation of services to attend to dual diagnosis issues in more meaningful ways within a whole systems context.

4 Aims and Principles

The strategy's fundamental aim is to improve service delivery for those with a dual diagnosis. This is heavily reliant on the direct care and support afforded to service users and their carers at every stage of the treatment journey. This involves the development and implementation of integrated care pathways and formal joint working protocols between services.

The main principle is to foster a culture of positive health and social care outcomes for those accessing mental health and drug and alcohol services by working together in partnership. To achieve this, as a common and ultimate goal we must provide services with the necessary resources to fulfil these tasks. The liaison model of working will provide the framework in which to deliver this.

Intended Outcomes:

- Reduce the number of drug related deaths in this client group
- Reduce the number of serious untoward incidents amongst the dually diagnosed
- Increase the knowledge of practitioners involved in the care of the dually diagnosed
- Improve the quality of care
- Improve clinical outcomes
- Reduce the incidence of clients continually being referred between services
- Implement practical integrated care pathways
- Improve communications both intra and inter agency
- Work collaboratively with commissioners to ensure sustained service provision

4.1 Strategy Objectives

The strategic objectives provide a range and depth of vision and broadly encompass multiple goals including the delivery and co – ordination of direct clinical care.

Strategy Objective 1: Delivery of Care

- Access to services to ensure diagnosis is timely and accurate
- Develop a coherent and collaborative approach to meeting the needs of dually diagnosed clients and develop best practice

Strategy Objective 2: Service Information

- Produce a service directory for information for users and carers, and all services which clearly explain the availability of services and how to access them.

Strategy Objective 3: Training and Workforce Development

- Deliver a comprehensive training package for all staff within adult mental health services and substance misuse services and relevant partner agencies.

Strategy Objective 4: Audit, evaluation and research

- All services to participate in audit activity and agree to monitor implementation of changes that may enhance the current service provision.
- All services to agree to participate in research activity as the strategy develops
- Learning opportunity from the MIDAS research trial

Strategy Objective 5: Commissioning of services

- Positively influence and inform commissioning plans

Strategy Objective 1: Delivery of care**To develop a coherent and collaborative approach for the needs of dually diagnosed clients and develop best practice**

	Action Point	Objective	Action required	Accountability	Comments
1.1	To implement integrated care pathways for those with a dual diagnosis. This should clearly define a care co-ordinator and a key worker.	To achieve a common and consistent approach to the care of those with dual diagnosis	Integrated care pathways to be implemented. To be audited	Dual Diagnosis Lead to co-ordinate audit. Team Managers and liaison workers	Special consideration for access to treatment for women, offenders, young people, homeless people and those from BME communities.
1.2	To produce a common assessment tool for both mental health services and drug and alcohol services, incorporating risk assessment.	To get a clearer understanding of need and to avoid duplication of work. To inform the care planning process.	To produce an agreed assessment tool that promotes joint working.	Team managers and liaison workers	Currently all LCT staff using the safety profile which reinforces joint working. Specific reference to waiting times and initial appointments
1.3	To provide information support and care to carers	To ensure that a carers assessment is routinely undertaken.	Undertake carers assessment, as per individual case requirements	Practitioners, as per clinical practice frameworks	Ensures carers are actively involved in the care planning process, and their own needs attended to as appropriate
1.4	Liaison workers role to be fully implemented.	To ensure clear responsibility for achieving clinical outcomes including effective care co-ordination and key working.	All service areas to nominate liaison workers with specific responsibility	Service managers Team managers	Clinical outcomes may be affected by length of stay in treatment and DNA rates
1.5	To implement Models of Care for drug and alcohol services	To appropriately refer clients through the substance misuse systems	As per implementation requirements	Drug and alcohol services	Mental health services to have an understanding of this framework
1.6	To implement Mental Health National Service Framework for Mental Health Services	To appropriately refer patients through the mental health systems	As per implementation requirements	Mental health services	Drug and Alcohol services to have an understanding of this framework
1.7	Identify and refer into detox and drug residential rehabilitation	To offer choice and maximise potential	As per budget	Funding panel	Detoxification and Rehabilitation proposal outlined

Strategy Objective 2: Service Information					
Produce a service directory for users and carers and services, which clearly explains the availability of services and how to access them					
	Action Point	Objective	Action required	Accountability	Comments
2.1	Literature to be produced to advise of services and how they may be accessed.	It will enable a service to be designed locally and specifically to meet the needs of its users.	Each service to produce entry for service directory	Service Managers for each area	Will need to be monitored to ensure updates are included

Strategy objective 3: Deliver a comprehensive training package for all staff within Adult Mental Health Services and Substance Misuse Services and relevant partner agencies.

	Action Point	Objective	Action required	Accountability	Comments
3.1	To conduct a formal training needs analysis	To obtain baseline measurement of experience, skills and knowledge	Conduct training needs analysis with reference to Knowledge Skills Framework (KSF)	Service Managers	Will inform appropriateness of training proposal
3.2	Deliver training to liaison workers	To equip staff with specialist skills to work with dual diagnosis clients	Staff to be released from duty to attend training sessions	Service Managers Team Managers Liaison workers	Topics will include Motivational Interviewing; Relapse Prevention and Harm Reduction.
3.3	Liaison workers to be able to meet all training objectives as outlined in training proposal	To enable a range of training experiences	Staff to be released from duty to engage in the process	Service Managers Team Managers Liaison workers	For further details see training and workforce development proposal
3.4	To roll out training to staff who are not from specialist services but who may come into contact with dual diagnosis clients	For all services to feel competent in providing care to this client group	To devise a training programme based on the needs/frequency of the particular service area	Service Managers Team Managers	Provision of interagency training will foster closer working alliances
3.5	To increase the number of practitioners completing the dual diagnosis module	To equip practitioners with specialist knowledge	As per identification of training needs via supervision, professional development plans and KSF	Service Managers Team Managers Practitioners	In collaboration with the University of Central Lancashire

Strategy Objective 4: Audit, evaluation and research.					
	Action Point	Objective	Action required	Accountability	Comments
4.1	Inpatient services to participate in audit activity.	Agree to monitor implementation of changes that may enhance the current service provision.	Audit tool developed; to be audited following implementation of care pathway	Dual Diagnosis Lead to co-ordinate audit Modern Matrons/ liaison workers supported by Clinical Governance Network	Audit of discharge planning into the community with particular reference to drug and alcohol issues
4.2	All community services to participate in audit activity.	Agree to monitor implementation of changes that may enhance the current service provision.	Audit tool developed; to be audited following implementation of care pathway	Dual Diagnosis Lead to co-ordinate audit Service Managers/ Team Managers/ liaison workers supported by Clinical Governance Network	Audit of referral and liaison pathways between mental health and drug and alcohol services
4.3	All services to participate in research activity as the strategy develops	To support strategy sustainability	Define research objective as strategy develops	Services identified by the research trial	Can inform evidence based clinical practice
4.4	All Lancashire Care Trust relevant services to participate in MIDAS research trial	To promote the efficacy of Motivational Interventions in those with a dual diagnosis of schizophrenia and drug and alcohol	As per research trial	Services identified by the research trial. Completed in some areas of the Trust	Research conducted and completed in collaboration with Manchester University

Strategy Objective 5: Commissioning of services

To positively influence and inform commissioning plans which ensure services are configured appropriately to meet the needs of this client group

	Action Point	Objective	Action required	Accountability	Comments
5.1	Devise business/ treatment plans for 2008/2009 with particular reference to dual diagnosis.	Ensure Service Level Agreements are compatible with strategy objectives	Commitment to commission services that will honour strategy objectives. As per commissioning cycles	Commissioning Managers from Primary Care Trusts Commissioning Managers from Drug and Alcohol Action Teams Network Directors Service Managers	Will ensure commissioning and Service Level Agreements are introduced and agreed in a mutually supportive manner between commissioners and providers
5.2	Commitment to increase availability of funds to providers	To support strategy implementation – resources and workforce development	As per commissioning cycles	Commissioning Managers from Primary Care Trusts Commissioning Managers from Drug and Alcohol Action Teams	Will ensure appropriate configuration of services

5 Supporting Service Change

The quality of service provision is varied. This may be due to practitioner skill, service design and the current lack of a formal and co-ordinated way of working between services. For this reason it is appropriate to re-examine traditional approaches to the ways problems associated with dual diagnosis are addressed. This section will focus on supporting service change and gives recommendations for modernised service delivery.

In order to implement the key themes of the strategy we need to build expectations and accountabilities regarding resource and capacity issues to ensure that this strategy receives guaranteed attention and priority at all levels of the health and social care system. The principle focus will be on how to address the need for service improvement and change in our existing services within current constraints. Commissioners will need to ensure services have the appropriate level of resources needed to operate effectively and to deliver the training and service strategy.

For those planning service provision there is an opportunity to develop a commissioning and performance management framework specifically with regard to dual diagnosis service provision. Investment in health and social care services provide a clear vision and sense of direction for modernising services setting out how we want services to develop and grow. When assessing need and planning services all aspects of service provision should be seen within the context of a whole system so that a comprehensive system of care can be developed. Given the necessity of multi professional multi agency input into service planning and delivery it is potentially important that governance and quality issues are addressed and embedded into the planning process.

Commissioners and providers must commit to achieving effective joined up working. This will involve strengthening partnerships in planning and delivering services to ensure stability and sustainability of service provision. We are already in a fortunate position, as in its 2007/2008 substance misuse strategy, Lancashire Drug and Alcohol Action Team (LDAAT) has committed to responding to the challenges presented by substance misuse across the county. LDAAT is the body responsible for delivering the National Drug Strategy in Lancashire. East Lancashire Primary Care Trust and Blackpool Primary Care Trust have identified funds to consolidate the dual diagnosis agenda. Positive commitments from our external partners and funding bodies add momentum to progress this area of service delivery. Some key performance indicators may include access to treatment; waiting times; clinical outcomes; length of stay in treatment and DNA rates.

Stepped Care Approach to Common Mental Health Problems

An essential consideration for supporting service change is to specifically consider the vital role of primary mental health care needs as designated services.

Common mental health problems that are often not the remit of the specialist mental health services, as their focus is on severe and enduring mental illness deserves appropriate attention. There is now increased recognition of the importance attached to addressing these issues at primary care level. It is now eight years since the launch of the National Service Framework for Mental Health and it is apparent that the primary care component of mental health services has historically been unstructured and underdeveloped with limited access to a range of therapeutic options for the care of patients with common mental illness and alcohol misuse. Services have developed in isolation and with limited recognition of the importance of the primary/secondary care interface. Equity of service provision is essential for the stepped care model to succeed.

Depression is the most common mental disorder in community settings and is a major cause of disease burden. One quarter of routine GP consultations are for people with mental health problems and around 90% of mental health care is provided solely by primary care (Tomson & Shiers 2003). Each year one woman in 15 and one man in 30 will be affected by depression and every GP will see between 60 and 100 people with depression (Department of Health, 1999).

Accurate information about the incidence and prevalence of anxiety disorders is difficult to obtain, however the Office of National Statistics estimates that 44 adults in every 1000 suffer from a generalised anxiety disorder (National Institute for Clinical Excellence, 2004). Adults with long term mental health problems are one of the most excluded groups in society. Additionally, there is a close association between mental ill health and substance misuse.

Alcohol misuse is the most common form of substance misuse with over 90% of the adult population drinking alcohol. The majority of course do so with no problems. For others, alcohol misuse is a real problem. Current estimates suggest that alcohol misuse is now costing around £20bn a year and recognises primary care as the first contact point for many with alcohol related problems (Prime Ministers Strategy Unit, 2004). In the UK it is estimated that a third of patients in drug and alcohol services have a mental health problem, most commonly depression or personality disorder (The Royal College of Psychiatrists, 2002). In a major study of people involved in substance misuse treatment, one in five people reported recent psychiatric treatment (J Marsden et al, 2000).

The recently published government white paper (Department of Health, 2006) outlining a new direction for community services advocates a shift in the way services are provided to local communities. More emphasis is placed on primary care with hospitals and secondary care services excelling in more complex and specialist treatment modalities. It has been widely recognised that effective primary care service provision has reduced demand on secondary care services. Evidence where this model has been in place for some time shows that referrals to secondary care mental health services have been reduced drastically.

The proposal is to develop a consistent stepped care service model that can be adapted from the guidebook “Primary Care Services for Depression – A guide to best practice” (National Institute for Mental Health England, 2006). For a patient to be referred to the primary care mental health service they should have an inability to function satisfactorily in various areas of their lives and cannot be managed with confidence in primary care, however they are not appropriate for a secondary care referral.

Stepped care has two key features both are appropriate for common mental health problems and substance misuse. Firstly, the recommended treatment should be the least intensive of those currently available, but still likely to provide significant health gain. More intensive treatments are reserved for patients who do no benefit from simpler first time treatments. Secondly, stepped care is self-correcting, in that results of treatment and decisions about treatment provision are monitored systematically, and changes are made (stepping up) if current treatments are not achieving significant health gain.

The stepped care mental health service would include provision of information, facilitated self help, signposting, social prescribing, condition management, managing medication concordance through case management approaches and provision of evidence based psychological interventions that are the treatment of choice for anxiety and mild depression (National Institute for Clinical Excellence, 2002). It is proposed that the primary care mental health team would implement the stepped care approach to managing common mental health problems

The single point of access into secondary care mental health services is via the community mental health teams during clinical hours and the crisis resolution home treatment service out of hours. The single point of access for some areas in the Trust into mental health services is via the integrated primary care mental health teams, who will then refer into the community mental health teams as needed. This is an invaluable resource for people with common mental health problems known to the substance misuse network and can have positive gains and benefits for the integrated care pathway between drug and alcohol and mental health services.

5.1 Models of working

The various models of working with this client group, as described in the Policy Implementation Guidelines are outlined below. Some of the limitations of these models are also highlighted. The recommended model of working is described in some detail.

Background

Patients with mental health problems often have complex needs which fall into the potential areas of responsibility of different services areas. At times, the dividing lines are administrative and there are few contentious issues. More commonly, the decisions are complex and mutually agreed thresholds and procedures need to be determined. Specialist services are involved

dependent on complexity and need and the co-existence of substance misuse and psychiatric illness should not absolve one service of responsibility nor automatically oblige another to care for that patient. Such a situation needs careful management. This needs to be negotiated with clear lines of responsibility with scope for flexibility rather than vague boundaries which may make service planning difficult.

Whilst there is no conclusive research evidence on the best way to meet the needs of people with dual diagnosis, the policy implementation guidelines (Dual Diagnosis Good Practice Guidelines, Department of Health, 2002) summarise current policy and good practice in the provision of mental health services to people with severe mental health problem and problematic substance misuse. The key points are that:

- The primary responsibility for the treatment of individuals with severe mental illness and problematic substance misuse should lie within mental health services. This approach is known as 'mainstreaming' and aims to lessen the likelihood of people being shunted between services or losing contact completely.
- Substance misuse services should provide specialist support, consultancy and training to mental health teams. Mental health teams should offer similar support to substance misuse agencies to enable them to effectively treat those with less severe mental health problems.
- The link between personality disorder and dual diagnosis is common. However, this client group is also faced with a higher potential for exclusion based on the stigma associated with diagnosis and the uncertainty of issues pertaining to their care and management.

The Department of Health reaffirms the need for assessment and access to services within the document 'Personality Disorder – no longer a diagnosis of exclusion (2003), advising that this client group should be offered treatment options within general mental health services.

Dual Diagnosis is a broad term. The nature and degree of both substance misuse and mental disorder may vary not only from individual to individual but within an individual over a period of time. A dual diagnosis client is defined as an individual with concurrent needs arising out of their mental disorder and their substance misuse past or present.

An inclusive criterion would suggest that:

- A diagnosis of personality disorder is included
- Clients currently sober or drug free who are at high risk of relapsing into substance misuse are included
- Consequently, clients whose mental state is altered due to substance misuse are included

National models of practice

It is recognised that there are three main models that are applicable in the treatment of dual diagnosis, i.e. serial, parallel and integrated.

Serial treatment model

Psychiatric and substance-use disorders are treated consecutively with little communication between substance misuse and psychiatric services. It is argued that serial models with separate treatment services are not appropriate in the majority of cases. Patients tend to be shunted between services that are inadequate to meet their needs. Moreover, some argue that many substance misuse services are insufficiently supportive of this group, as they place emphasis on clients motivational and personal responsibility.

Serial treatment has traditionally been the treatment model for supporting people with a dual diagnosis. Some of the limitations of this model are:

- It is not conducive to holistic assessment; care planning; treatment and review
- The responsibility for each service is assumed and not made clear
- The involvement of each service is assumed and not made clear
- Negative implications for clinical risk management

Parallel model

Substance-misuse and mental health services establish liaison to provide the two services concurrently. Some NHS trusts have set up specific liaison posts between psychiatry and substance misuse to facilitate patient assessment and referral. In other Trusts, while there is nominal commitment to such a model, the practical representations of such a service are not satisfactory and 'liaison' may also be a recipe for 'passing the buck'. It has also been noted that substance misuse and mental health services may operate referral criteria that specifically exclude co-morbid patients, particularly in the residential rehabilitation sector. Some commentators argue that improved liaison and communication is not a panacea. The medical model of psychiatry contrasts with the psychosocial orientation of substance misuse services.

This model is preferred over the serial model. However, the following flaws still remain:

- It is not conducive to holistic assessment; care planning; treatment and review
- The responsibility for each service is assumed and not made clear
- The involvement of each service is assumed and not made clear
- Negative implications for clinical risk management

Liaison model

Clinical experience emerging from the USA suggests that the successful treatment and management of dual diagnosis disorders is best achieved through an integration of substance misuse and psychiatric treatment. It is increasingly argued that integrated treatment specifically for co-morbidity must underpin an approach based on assertive community treatment and that specific interventions must provide treatment for both types of disorder without cross-referral to other agencies. Evidence also suggests that clinical teams must provide a treatment approach that incorporates motivational and behavioural interventions, relapse prevention, pharmacotherapy and social

approaches. In the USA there is now a marked trend to generate a new speciality of dual diagnosis psychiatry with staff, facilities and services especially dedicated to the client group.

This is the preferred model of working and Lancashire Care Trust will adapt this model.

5.2 Recommended Model - The Liaison Model within Lancashire Care Trust

This strategy promotes and supports the liaison model and considers it to be the model most likely to succeed in delivering a service for the dually diagnosed.

Rationale for choice:

- Increased communication between services.
- Joint working is delivered; not merely assumed. The framework to deliver joint working is provided. Service users will not be shunted between services in order to deal with primary diagnosis issues. This is a sequential model of working which the strategy is actively discouraging.
- Vigilant clinical risk management.
- Responsive to and focused on needs.
- The model will be evaluated at regular intervals – this is best achieved through planned audit of referral and liaison pathways between mental health and substance misuse services.

The liaison model will utilise existing resources within services. It will be delivered via the CPA process and therefore will not introduce resource intensive issues into service delivery. The model is a formal way of working within the CPA process for caring for people with a dual diagnosis.

Philosophy of Service

The overall philosophy of services should enable clients to maintain a therapeutic relationship where possible with the current key worker. We should avoid at all costs the situation where service users are continually referred between services and advised to address their mental health problem or substance misuse problem before the other can be treated. This does not support holistic care planning or whole systems intervention but rather focuses attention on and reinforces a parallel model of working. The strategy is actively discouraging this as it is not conducive to facilitated through care which is a critical element of service delivery. The respective service that is treating the service user can expect advice, support and guidance from its partner service to enable them to draw up a good quality care plan, which will meet the needs of the client. Exceptions to this would be those clients who are cared for under the Care Programme Approach whereby the mental health practitioner takes the role of care coordinator.

Given the chronic relapsing nature of substance misuse it is important that once a client has reduced their misuse, or become abstinent, we offer interventions aimed at the prevention and management of future relapses into problematic substance misuse or to mental health problems. The principles and strategies of 'relapse prevention' for substance misuse and the management of relapses to psychosis are recommended for this purpose. This approach aims to identify high-risk situations for substance misuse and rehearse coping strategies proactively. Attention should also be given to the redesign and development of contingency plans should the service user return to damaging substance misuse.

It is rare that clients pass through these treatment stages in a linear fashion. Some will enter treatment ready to begin change whilst others, having made progress, will relapse to earlier stages. It is also possible that a client will be in different stages at the same time in relation to their mental health problems and substance misuse. Flexibility and adaptation are essential skills for a workforce charged with providing treatment and care for this client group.

The liaison model remains the backdrop to effective collaborative working between services. In addition, we are proposing the formation of a 'virtual team' to enhance the liaison model. The purpose of the virtual team is to engender a sense of being a team that will proactively engage practitioners, it is a preventative model that will respond to clinical needs and does not necessarily require additional resources as it uses the CPA review process to case review. The virtual team will bring together practitioners who are working on the same cases to engage stabilise and treat a person with dual diagnosis. The frequency of meetings will be determined by clinical need and until such time that a service can withdraw support but still have the option of remaining in contact with the other service to provide consultancy support.

Main principles of this model:

- **Dual diagnosis is common** – increasing overlap between the two services as evidenced in literature. The message is therefore to expect substance misuse in psychiatry. Similarly, substance misuse services should be vigilant in detecting mental health related issues.
- **Don't create a super specialism** – every worker that a dual diagnosis client makes contact with is a dual diagnosis worker
- **Its good to talk** – communication and information sharing is the backbone of this model. Its importance is highlighted in the Report of the National Confidential Inquiry (Appleby, 2000)
- **Do not argue what is a primary problem** – Dual diagnosis clients present with multiple needs. They require expert and high quality response from both services. In a significant number of cases the chronology of the disorder is not clear. This model encourages joint assessment and joint working between the two services.
- **Collaboration not conflict** – best care for dual diagnosis clients can only be provided by collaboration and joint working between mental health and substance misuse services. Services provided concurrently can result in

higher chances of engagement as opposed to the serial or parallel model of service delivery. The liaison model is flexible enough to allow a service via consultation with the other services involved and to negotiate a case closure at an appropriate and relevant stage of the client's treatment.

- **Developing competencies** – a commitment to provide intensive and comprehensive training.

The liaison model moves away from the traditional 'no motivation – no service' argument. It also challenges the historical approach of expecting every client to turn up at the clinic and to have total abstinence as the only goal of treatment on offer. There is evidence that outreaching dual diagnosis clients and educating them regarding the potential harm done by drug use can result in their engagement and positive steps taken by the client to address their issues which in turn may have a positive impact on their mental health issues (Drake et al, 2001; Johnson 1997)

5.3 Roles and responsibilities of the liaison worker

Following the introduction of the liaison model of working all services will identify liaison workers to support the implementation of the liaison model. It is therefore necessary to state what the role and responsibilities of a liaison worker will be. It is anticipated that roles and responsibilities will be an addition to existing duties; much of these will already provide a liaison function under the care co-ordination remit. Resource and Capacity issues will need to be determined by each service.

The liaison worker will be responsible for developing and maintaining the interface between mental health and substance misuse services. The post holder will act as a specialist resource within their service area and carry a designated caseload focusing on the most complex cases with dual diagnosis. Each team will identify a liaison worker. The main tasks of the liaison worker are as follows:

- To respond to all requests for joint assessments of dual diagnosis clients either in community or inpatient services
- To attend allocation meetings, where appropriate and
 - Identify cases where joint assessment is needed
 - Advise mental health services on strategies that could be in place where substance misuse is causing difficulties in that clients treatment
 - Discuss substance misuse clients who may require mental health intervention or resources
 - Feedback on cases jointly worked
- Attend other meetings such as CPA reviews, section 117 etc as appropriate in order to maximize the face to face contact and the communication between the two services
- Create maintain and foster effective communication and working relationships between each service
- Contribute to the initiation and implementation of change and improvement to service and care delivery

- To actively engage in and foster multi disciplinary/multi agency co – operation and collaboration in respect of patient care and service development
- Contribute to the formulation and review of care pathways, policies and protocols
- Assess, plan, implement and evaluate the care for a designated caseload of clients
- To engage in clinical supervision
- Facilitate plan and contribute towards the teaching and training of other staff. This will be introduced later in the strategy.

5.4 National Policy and Clinical Frameworks

National policy and clinical frameworks for mental health and substance misuse provide best practice guidance to deliver planned and integrated local treatment systems.

Mental Health

- **National Service Framework for Mental Health**

The National Service Framework for Mental Health (1999/2004) focuses on the mental health needs of working age adults up to 65 and covers health promotion, assessment and diagnosis, treatment, rehabilitation and care and encompasses primary and specialist care and the role of partner agencies. The seven standards are realistic, challenging and measurable and are based on the best available evidence. They help to reduce variations in practice and deliver improvements for service users and their carers.

- **Care Programme Approach**

The Care Programme Approach was introduced in 1991 to provide a framework for effective mental health care. Its four main elements are:

- Systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services
- The formulation of a care plan which identifies the health and social care required from a variety of providers
- The appointment of a key worker to keep in close touch with the service user and to monitor and co – ordinate care
- Regular review and where necessary agreed changes to the care plan

The CPA was reviewed in 2006 in response to the drive to modernise mental health services and be more responsive to the needs and wishes of the people that use them. It outlined proposals to strengthen the role of the care co-ordinator, improve standards and training, enhance the way professionals work together and focus more on individual patient needs.

- **Mental Health Act 2007**

Services should be mindful of the implications and changes to clinical practice of the amended mental health act

- **Health of the Nation Outcome Scales (HoNOS)**

In 1993 the UK Department of Health commissioned the Royal College of Psychiatrists' Research Unit (CRU) to develop scales to measure the health and social functioning of people with severe mental illness. The initial aim was to provide a means of recording progress towards the Health of the Nation target 'to improve significantly the health and social functioning of mentally ill people'. The English National Service Framework recommends the use of HoNOS for Mental Health as does the working group to the Department of Health on outcome indicators for severe mental illnesses.

Development and testing over three years resulted in an instrument with 12 items measuring behaviour, impairment, symptoms and social functioning (Wing et al, 1996). The scales are completed after routine clinical assessments in any setting and have a variety of uses for clinicians, researchers and administrators, in particular health care commissioners and providers. The scales were developed using stringent testing for acceptability, usability, sensitivity, reliability and validity, and have been accepted by the NHS Executive Committee for Regulating Information Requirements for entry in the NHS Data Dictionary. The scales also form part of the English Minimum Data Set for Mental Health.

These are the 12 scales used to rate mental health service users of working age adults. They consider different aspects of mental and social health, each on a scale of 0-4. They are designed to be used by clinicians before and after interventions, so that changes attributable to the interventions (outcomes) can be measured.

The scales are as follows:

1. Overactive, aggressive, disruptive or agitated behaviour
2. Non-accidental self-injury
3. Problem drinking or drug-taking
4. Cognitive problems
5. Physical illness or disability problems
6. Problems associated with hallucinations and delusions
7. Problems with depressed mood
8. Other mental and behavioural problems
9. Problems with relationships
10. Problems with activities of daily living
11. Problems with living conditions
12. Problems with occupation and activities

Each scale is rated as follows:

0. No problem
1. Minor problem requiring no action

2. Mild problem but definitely present
3. Moderate to severe problem
4. Severe to very severe problem
9. Not known

For the purpose of this strategy, particularly scale 3 (problem drinking or drug taking) is highlighted for interest for identifying extent of problem drinking or drug taking as it is recorded by mental health services when completing the HoNOS scales.

Substance Misuse

The following can provide context of service response to dually diagnosed clients within drug and alcohol treatment services. Treatment Effectiveness within the Models of Care context is described in detail. Clinical effectiveness and outcome measures for alcohol services are similar.

- National Drug Strategy (1998)
- National Drug Strategy Update (2002)
- Models of Care for Substance Misuse (2002)
- National Alcohol Harm Reduction Strategy (2004)
- Models of Care for Alcohol Misuse (2006)

• Models of Care for Substance Misuse – Treatment Effectiveness

Models of Care (NTA, 2002) sets out a national framework for the commissioning of adult treatment for drug misuse in England. According to the Department of Health, Models of Care has the same status in terms of local planning and delivery as a National Service Framework for drug treatment.

As Models of Care encompasses the entire treatment journey incorporating specialist drug treatment provision and generic and non specialist interventions, the framework is illustrated here in detail as an example of the context in which to deliver care and treatment for the dually diagnosed via substance misuse treatment systems. This should be implemented alongside the Care Programme Approach, where appropriate.

Models of Care provides the framework required to achieve equity parity and consistency in the commissioning and provision of substance misuse treatment and care in England. It will support Drug Action Team's, Joint Commissioners and treatment providers in the development of an efficient and effective treatment and care system for drug misusers. Models of Care also provides specific guidance to support the co – ordination of drug and alcohol treatment and the effective management of care across drug misuse treatment services and general health, social and other care.

Models of Care advocates a systems approach to meeting the multiple needs of drug and alcohol misusers. This is achieved through the development of local systems that maximise the gains achieved through local drug and

alcohol treatment by having explicit links to the other generic health, social care and criminal justice services, including through care and aftercare.

Models of Care Update (NTA, 2006) is intended to build on the framework and concepts in Models of Care (2002) rather than totally replace them. It requires drug treatment commissioners and providers to have implemented the key tenets previously described in Models of Care 2002 including:

- The four tiered model of commissioning
- Local screening and assessment systems
- Care planning and the co – ordination of care
- Development of integrated care pathways

In addition to the above, there is now a greater focus required from commissioners and providers of drug treatment on improving client's journeys and the effectiveness of drug treatment.

The treatment journey is conceptualised into four overlapping segments, each with key objectives:

Treatment Engagement

- Assessment - assessment of need
- Motivation - assessment of level and stage of motivation to change
- Induction into treatment - clear explanations of the expectations of the service for the service user and likewise, how the goals of the service user may be met
- Care planning - the process of formulating and co – ordinating care

Drug Treatment Delivery

- Drug treatment providers need to deliver effective evidence based drug treatment interventions and need to work positively through the active fostering of positive therapeutic relationships
- There is a greater need to stem the increase of Blood Borne Virus and drug related deaths among the drug using population
- A greater emphasis is required on improving service users physical and mental health
- Children and carers of service users should also be considered during care planned treatment. The needs of the children of drug misusing parents also require greater attention (ACMD, 2004)

During this phase other work not just specialist drug treatment should commence to meet wider needs e.g. mental health, housing, healthcare and work and education.

Improving community integration

- Create better pathways and exits from specialist drug treatment including improved social support housing education and employment opportunities to maximise treatment gains

Improving treatment completion

- Drug related aftercare support e.g. accessing community support groups such as Narcotics Anonymous (NA)
- For stable individuals who do not need to continue in specialist drug treatment services there should be clear exit pathways into maintenance and monitoring in primary care settings with ongoing community integration and support

- **Models of Care for Alcohol Misuse (MoCAM) (2006)**

Similar to substance misuse, MoCAM develops the notion of:

- Integrated local treatment systems
- The tiered framework of provision
- Effective use of screening and assessment
- A central role of care planning in structured treatment
- The development of integrated care pathways to enhance pathways of care ('alcohol treatment pathways')

It develops the interventions and specific treatment options that could be commissioned for people affected by alcohol misuse and associated mental health issues.

It is expected that MoCAM will be used by Primary Care Trusts working in partnership with local commissioning groups and local service providers. The purpose will be to develop and build integrated systems to meet the needs of local people whose alcohol misuse is harmful and requires intervention or treatment.

5.5 Inpatient Detoxification and Residential Rehabilitation

A further consideration for management and treatment of substance misuse is to offer and provide detoxification and residential rehabilitation as a care plan option, where appropriate. This will fall within the care framework of Models of Care for substance misuse services.

Detoxification and residential rehabilitation should be a treatment option within an integrated care plan as outlined in Models of Care (NTA 2002), and more recently in Models of Care – Update, 2006.

The treatment effectiveness strategy, Models of Care – Update, 2006 recognises that Tier 4 interventions are increasingly important for a number of reasons:

- There is a high level of expressed need for residential provision from service users and carers

- Specialist inpatient interventions are necessary to provide the optimal local drug treatment system for clients with complex drug, alcohol and other health needs; those in crisis; those requiring medication stabilisation
- Inpatient detoxification followed by residential rehabilitation is the most effective way for drug and alcohol misusers to become drug/alcohol free, if they are motivated and this is the agreed objective
- There is evidence to show that detoxification in specialist substance misuse facilities is more effective than in general hospital or psychiatric wards which are associated with low success rates
- It is recognised that service users must have social support upon leaving rehabilitation units and secure adequate housing to maximise the benefits of treatment and to reduce risk of relapse and fatal overdose

Inpatient drug/alcohol interventions can offer:

- Medically supervised assessment
- Stabilisation on substitute medication
- Detoxification from illicit and substitute drugs/alcohol
- Specialist inpatient treatment for stimulant users
- Emergency medical care for those in crisis

Inpatient provision in the context of general psychiatric wards may only be suitable for some patients with co – morbid severe and enduring mental illness, but many such patients will benefit from a dedicated substance misuse inpatient unit.

There are several overlapping issues to consider when identifying residential rehabilitation as an appropriate care plan option. This is further made complex when there is psychiatric co – morbidity:

- Care Programme Approach – Ensuring that all treatment needs pre and post detoxification and rehabilitation respond to the requirements of the care programme approach process
- Care planning - Service User has undergone either community or inpatient detoxification. There should be minimal delay in commencing a rehabilitation programme following detoxification
- Community Care Assessment
- Identification of appropriate residential rehabilitation programme to serve individual needs
- Funding for inpatient detoxification and residential rehabilitation
- Care co – ordination
- Joint working between all provider services to ensure smooth transition from community services, inpatient services and rehabilitation services
- Community follow up following planned discharge on completion of programme
- Community follow up following disengagement/ self discharge from programme

5.6 Operational guidelines for collaborative working between substance misuse and mental health services

The four tiers are described below together with eligibility criteria for referral into substance misuse services by mental health services. A description of care co-ordination eligibility criteria for referral into mental health services by substance misuse services is also provided. Some basic guidelines are detailed below for establishing formal joint working protocols between services.

Tiers of Substance Misuse Services according to Models of Care

- Tier 1 - non specialist substance misuse services e.g. primary care, mental health services (any mental health service). However, not just the generic services themselves but rather the range of interventions that can be provided by generic providers
- Tier 2 - open access or 'street' level substance misuse agency
- Tier 3 - structured community treatment e.g. community alcohol/substance misuse service or structured day care
- Tier 4 - specialist planned inpatient detoxification or residential rehabilitation

Substance misuse severity and eligibility criteria: (for mental health services)

Severe:

- Physically dependent with risk of complex withdrawal symptoms if supply of drug interrupted
- High risk pattern of use and/or consequences on health, overdose, legal or child care risks
- Requires Tier 3 and possibly Tier 4 care

Moderate:

- Problematic use of substance(s); borderline/intermittent physical or psychological dependence
- Suspicion of risk of physical social or mental harm
- Requires specialist assessment and possibly specialist intervention (tier 2 or possibly tier 3)

Mild:

- Occasional, non dependent use of substance(s)
- Low risk pattern of use or consequences
- Unlikely to require specialist services (possibly tier 1 or tier 2)

It would not be unreasonable to expect mental health services to be involved in the care and treatment of service users identified as 'mild' *without* input from substance misuse services. This will be considered to be part of the work undertaken by Tier 1 services. However, it may be appropriate for liaison arrangements to be in place as and when the need for more formal joint working arises. By definition, a complex dual diagnosis case that would

indicate the need for formal joint working under CPA arrangements would be those service users identified as 'moderate' and 'severe'.

Care Co – ordination eligibility criteria (for substance misuse services)

This will be for clients with severe mental disorder, including personality disorder with concomitant use of drugs that present particular challenges to mainstream mental health services.

These challenges include:

- Impaired motivation to engage in attempts at therapy
- At high risk of severe self harm or suicide as assessed under CPA
- Recurrent readmission to hospital
- Anti social and chaotic behaviours – criminal and forensic activity
- Adverse impact of substance misuse on symptoms

Mental health eligibility criteria (for substance misuse services)

Levels of urgency:

Crisis - Serious risk to self or others; imminent marked deterioration in mental state.

High: - Risk to self or others; disturbance greatly affects normal functioning; enhanced CPA or Sec 117; severe or enduring mental illness or acute phase of illness.

Medium - Low risk to safety but daily function considerably affected; stabilization phase of acute illness; standard CPA.

Low - Capable of daily functioning; bereavement, relationship difficulties, reactions to life stresses or physical illness.

It would not be unreasonable to expect substance misuse services to be involved in the care and treatment of service users identified as 'low' and 'medium' *without* input from mental health services. This will be considered to be part of the work undertaken by Tier 2, Tier 3 and Tier 4 services. However, it may be appropriate for liaison arrangements to be in place as and when the need for more formal joint working arises. By definition, a complex dual diagnosis case that would indicate the need for formal joint working under CPA arrangements would be those service users identified as 'high' and 'crisis'.

In line with national guidance, community substance misuse team personnel cannot take CPA care co-ordinator responsibility. This is for these reasons:

- Community substance misuse teams use the Models of Care documentation developed specifically for substance misuse care, rather than the CPA mental health care documentation
- They (and their managers) cannot take clinical legal responsibility for care which is the responsibility of another team

- They cannot tell someone from another team e.g. a community mental health team what to do (though they can give advice)
- As they are not part of a community mental health team they do not have the resources and communication channels which are available to community mental health team personnel.

CPA care plan documentation allows more mental health care options than the Models of Care documentation. The latter does include complex care and contingency planning and risk management, but is tailored to substance misuse needs and services rather than mental health care. CPA therefore 'trumps' Models of Care when both services are required, though the Models of Care risk and care plan documents may still be useful

Referrals

When a referral is received, from any source, alcohol service/substance misuse/mental health services will decide on the following and make the necessary arrangements:

- Is the referral suitable for an initial assessment at either service
- Is the referral suitable for a joint assessment with both services

On receipt of referral either team will:

- Screen referral to ensure criteria met and relevant documentation included
- Determine whether referral needs to be internally prioritised
- Allocate a worker to undertake assessment via internal allocation process
- Assessment to be undertaken and if appropriate, this will be a joint assessment with the referrer
- Assessment to be feedback to the team
- Decision to be made regarding suitability for service

Initial assessment - It is estimated that this process will take at least three weeks to complete

If the client is suitable:

- Care co – ordinator hand over process to be initiated where indicated
- Treatment goals to be agreed, care plan formulated and individual discharge criteria to be agreed with originating care co – ordinator

If the client is not suitable:

- Liaison with referrer. This will include advice and support as appropriate. Copy of assessment to be given to referrer with feedback and rationale for non-inclusion in the service.
- No further action to be taken at this stage

Allocation

All assessments carried out jointly or otherwise will be discussed in the teams referral triage meeting

- If the case is allocated, the allocated worker will contact the client, the referrer and the other professionals involved
- If the case is not allocated, the assessor will feedback the decision of the multi disciplinary team to all parties as above. In some cases, a referral may be made to another service with the client's permission and the decision communicated to all parties as above.
- Some cases may be put on a 'pending' list for a specified time and the decision communicated to all parties as above. The service user should be monitored for changes during this time. If there is no ongoing contact, all parties should reach agreement and the case should be closed.

Joint working

Both staff will endeavour to engage the client into treatment. Joint working may include joint assessments, home visits, appointments at services, attending CPA, team meetings, panel presentations, ward round, section 117 meetings and regular communication. It is expected the care co – ordinator will take the lead especially in the severely mentally ill clients in setting up CPA reviews. The risk assessment and risk management plan will be completed with joint consultation with all the services involved.

Closure of cases

Where a client is showing signs of stability and the involvement of another service is no longer necessary then the two services involved should reach an agreement for one or more teams to close the case. For example, if a service user is doing well in a substance misuse residential rehabilitation placement, which could last for up to 6 months then it may be appropriate for mental health services to close the case.

Similarly, if a service user has either stopped or reduced the use of drugs to the level, which is stable or no longer interfering with their treatment of their mental disorder, substance misuse services may wish to negotiate closure with the mental health services. However, should the client relapse or is at high risk of relapse, the other service should respond to the request and reassess as appropriate.

Dealing with disagreements

From time to time a situation could arise where there is a disagreement regarding continued involvement or input from a service. If the disagreement cannot be resolved effectively, it should be referred to the appropriate team manager in the first instance, and if appropriate to the senior/service manager in the locality

Resources

Practitioners from both services will take joint responsibility in accessing other services for the client as appropriate to the care plan and their own remits. Where there may need to be a joint approach, or onward referral to another service then the care co – ordinator and the drugs worker will take equal

responsibility/measures to ensure this happens e.g. statement in support for housing application

Clients on inpatient wards

Effective management of clients on inpatient wards can additionally be achieved by also referring to the admission and discharge and delayed discharge integrated care pathways.

- All requests for assessment for dual diagnosis clients on acute admission wards will be treated as urgent referrals
- Service users admitted to acute psychiatric inpatient care in crisis, who subsequently turn out to have substance misuse problems and are not currently under substance misuse services care should be referred as soon as possible with valid consent.
- If the client can attend the substance misuse service, ward staff will take appropriate steps to ensure this happens
- If the client cannot attend the substance misuse service, e.g. the client is detained under the Mental Health Act or otherwise unable to leave the ward for any reason, they will be assessed by the liaison worker attached to the mental health service the client is admitted under.
- If service users with substance misuse problems who are currently under substance misuse services care are admitted out of hours, in mental health crisis, the substance misuse team should be notified as soon as possible the same or next working day. The substance misuse services, inpatient care team and the care co-ordinator can then reassess the patients care needs jointly, within an agreed timescale
- Prior to discharge a care co-ordination review would take place involving the service user and relevant people involved in the persons care and treatment and an agreed care plan relevant to the discharge period would be drawn up.

Prescribing

- Opiate substitute prescribing – If there is a community mental health team care co-ordinator and care is shared between substance misuse and mental health services, the responsibility for any opiate substitute prescribing should be clearly agreed between the Consultants for the two teams, incorporated into the patients written care plan and implemented according to the prescribing guidelines of the substance misuse services. Any doctor prescribing for the patient must see the patient on a regular basis.
- Other prescribing – if there is a mental health service care co-ordinator, treatment should be provided by the mental health service unless agreed otherwise. Advice and guidelines on prescribing for patient with substance misuse problems e.g. on community detoxification are available from the substance misuse service

Ending shared care between substance misuse and mental health services

- Patients discharged due to non contact or withdrawal of consent – if high risk patients under shared care between mental health and substance

misuse services fail to maintain contact with one service but remain in touch with the other, it is essential to notify the other service of intention to discharge before discharging to the care of the other, as the team which remains in contact has a clearer idea of the current risks. There must be a commitment to support the partner team who remain in contact, which includes prioritised reassessment should the patient consent to this.

Rehabilitation

- Access to residential (substance misuse) rehabilitation follows joint assessment including a comprehensive substance misuse assessment (which is required to access community care funding for substance misuse)

5.7 Integrated Care Pathways

An integrated care pathway (ICP) describes the nature and anticipated course of treatment for a particular client and a predetermined plan of care. A system of care should be dynamic and able to respond to changing individual needs over time. It should also be able to provide access to a range of services and interventions that meet an individuals needs in a comprehensive way.

The requirement to have clear 'pathways', 'liaison' or 'links' between teams delivering mental health and substance misuse services is identified within the Dual Diagnosis Policy Implementation Guidelines (DoH, 2002). These integrated care pathways have been developed with the intention to deliver those expectations and improve the understanding and co-ordination of care for dual diagnosis service users within Lancashire Care Trust. They are designed to sit alongside operational policies and procedures and are supported by both mental health and substance misuse services. The pathways have also been developed in consultation with service users and carers.

Audit

Following implementation of the care pathways, they will be subject to audit and evaluation. The dual diagnosis lead will facilitate the audit activity; this will be supported by the liaison workers from the appropriate services. The findings and recommendations will be disseminated throughout the Trust.

Pathway Standards

The Intergrated Care Pathways have been based on the following evidence based, agreed best practices

- Dual Diagnosis Good Practice Policy Implementation Guidelines (DoH, 2002)
- Care Programme Approach standards
- Performance reporting
- Sound caseload management principles

- Clinical risk management as defined by Care Programme Approach
- Stepped care approach to managing common mental health problems
- Choice and good practice in regard to Advanced Directives
- Multi Disciplinary Team working as defined under Care Programme Approach
- Department of Health – ‘For the Record’ principles
- Guidelines on clinical management and dependence (DoH Prescribing Guidelines)
- Models of Care for substance misuse (2002)
- Mental Health National Service Framework (1999; 2004)
- Mental Health Minimum Data Set
- Substance Misuse Minimum Data Set

Integrated care pathways should be delivered for service users with a dual diagnosis for the following reasons:

- Integrated care pathways ensure consistency and parity of approach
- Service users often have multiple problems which require effective co – ordination of treatment
- Several specialist and generic service providers may be involved in the care of a service user simultaneously
- A service user may have continuing and evolving care needs requiring referral to services providing different interventions over time

Elements of Integrated Care Pathways

Integrated care pathways should contain the following elements:

- The service user and carer at the centre of the care planning process
- A definition of the treatment intervention provided
- Aims and objectives of the treatment intervention
- A definition of the client group served
- Eligibility criteria (and priority groups)
- Exclusion criteria and contraindications
- A referral pathway
- Screening and assessment processes
- Development of agreed treatment goals
- A description of the treatment process or phases
- Co – ordination of care
- Departure planning, aftercare and support
- Onward referral pathways
- The range of services with which the intervention interfaces

These elements are designed to provide clarity – what the service user can expect treatment services to provide and the roles and responsibilities of the service within the integrated care system and towards the individual service user.

The dual diagnosis care pathways describe the links between specialist mental health services and substance misuse services in respect of the protocol of delivery of care and treatment. Any dually diagnosed or potentially dually diagnosed service user with specialist needs arising from both mental health and substance misuse is likely to come into contact with two separate services. Referrals between those two services will involve the use of distinct care frameworks – Care Co-ordination (CPA Care Management) in Mental Health and Models of Care in Substance Misuse Services.

It is essential for the sake of continuity for the service user and carer and for clarity of communication between practitioners of the respective services that the different frameworks sit comfortably together and support a continuous process for the delivery of assessment, care planning, treatment and review. (Drake and Noordsy, 1994; Ward and Applin, 1998; Anon, 2002; Anon, 2000). It is important to note that in keeping with national guidance, any dually diagnosed patient with care needs for specialist mental health services receives the care and treatment within the mental health care co-ordination framework (Health Advisory Service, 2001). In order to facilitate more detailed understanding of the needs of people with dual diagnosis, it is proposed that more detailed assessment of these particular needs is introduced and for this to be recorded in a systematic way across services, linked to the care co-ordination arrangements. This means that the mental health care co-ordinator must retain responsibility for the care of any service user to whom the term ‘dual diagnosis’ applies.

Guidance from the Department of Health in 2002, ‘Mental Health Policy Implementation Guide – Dual Diagnosis Good Practice Guide’ emphasised that substance misuse among those with mental health problems is usual rather than exceptional; it advised that it is necessary to consider its presence in all assessments undertaken by mental health services.

The guidance suggests that different approaches will be necessary in order for the following components to be captured in the assessment process:

- Detection and screening
- Specialised assessment
- Risk assessment

The Health Advisory Service (2001a) recommends that:

- The assessment of all individuals with mental health problems in general psychiatry actively considers the potential role of substance misuse
- Specialist substance misuse treatment providers identify and respond to problems of combined psychiatric illness and substance misuse.

Treatment approaches will need to be as varied as the individuals presenting with co-morbid mental health and substance misuse problems. There is therefore no specific treatment approach, as each person will need to be assessed individually and the treatment approach will need to be tailored to the individual needs of each client. Key elements in treatment will include:

- Engagement of clients into services
- Retaining clients in active care
- Providing interventions which facilitate motivation to change
- Addressing the relapsing nature of a chronic condition through relapse prevention work
- Facilitating re-integration into the community with appropriate support

The pathways outlined in this strategy identifies the ways in which service user needs are to be identified and responded to by means of holistic assessment, followed by appropriate care planning and review.

Care Pathway Aims and Objectives:

- Adhere to mainstreaming by working closely with all mental health services and substance misuse services
- Improve adherence to treatment by promoting engagement
- Minimise risk by promoting harm reduction strategies and interagency communication
- Stabilise mental health and/or substance misuse and therefore reduce the need for hospital admissions
- Motivate service users to work through the cycle of change
- Help service users maintain any changes made and provide relapse prevention strategies
- Improve service users overall social functioning, well being and quality of life
- Offer support and education to carers
- Improve access to mental health services for those already known to substance misuse services
- Provide direct links between mental health and substance misuse services
- Offer evidence based interventions, e.g. Motivational Interviewing, Cognitive Behaviour Therapy, Dialectical Behaviour Therapy
- Establish and maintain links with statutory and non statutory organisations and provide advice and support as appropriate

These will be achieved by:

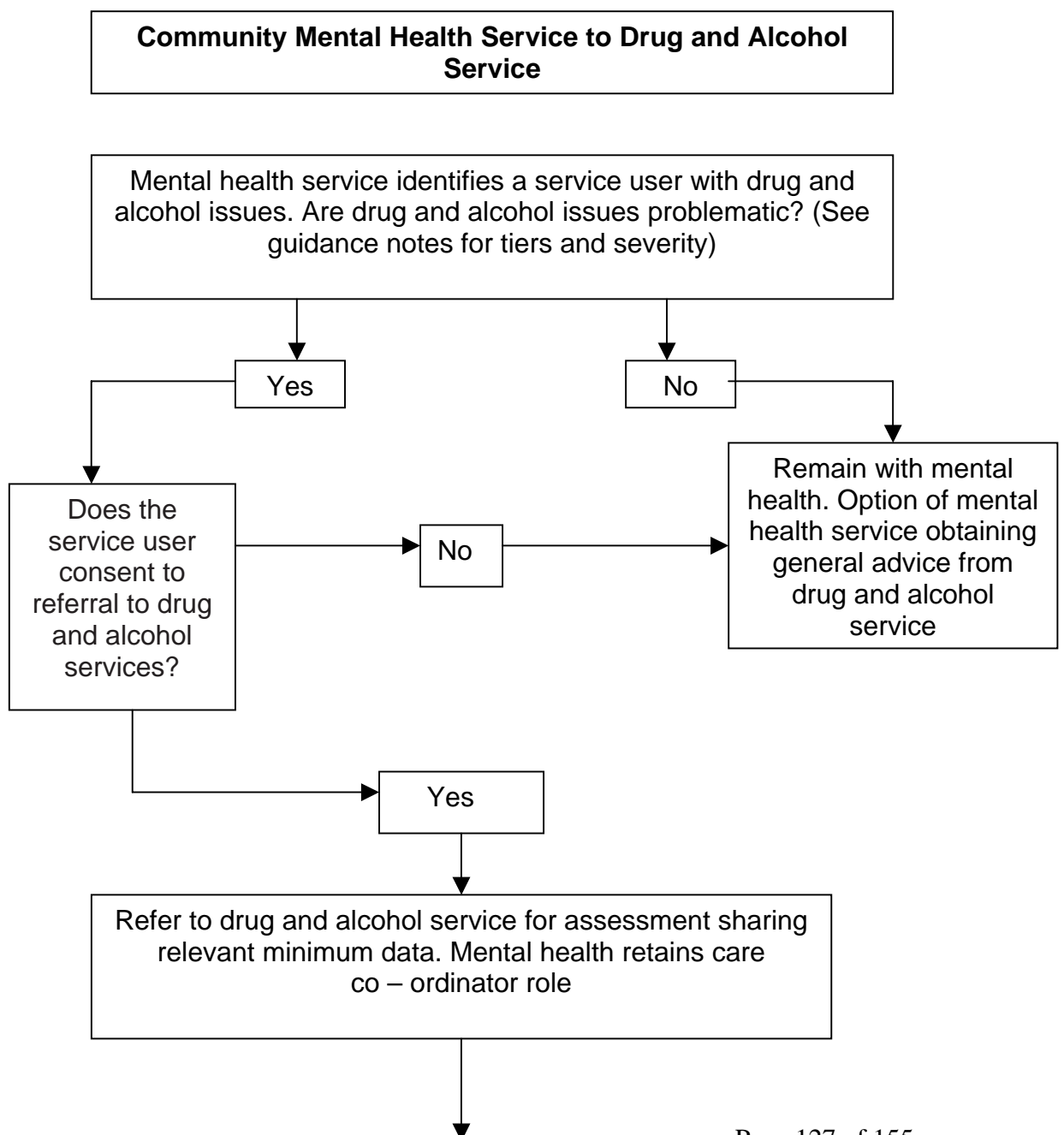
- Establishing a therapeutic alliance, encouraging an open and trustworthy rapport
- Undertaking a thorough holistic assessment of substance misuse and mental health needs and risks
- Providing individual packages of care which address both substance misuse and mental health needs

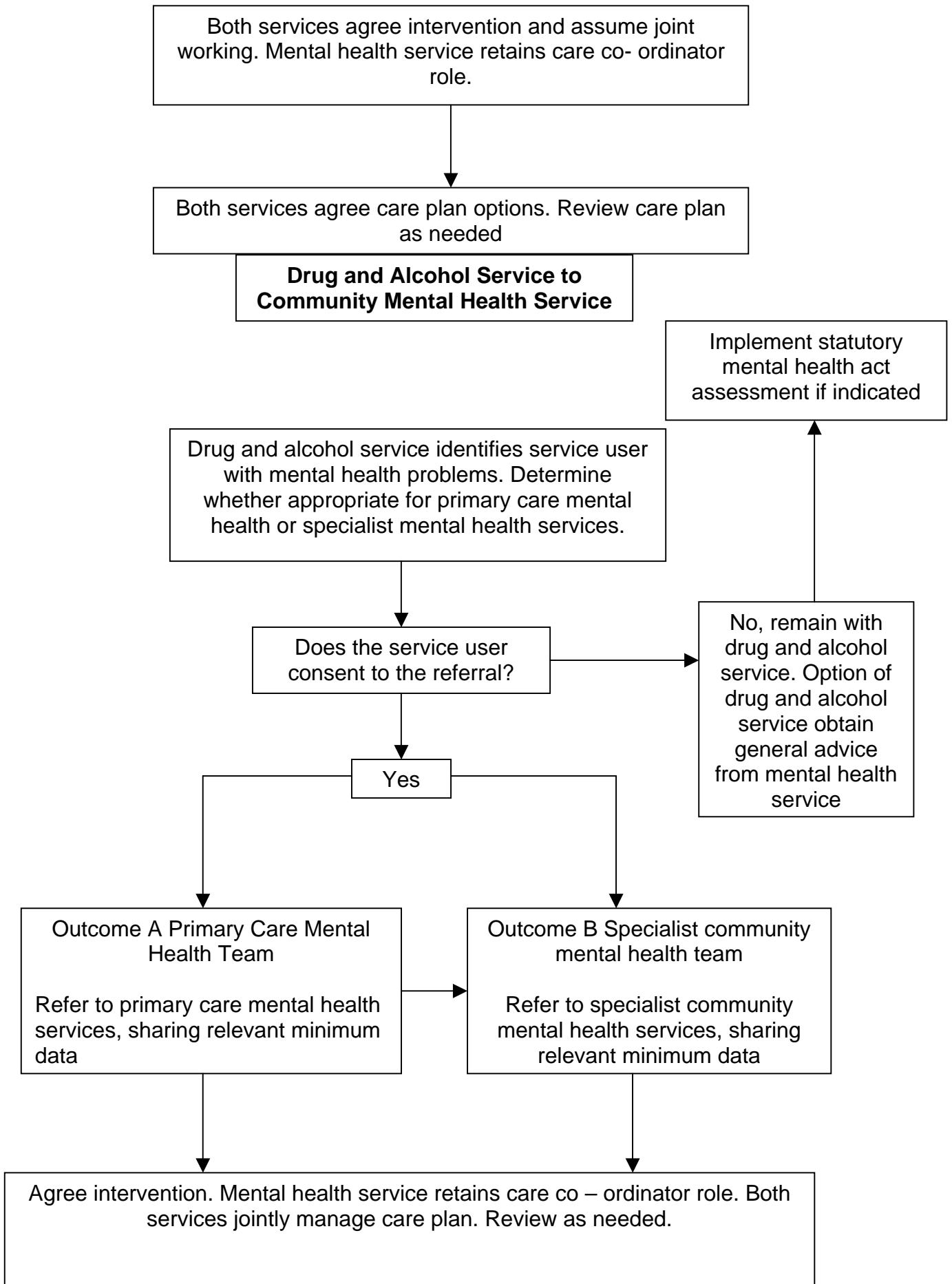
- Maximising client potential and increasing choices by encouraging and motivating changes in behaviour
- Maximising client choices with regard to treatment options
- Assisting access to a variety of services in the community that improves well-being, self confidence and self esteem e.g. services that provide structured daytime activity, educational and employment opportunities
- Assisting in access to wider harm reduction services e.g. hepatitis testing, HIV testing and needle exchange services
- Provide harm reduction education e.g. blood borne virus transmission, safer injecting techniques, early warning signs of psychosis, medication management (psychiatric and substitute prescribing) urine testing
- Provide complementary therapies as appropriate
- Provide short term interventions, possible group work as appropriate
- Provide one to one interventions and support

In summary, the dual diagnosis care pathway should:

- Provide clear information so that service users and carers can make informed decisions
- Ensure there is a sound evidence base for effective interventions based on practice and on current research
- Develop managed networks so that providers can collaborate to deliver services jointly
- Evaluate the benefits of more collaborated services
- Set standards for the support treatment and care for all those affected by dual diagnosis
- Set priorities for future service development, involving commissioners, service providers and users and carers in this process
- Address the training and development needs of the workforce

Dual Diagnosis Care Pathways are diagrammatically presented below.





**DUAL DIAGNOSIS CARE PLAN
OPTIONS**

Care plan options if service user has
mental health issues and problematic drug
and alcohol misuse

Mental Health Care Co – ordinated by mental health care co –
ordinator, with drug and alcohol advice/support or liaison

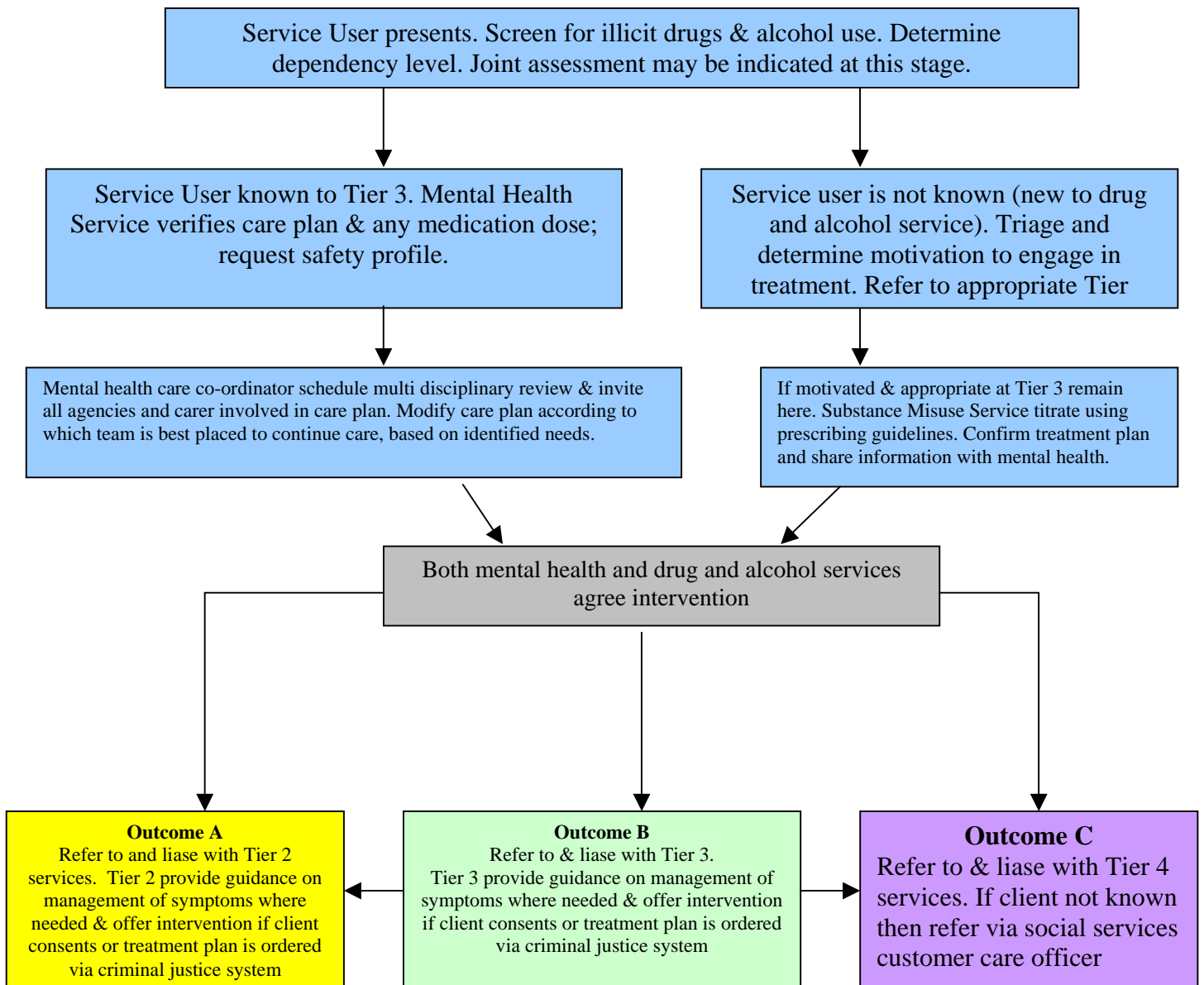
Assertive Outreach Care (refer to AOT care pathway) **OR**
Crisis Resolution/Home Treatment (refer to CR/HT pathway) or any
other specialist mental health service

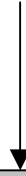
Drug and Alcohol Care Co – ordinated by substance misuse service
with mental health advice/support or liaison

Fully Shared Community Based Care If both drug and alcohol and
mental health problems are complex, CPA is the dominant care
framework. Care plan co – ordinated by mental health care co –
ordinator with specialist input from drug and alcohol services

→ Drug and alcohol service refer for inpatient detoxification/ stabilisation and/or residential rehabilitation

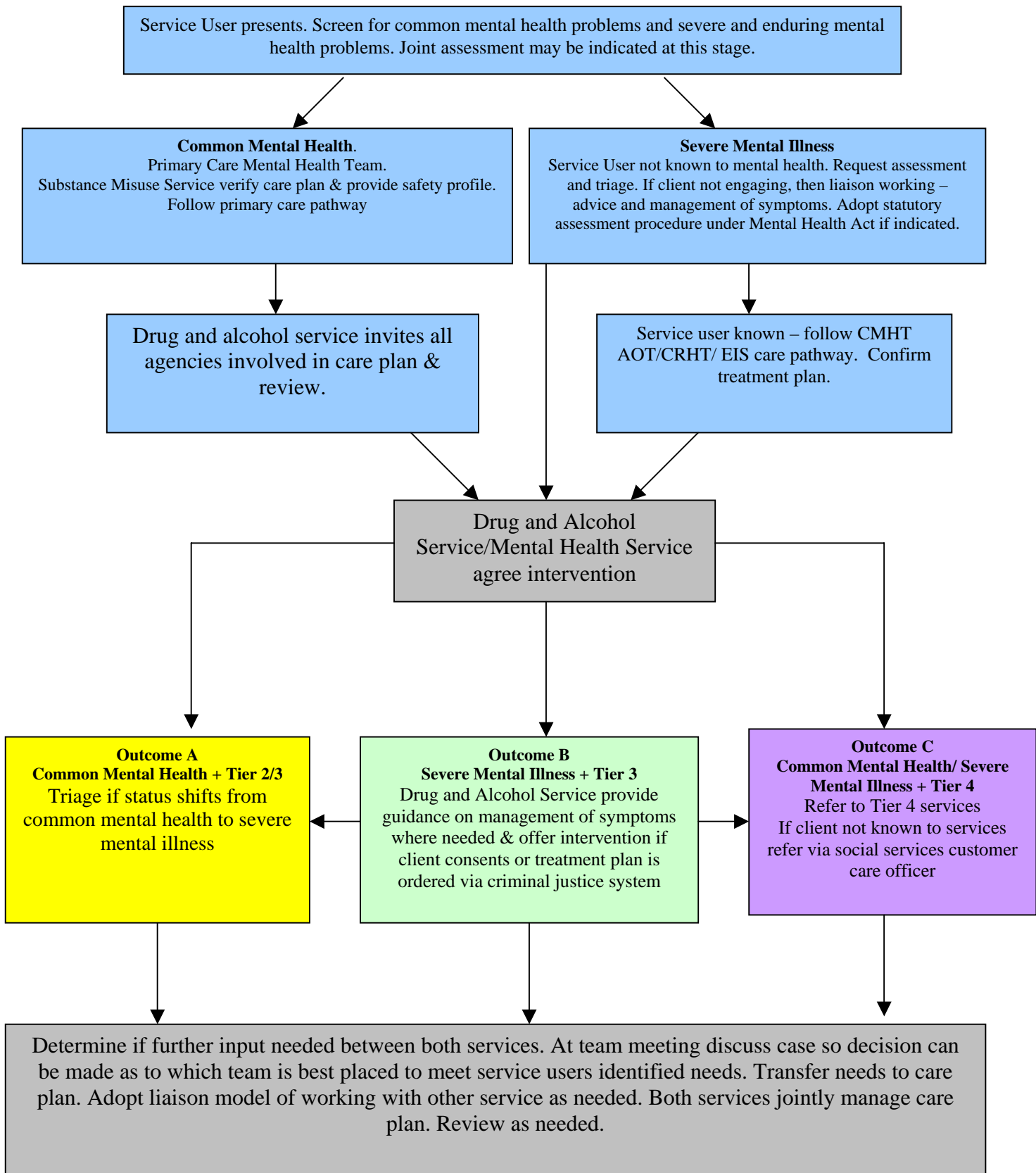
Community Mental Health Services (Tier 1) to Drug and Alcohol Services (Tiers 2, 3 & 4) Integrated Care Pathway





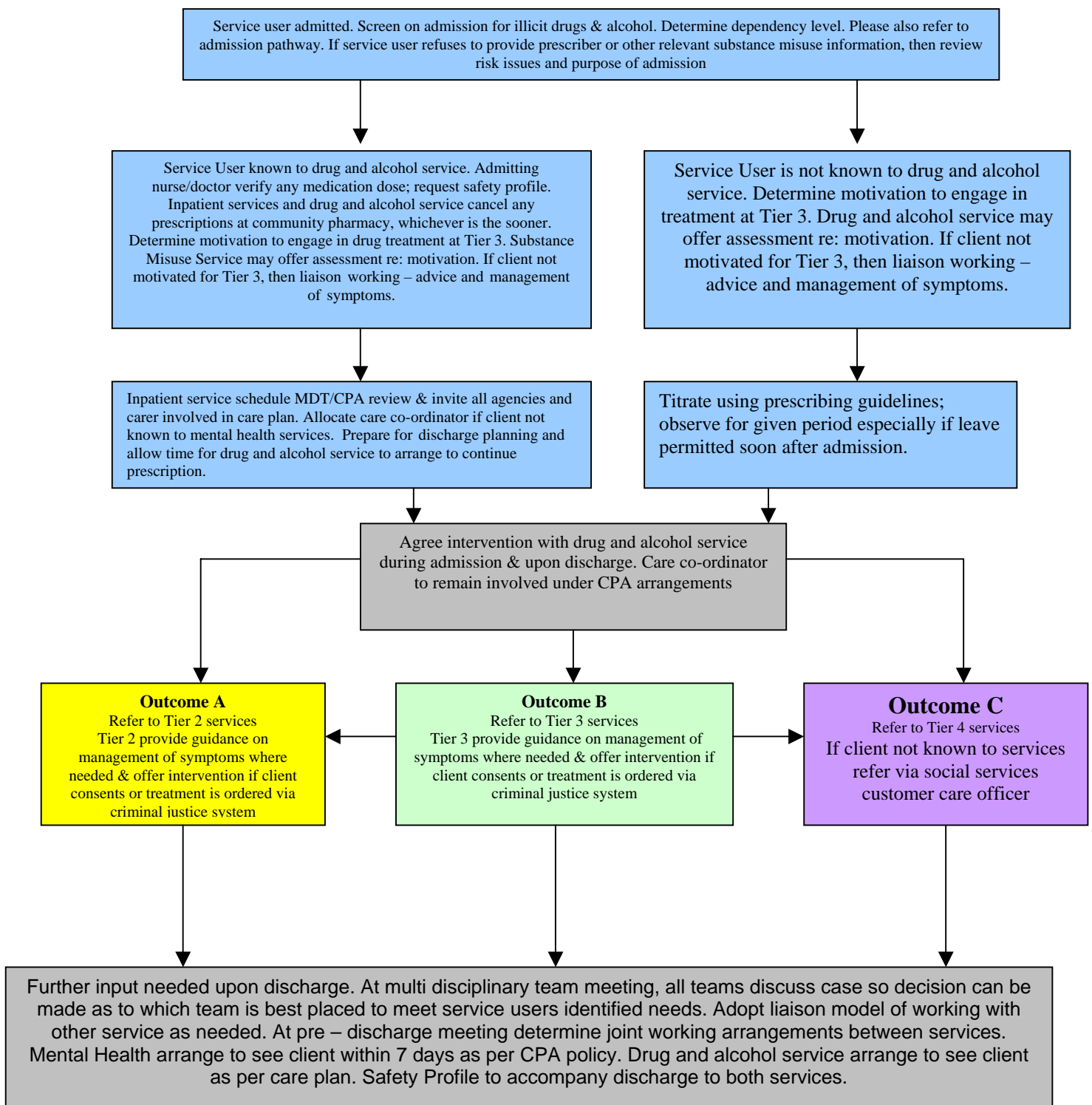
Determine if further input needed between both services. At team meeting discuss case so decision can be made as to which team is best placed to meet service users identified needs. Transfer needs to care plan. Adopt liaison model of working with other service as needed. Both services jointly manage care plan. Review as needed.

**Drug and Alcohol Services (Tiers 2, 3 & 4)
to Community Mental Health Services (Tier 1) Integrated Care Pathway**



Pathway guidance	Information Contained within	Variance Tracking
<p>Known Service User Defined as someone who is currently receiving drug and alcohol service and/or mental health services</p>		
<p>Guidance</p> <ul style="list-style-type: none"> • Receiving/presenting service process referral • Joint care plan to be based on identified needs • Best practice would be that patient had been discussed or reviewed by team prior to referral to other team • Safety profile completed/requested/received from both sides highlighting current risk issues 	<p>Continuation sheet (e-CPA) Drug & alcohol records Health & Social care needs assessment Safety profile Crisis & contingency care plan</p>	
<p>Or Person is not known, Someone who is not currently receiving drug and alcohol service and/or mental health services</p>		
<p>Guidance</p> <ul style="list-style-type: none"> • Receiving/presenting service process referral • Determine risk issues by dialogue with substance misuse service/mental health service • Both complete assessment if indicated • If not known to mental health service, CMHT to identify prospective care co-ordinator at point of referral or within 3 working days, if mental illness identified • Safety profile completed highlighting current risk issues 	<p>Continuation sheet (e CPA) Drug & alcohol records Health & Social care needs assessment Safety profile Crisis & contingency care plan</p>	
Agree intervention		
<p>Guidance All services will consider the following areas prior to agreeing an action</p> <ul style="list-style-type: none"> • Risk profile • Use of Mental Health Act where indicated • Mental Health follow up • Drug and alcohol service input • Any existing strategies e.g. friends, family services <ol style="list-style-type: none"> 1. Commissioning services 2. Signposting 3. Housing 4. Voluntary sector, 5. GP or 6. routine drug and alcohol services input 	<p>Drug & alcohol records health & social needs care assessment Safety profile Crisis & contingency care plan</p>	
<p>Agree outcome Outcome A – Tier 2/3 intervention Outcome B – Tier 3 intervention Outcome C – Tier 4 intervention</p>		

Inpatient Mental Health Services (Tier 1) to Drug and Alcohol Services (Tiers 2, 3 and 4) Integrated Care Pathway



Pathway guidance	Information contained within	Variance Tracking
<p>Known Service User Defined as someone who is currently receiving drug and alcohol services and admitted to acute care</p>		
<p>Guidance</p> <ul style="list-style-type: none"> • Admitting nurse record/process admission • Admission to be based on relapse indicators as recorded on crisis plan • Best practice would be that patient had been discussed or reviewed by Consultant 24 hours prior to referral to drug and alcohol services • Safety profile completed highlighting current risk issues • Safety profile from drug and alcohol services requested & received highlighting current risk issues 	<p>Continuation sheet (e-CPA) Drug/alcohol assessment Safety profile Crisis & contingency care plan</p>	
<p>or Person is not known, Someone who is not currently receiving drug and alcohol services but has been assessed by acute care / screened by a Care co-ordinator/ within the previous 24 hours of admission.</p>		
<p>Guidance</p> <ul style="list-style-type: none"> • Admitting nurse record/process admission • Determine risk issues by dialogue with drug and alcohol services • Acute care to complete assessment • If not known to mental health, Community Mental Health Team to identify prospective care co-ordinator at point of referral or within 3 working days, if appropriate. • Safety profile completed highlighting current risk issues 	<p>Continuation sheet (e CPA) Drug/alcohol assessment Safety profile Crisis & contingency care plan</p>	
<p>Agree intervention</p>		
<p>Guidance Acute care, drug and alcohol services and mental health services will consider the following areas prior to agreeing an action,</p> <ul style="list-style-type: none"> • Risk profile • Use of Mental Health Act where indicated. • Mental Health follow up • Any existing strategies e.g. friends, family services <ul style="list-style-type: none"> 1. Commissioning services 2. Signposting 3. Housing 4. Voluntary sector, 5. GP or 6. Routine drug and alcohol services follow up etc. 	<p>Drug/alcohol assessment Safety profile Care plan CPA (daily record)</p>	
<p>Agree outcome Outcome A – Tier 2 intervention Outcome B – Tier 3 intervention Outcome C – Tier 4 intervention</p>		

5.8 Specific groups within the population



Our strategy aims to provide equity and priority of access to assessment and treatment to specific groups as outlined in the Dual Diagnosis Good Practice Guide. (Department of Health (2002) Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide)

These groups are:

- Young People
- Homeless People
- Offenders
- Women
- People from Ethnic Minorities

We are in a fortunate position to have the following positive practice examples in the Trust:

- **Young People**

Lancashire Care Trust Early Intervention Service (EIS) is an example of working with young people who may be experiencing first episode psychosis and related issues. The service, which operates extended hours has recently reviewed and updated its operational policy. The service is for:

- People aged between fourteen and thirty-five with a first presentation of psychotic symptoms
- People aged fourteen to thirty-five during the first three years of psychotic illness
- People meeting specific criteria indicating they are at high risk of developing psychotic illness

Offering an age-appropriate service is important in achieving engagement and satisfaction with services, and avoiding additional stigma that may arise from services being inappropriate to age. It means responding to the variation in age-related needs that occur across the wide fourteen to thirty-five age ranges. There are particular psychological needs associated with younger clients, for example, identity and separation issues and feelings of being indestructible. Younger clients may have different priorities e.g. placing a high value on social and peer group acceptance. They have particular needs from services e.g. for attention to confidentiality, agreement of arrangements for communication with families, more frequent need for family interventions. They may be deterred from using services because they perceive services as similar to school and to other agencies with negative associations. For adult practitioners there will be a wide range of new youth-related issues and agencies to learn about.

The service interfaces with other services as needed including, primary care; crisis and home treatment teams; inpatient care; provision for people with personality disorder and forensic services. Younger clients will be admitted through Child and Adolescent Mental Health Services (CAMHS) pathways, with EIS liaising closely with CAMHS teams, and aiming – as for adult clients - for effective shared care in the least restrictive environment for the shortest possible time. Where admission is needed, the CAMHS pathway is through The Junction.

- **Homeless People**

Health for the homeless is an innovative approach to treatment. It creates opportunities for the team to reach traditionally hard to reach populations and offer treatment for their presenting health and social problems. The team have strong links via care pathways with all partnerships within their locality including other homeless services, mental health, housing, general practitioners and all primary care services.

The team is a nurse led service providing comprehensive assessment and treatment to those who find it difficult to access mainstream services. A 'one stop' approach is adopted which attracts potential clients in through the door in order to facilitate further access into mainstream services by a mixture of mentorship, liaison and advocacy. The focus is on assessment, an interactive experience which encourages the service user to focus on their own needs both in the future and the here and now.

Service user comments:

“They empower you to empower yourself”

“Befriending was the most important part for me“

“Time to talk, flexibility and a choice of where to be seen helped me stay treatment“

“Medication is the last resort, they helped me make choices for myself“

“Laid back approach, not rushed or under pressure“

“Reliable, do what they say“

The people who access this service in the majority of cases, present with multiple problems. They have experience of mainstream services but have not managed to stay in treatment because of the nature of their lifestyle on the streets. They are more likely to use services inappropriately because of their situation, for example using A & E departments, rather than appropriately using a General Practitioner.

The service is a start of a process of stabilisation through assessment, treatment, liaison and preparation for referral into mainstream services. The service helps 'fast track' service users into other appropriate services to ensure that treatment meets the users individual needs. The team adopt a flexible approach and assertively outreach anyone who is having difficulty meeting appointments.

- **Offenders**

Lancashire Care Trust provides considerable treatment interventions and support for service users with a dual diagnosis that may bring them into contact with various criminal justice agencies. Within mental health services, the mentally disordered offenders services signpost a service user to substance misuse services and within substance misuse services, the Trust enjoys partnership working with Addaction, who has recently taken over criminal justice work and provides treatment interventions via the Drug Intervention Programme.

There is also a dedicated secure unit, within the Trust, Guild Lodge which provides secure mental health services for the more complex service users who require a secure environment. This includes inpatient care and community outreach support for people with a mental disorder coupled with a history of offending or related behaviour. Many of these patients will have a dual diagnosis. The primary aim is to offer high standards of assessment, care, rehabilitation and treatment for individual's mental health needs and to respond to these needs while safe guarding service users, staff, public and the community.

Prisons within Lancashire will have their own systems of referral between mental health in-reach teams and the CARATs services for substance misuse (Contact Assessment Rehabilitation Aftercare and Throughcare). Release from Prison will follow the CPA process where indicated, for prisoners released under the care of community mental health services.

- **Women**

There are liaison midwife services throughout the Trust and acute mental health inpatient units are gender sensitive in accordance with the national policy implementation guidelines for developing women's services.

Dual Diagnosis service provision for women should consider specific issues:

- Women may hide their support needs due to fear of labelling and stigmatisation
- As a consequence, women may present later to specialist services
- Women may not feel confident in services due to fears of risk regarding child protection issues
- They may be leading chaotic lifestyles
- Co – dependency may be an issue
- There may be specific issues relating to women working in the sex industry

- **People from Ethnic Minorities**

Burnley Pendle and Rossendale substance misuse service is one example of how a service may cater to the needs of people with dual diagnosis from ethnic minorities. The geographical area has large Pakistani Indian and Bengali communities; the drug of choice of service users from these communities accessing the service is heroin and cocaine. Whilst professional standards for example cultural sensitivity are always adhered to, as they

would be for any service user, the service is currently in negotiation with local councillors and the Lancashire Council Of Mosques to identify increased access to the service. Anecdotally, service users fear breach of confidentiality in close-knit communities. Clients will often seek advice for extended family members. Whilst there remains some obvious gaps of joint working with local mental health services this is a very positive example of joint working with community groups who are not from specialist services. It is hoped this whole systems approach may address the varying needs of service users; each having a positive effect on another within a specified care plan.

Specific consideration for support and treatment for people from ethnic minorities should include the following:

- Support needs may be hidden due to fear of labelling and stigmatisation
- Communities may be in denial of problems due to cultural beliefs
- Communities may need support in accessing appropriate services
- Language barriers may distract individuals from accessing appropriate services
- Awareness raising strategies in mental health issues
- Awareness raising strategies in substance misuse issues
- The appointment of Community Support Workers should facilitate positive engagement of people from ethnic minorities with a dual diagnosis into services.

5.9 Training and Workforce Development

Education and training for those who provide services for people with dual diagnosis is another underpinning element of this strategy and needs to cover both generic and specialist skills. Training needs to cover core skills and issues such as awareness and attitudes. As well as training staff in generic core skills there is a need to equip specialist providers to deliver broader services.

The development and implementation of the Dual Diagnosis Strategy will indicate the need for training staff that work in both the substance misuse and mental health sectors. Continuing Professional Development which incorporates reflective practice and evidence based practice will be key to ensuring that services and practitioners are adequately equipped to support service users who present with dual diagnosis issues. In turn, this will ensure that service users whole needs are met. Delivery of training will be a multi agency multi disciplinary process, thereby incorporating a whole systems approach to health and social care.

Support to deliver the training programme should be provided by the training departments of all partner agencies, following training needs analysis.

Training can be broadly identified at three levels as outlined in the Knowledge and Skills Framework:

- Formal training sessions
- Reflective Practice
- Secondment opportunities

Formal training

Formal training sessions can be delivered at basic and advanced levels. Some of the basic topics will include:

- Drug awareness
- Mental health awareness
- Dual Diagnosis awareness

These awareness sessions can be for practitioners who have no knowledge or skills based experience of the above

For those practitioners, who regularly are in contact with service users with a dual diagnosis (liaison workers), the following can be offered:

- Motivational Interviewing
- Harm Reduction
- Relapse Prevention
- Prescribing/Substitute Prescribing

It will also be essential at the outset to deliver training on each sector's service framework as this will underpin any learning and provide the context for service delivery. These are, namely, Models of Care for substance misuse and the National Service Framework for mental health services.

Each topic will have specified course objectives and be evaluated by the attendees. Feedback will be given to the trainers. Each service will have an identified liaison worker.

Reflective Practice

The aims of these sessions are to provide ongoing peer support, in addition to clinical supervision and can be delivered on a quarterly basis.

Secondments

Services can also consider secondments of staff to enhance and inform each other's practice. These secondments are designed to be short term i.e. one week to enable an overview of how the other service operates. This can be achieved on non consecutive days, to allow flexible secondment arrangements. Secondees will be matched, where appropriate, to their equivalent professional grade to the area in which they will be seconded. Continuous service delivery with minimal disruption to service users will be key. Thus, it is proposed that a service is in secondment with only one staff member at any one time.

Secondments will be on a voluntary basis and can be identified from learning needs identified in clinical supervision and contribute to appraisal/performance management. The team manager of the host service will act as the line manager and may elect a senior member of their team to act as clinical supervisor where appropriate and possible. Team managers from both services will remain in contact with each other as necessary throughout the secondment period.

Managers from both services will be setting broad aims and objectives and the secondee will be expected to define their own aims and objectives and to be able to demonstrate how this will enhance their own clinical practice in their own area of work.

The overall aim is that it will help deliver the following points:

- Facilitate staff having basic knowledge of dual diagnosis
- Monitor the implementation of the care pathway for dual diagnosis clients
- Encourage staff to take ownership of the pathway as they will recognise the benefits
- Encourage better communication between the services
- Inform evidence based practice
- Support better multi disciplinary team working

Training will offer all practitioners and those who are regularly supporting this client group the opportunity to develop practical skills and theoretical knowledge regarding co – morbid substance misuse and mental health

problems. It will provide evidence based practice examples that are informed by the latest advances regarding this practice area.

On completion, practitioners will be able to conduct informed drug and alcohol assessments and mental health assessments, identify problems in recognising and managing dual problems and describe treatment interventions and how they can be implemented within a care plan.

There are several planned and ongoing service and workforce developments that will support and influence positive practice. These include:

- Implementation of the liaison model of working
- Implementation of integrated care pathways to ensure needs led service provision for all users.
- Audit of transfer from inpatient to community mental health services with particular emphasis on service users with complex needs whose problems are compounded by drug and alcohol misuse
- Audit of referral and liaison pathways between mental health and drug and alcohol services
- Provision of GP Shared Care Services for substance misuse service users
- Provision of Assertive Outreach, Crisis Resolution & Home Treatment and Early Intervention Services to provide alternatives to inpatient care and additional support for service users with complex needs focusing on the Recovery Model.
- Provision of Primary Care Mental Health Workers, Support Time and Recovery Workers and Gateway workers to provide additional support to secondary mental health services

Recruitment of service users and carers

Service users and carers will be actively encouraged to assist with training. Feedback on training will be sought regularly through local service user and carer groups and there is also user and carer representation within strategy development. They have also contributed to the development of care pathways.

The training will ensure the following values and principles from The Ten Essential Shared Capabilities Framework (2004):

- **Working in partnership** - Encourage practitioners to treat service users as equals and put their needs first irrespective of the values of the treatment provider
- **Respecting diversity** – incorporate the equality and diversity principles of each organisation
- **Practising ethically** – evidence based training which can be monitored via clinical governance

- **Challenging inequality** - training will focus on values and participants will be encouraged to reflect on their own practice before trying to promote social inclusion for service users
- **Promoting recovery** – training will be multi agency so participants can benefit from colleagues experience and knowledge and become more aware of other services that can support service users in their recovery e.g. supported employment, self help groups with the ultimate goal of reduced or no contact with statutory services. Thus allowing service users to live their lives to the full without focusing on their illness.
- **Identifying people’s needs and strengths** - training will focus on treating service users as individuals with varied lifestyles and experiences. Participants will be encouraged to get beyond a service users diagnosis to discover their aspirations, talents and interests.
- **Providing service user centred care** – training will focus on providing needs led services. Participants will be encouraged to offer holistic care.
- **Making a difference** – training will be delivered as a process and not as an event. Training outcomes will be evaluated against course objectives to measure impact. Practitioner attitudes and values can also be measured before and after training; this can feed into research interests within the Strategy.
- **Promoting safety and positive risk taking** – a multi disciplinary approach to training will encourage participants to consider therapeutic risk taking as part of a holistic package of care developed by the multi disciplinary team, service users and carers.
- **Personal development and learning** – as all the training will be evidence based, participants will have the opportunity to increase their knowledge and skills. As liaison workers will be identified within each service area, and as the liaison model of working is introduced and implemented there may be opportunities for these practitioners to become future trainers. Development of specialist clinical skills combined with abilities to impart knowledge and skills to others will ensure that individual practitioners have their Continuing Professional Developments needs met.

In addition to delivering against the Ten Essential Shared Capabilities training will also ensure compliance with the Service Delivery areas of the DANOS Standards:

- **Help individuals access substance misuse services**
 Recognise indications of substance misuse and refer individuals to specialists
 Relate to and interact with individuals
 Support individuals to access and use services and facilities
 Promote the equality, diversity, rights and responsibilities of individuals
 Interact with individuals using telecommunications

Promote choice well being and the protection of all individuals

- **Support individuals in difficult situations**
 - Support individuals who are distressed
 - Support individuals who are substance users
 - Contribute to the prevention and management of abusive and aggressive behaviour
 - Contribute to the protection of individuals from harm and abuse
 - Assess and act upon immediate risk of danger to substance users
 - Support individuals to deal with relationship problems
 - Provide services to those affected by someone else's substance use
 - Contribute to assessing and act upon risk of danger, harm and abuse
 - Work in collaboration with carers in the caring role
 - Relate to families parents and carers

- **Develop practice in the delivery of services**
 - Reflect on and develop your practice
 - Make use of supervision
 - Contribute to the development of the knowledge and practice of others
 - Support and challenge workers on specific aspects of their practice

- **Educate people about substance use, health and social well being**
 - Raise awareness about substances, their use and effects
 - Facilitate learning through presentations and activities
 - Facilitate group learning
 - Develop and disseminate information and advice about substance use, health and social well being

- **Test for substance misuse**
 - Test for substance misuse

- **Assess substance misusers' needs for care**
 - Carry out screening and referral assessment
 - Carry out assessment to identify and prioritise needs
 - Carry out comprehensive substance misuse assessment

- **Plan and review integrated programmes of care for substance misusers**
 - Develop implement and review care plans for individuals
 - Contribute to care planning and review
 - Assist with the transfer of individuals between agencies and services

- **Deliver healthcare services**
 - Prescribe controlled drugs for substance users
 - Prepare to and administer medication to individuals and monitor the effects
 - Supply and exchange injecting equipment for individuals
 - Support individuals to undertake and monitor their own health care
 - Undertake treatments and dressings related to the care and lesions of wounds

Undertake physiological measurement
Support individuals through detoxification programmes
Dispense medicines and products
Supervise methadone consumption
Carry out brief interventions with alcohol users
Prepare prescriptions for controlled drugs
Enable individuals to take their medication as prescribed

- **Deliver services to help individuals address their substance use**
Counsel individuals about their substance use using recognised theoretical models
Help individuals address their substance use through an action plan
Counsel groups of individuals about their substance use using recognised theoretical models
- **Help substance users address their offending behaviour**
Help individuals address their offending behaviour
Enable individuals to change their offending behaviour
- **Support individuals' rehabilitation**
Help individuals to access employment
Help individuals to access learning, training and development opportunities
Enable individuals to access housing and accommodation
Support individuals to manage their financial affairs

As the development and implementation of the strategy is progressed, there will need to be consideration of the mandatory and optional training needs of practitioners. It is advisable however, that as research advances in this clinical area are regularly highlighted as examples of good practice, that training is updated annually to match this progress. This should be offered to all service areas particularly as integration and joint working becomes more formalised. This can be progressed via the Trust's Education Strategy Group to ensure training for dual diagnosis is embedded within the workforce development agenda.

6 SWOT Analysis

Services are currently operating on an ad hoc basis with regard to effectively meeting the needs of dual diagnosis service users. This may be reliant on the individual skills of the practitioner, the informal joint working practices which are currently adopted between services and perhaps the lack of opportunity to fully utilise skills gained in training programmes. Nevertheless, there are anecdotally examples of good joint working. Unfortunately, there are no joint training events or joint team meetings. However, these should be encouraged as a means of supporting joint working.

Currently, throughout the Trust, the following services operate:

- Substance Misuse Services
- Alcohol Services
- Community Mental Health Teams
- Assertive Outreach Teams
- Crisis Resolution/Home Treatment Teams
- Mental health acute inpatient units
- Psychiatric Intensive Care Units
- Mental Health Liaison Teams
- Support, Time and Recovery services
- Early Intervention Services
- Secure services
- Forensic services
- Primary Care Mental Health Teams
- Mental Health Prison In-reach Teams

Almost all services are integrated teams consisting of multi disciplinary professional groups. Some of these services most notably assertive outreach, early intervention and home treatment/crisis resolution services operate extended hours.

Lancashire Care NHS Trust Dual Diagnosis SWOT Analysis

<p style="text-align: center;">Strengths</p> <ul style="list-style-type: none"> • Dedicated Lead in post to lead on the development and implementation of the dual diagnosis strategy • Strategy has commitment from the Lancashire Drug and Alcohol Action Teams and the various Primary Care Trusts in Lancashire • Service Transformation Programme will ensure dual diagnosis remains on the agenda • Dual Diagnosis Strategy implementation underway in Blackburn with Darwen • Services have a wealth of experience in both mental health and substance misuse. This is a strong position in which to develop a co-ordinated approach when caring for those with a dual diagnosis, via adoption of the liaison model • There are examples of good practice e.g. care pathway work being undertaken • Common risk assessment used by both sectors 	<p style="text-align: center;">Weaknesses</p> <ul style="list-style-type: none"> • Lack of clarity of approach • Episodic engagement or lack of engagement leading to deterioration • Lack of training and training opportunity which is consistent and meaningful • Lack of commissioning of services specifically for this client group
<p style="text-align: center;">Opportunities</p> <ul style="list-style-type: none"> • Learning opportunity following implementation of dual diagnosis strategy in Blackburn with Darwen • Learning opportunity following involvement in the MIDAS research trial • To influence the development of other strategies that collaborate with the dual diagnosis strategy • To develop a co-ordinated and comprehensive training package to enhance the skills and knowledge base of practitioners • To develop an effective liaison model for dual diagnosis service users • To inform commissioning plans and lead the development of more comprehensive services 	<p style="text-align: center;">Threats</p> <ul style="list-style-type: none"> • No user and carer representation • No dedicated medical representation • Competing demands and target driven areas of work • Service criteria which currently excludes dually diagnosed clients

7 Conclusions

Dual diagnosis is often perceived as a complex, untreatable condition. Staff do not always feel equipped with the necessary skills to care for the dually diagnosed and the strategy is likely to fail if we do not provide adequate training and introduce service re-design. Improvements need to be made in relation to in-house training for frontline staff with regards to the issue of dual diagnosis and risk management. Cross fertilisation is required in order that staff within mental health teams and substance misuse services acquire skills. The liaison model will be an amalgamation of existing strengths structures and skills and should include:

- Assertive Outreach
- Close Monitoring
- Supportive Accommodation
- Optimism
- Longitudinal perspective
- Effective Care Co-ordination
- Models of Care Co-ordination

In order to ensure that models are applied, structures need to be put into place, which can be used to help ascertain the expected stage and movement of the client within services. It is our collective responsibility to provide an evidence-based, effective service.

We can no longer continue to provide inadequate services that do not meet the needs of this disenfranchised client group. More effective ways of managing this client group can prove to be beneficial therapeutically and extremely cost effective. The liaison model would support this required response provided that sufficient training is provided.

There should be a named Consultant and named staff within every mental health team and substance misuse service with care programme approach and models of care fully embedded within the respective services. The care programme approach is a well-recognised approach to engaging patients in treatment and coordinating their care. This system should be utilised to its maximum to ensure that dual diagnosis clients do not fall between the gaps in services.

Co-morbidity services must form part of the Local Implementation Plans. They should be established as a long-term part of the system. Our actions must include collaborative working and planning with partners and commissioners to achieve the strategic aims. It is imperative that there be a coordinated approach to commissioning involving both mental health planners and commissioners and the substance misuse joint commissioning group. This will move away from the current position of commissioning and service development in total isolation from each other.

Any improvement and development of services will require a radical change in attitudes, including true and respectful collaborations, with properly trained

workforces. The development of high quality services and the maintenance of these services will depend upon a continuous improvement approach within the Clinical Governance Framework of the Trust and its partnership agencies.

Dual Diagnosis is a difficult condition. The introduction of the various recently commissioned services has improved the response offered to service users and their carers. But these services have also presented fresh and difficult challenges for those involved in the treatment care and support of those affected by dual diagnosis. It is acknowledged that the health and social care treatment and support systems are not currently operating at optimal or consistent level. There may be circumstances beyond the control of providers and commissioners. The response from service users and carers may be equally dissatisfying to all concerned. Nevertheless, what we do have is a broad range of services providing specific and specialist interventions. This is a strategy that acknowledges and addresses the complex issues associated with Dual Diagnosis. This is a very strong position from which to move forward.

This strategy is ambitious and comprehensive and it requires a commitment to deliver what it proposes. If the strategy succeeds it will have contributed to reducing health inequalities. It will have set in place modern efficient and patient centred services. It has been developed with the help of those working in the field, service users and carers and members of targeted working groups. It is referenced to the various policy implementation guidelines that aim to modernise services and the needs of service users.

We believe this strategy provides a basis for developing comprehensive dual diagnosis services in ways that can make a real difference. We have set out a new model for services based on clear standards. This will improve access to information and services and end the inequities that have existed for too long.

To summarise key aspects of service delivery, where improved clinical outcomes can be measured:

- There are currently a range of services that provide support and treatment to people with a dual diagnosis.
- There are service development plans via the Service Transformation Programme that can provide refined support and treatment
- The needs of people with dual diagnosis through existing mental health and substance misuse services can be addressed through the liaison model of working.
- People with common mental health issues and substance misuse can receive appropriate and responsive care. This will include triage into specialist mental health services when needed
- People with severe mental illness and substance misuse can receive appropriate and responsive care. This calls for a longitudinal approach and a willingness to be flexible in ways that will complement the recovery model.

- What is needed from treatment is that it is efficient, evidence based, provides a range of services, matches treatment to presenting need, is responsive to evolving need and is seamless and co-ordinated both within and between services.
- This calls for a change to current working practices between and within services.
- All specialist teams must be adequately resourced and trained
- Commissioning must be in line with strategy objectives

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