

# The Norfolk Dual Diagnosis Strategy - The Inclusive Model of Integrated Care

Recommendations for change within  
current treatment provision





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2005***

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## 1. Background

The model of service delivery has been formulated using a number of sources; namely Department of Health guidance documentation, an evaluation of models being carried forward within other areas across the country as well as national prevalence, and an in-depth study of local prevalence, current treatment provision, and provider and service user/carer feedback.

The Dual Diagnosis Development Worker has had to present/update, throughout the entire process, to the Steering Group, the Local Implementation Teams for mental health and the County-wide Treatment Implementation Group. Coupled with this has been the requirement to attend and update other membership groups as and when requested to do so.

Consequently the developing strategy has been accountable at all times to providers, service users, carers and commissioners, and has adapted and evolved through constant consultation with the above parties. This is not a prescriptive document and it is intended that it be viewed as a working model for services to tailor according to locality-need.

The Dual Diagnosis Development Worker was brought into post on the 1<sup>st</sup> December, 2003 in a time-limited position due to end June 2005. It has been the sole remit of the post holder to develop a strategy for change in accordance with the Department of Health's dual diagnosis document as well as local prevalence and need. It was considered appropriate upon commencement of the post that the emerging strategy would look to include younger, adult and older peoples services, as well as the wider provider groups, voluntary and statutory services and service user and carer organisations and advocacy networks.

Running concurrently with this piece of work has been the formulation of a prevalence and incidence needs assessment, commissioned by Norwich Primary Care Trust and undertaken by the University of East Anglia. The Incidence and Prevalence of Dual Diagnosis (IPoDD) will study dual diagnosis individuals within city and rural Community Mental Health Teams and drug and alcohol services and also look to identify whether there are any differences in prevalence in either geographical setting. The findings should be ready for dissemination by the end of 2005. This is important, not only for local interest and information, but also nationally as there are very few, if any, actual needs assessments undertaken in rural or sparsely populated settings. The model discussed within this document refers to perceived prevalence and need as identified by all the aforementioned organisations.

### Department of Health guidance

On the 1<sup>st</sup> May, 2002 the Department of Health published the Dual Diagnosis Good Practice Guide showing current policy and best practice protocols within the field of co-morbidity. Due to the lack of sufficient evidence-based knowledge and coupled with the intricate and complex needs experienced by this client group, care, treatment and diagnosis was perceived to be difficult.

One of the main problems highlighted was the number of agencies concurrently involved in the care of the individual; these agencies often had very different agendas and staff working in isolation were seen to feel unsupported and inexperienced. Similarly the fragmented care received by the individual could make them more prone to relapse and/or disengaging from services altogether and their immediate needs could go un-attended.

In an attempt to address these issues the guide made a number of recommendations to enable services to work collaboratively and for staff to be supported and confident in their working practice.

#### *County-wide definition*

It was recommended that a County applicable definition be agreed by all relevant parties, reflecting local patterns of need and use and clarifying the target group. Although the guidance document was specifically written with a dual diagnosis taken only to constitute those with severe and enduring mental illness; the ability to tailor this definition for local 'use' enabled the end term to be much more provider and service user led.

#### *Mainstreaming*

This can be defined as delivering care within an integrated model of treatment through mental health services. In allocating the lead to mental health this did not mean that they then were responsible for all those individuals coming under the remit of a dual diagnosis. On the contrary, it was recommended that through identifying locally agreed care pathways and a definition, substance misuse agencies would be able to continue to treat people with less severe mental health problems with support and joint working with mental health services; and that this working arrangement should be reciprocal.

Integrated care, the concurrent provision of both psychiatric and substance misuse treatment by one staff member or clinical team in a single setting, was seen to be viable through the formulation of agreed integrated care pathways, joint working and clear care coordination protocols between all agencies involved. In order for this to be an achievable aim, guidelines around information sharing and confidentiality would need to be addressed and implemented; and data collection needed to be clarified for future accountability/auditing purposes.

#### *Training strategy*

The guidance document recommended that all staff, including medical staff, should receive regular and relevant training, clinical supervision and clear policies and procedures supported by senior management. The training should form part of a rolling programme thereby keeping abreast of new developments in the field and ensuring new staff were effectively trained and supported in their post. The training should be made available to both the voluntary and statutory sectors and to the wider provider groups as a whole. It was also felt that any training should look to incorporate three main elements: interagency training, theoretical and skills based training and practice development and supervision.

### *Specific groups*

A number of groups were identified as warranting further attention under any new strategy for change. These were young people, homeless people, offenders including prisoners, women, the ethnic minorities and older people

Within the context of the Guidance document itself, Dual Diagnosis was taken to mean severe and enduring mental illness and problematic substance misuse, as already mentioned; personality disorder was not to be automatically excluded. Finally any substances referred to was taken to mean legal and illegal drugs including alcohol and solvents. Tobacco was not included.

### Other relevant strategic documents

In 1999 the National Service Framework for Mental Health (NSF) was published by the Department of Health. Dual Diagnosis was discussed within the strategy by way of:

“People with co-morbidity pose a major challenge for services. Their problems and needs are the responsibility of a range of services such as primary care, specialist services, drug and alcohol services, probation or housing associations. However, none of these has the statutory responsibility or the expertise to deal with the full range of difficulties presented by these people. Their behavioural problems and reluctance to engage with services adds to the challenge. Consequently, this group tends to be stigmatised and responsibility passed across agencies. The needs of people with a dual diagnosis should be met within existing mental health and drug and alcohol services.” NSF 1999

The document went on to recommend:

“...the need for stronger links between drug and alcohol services and community mental health services as part of an overall suicide prevention strategy.” NSF 1999

“Assessments of individuals with mental health problems, whether in primary or specialist care, should consider the potential role of substance misuse and know how to access appropriate specialist input.” NSF 1999

Coupled with this has been the recent publication of the National Service Framework for Mental Health (NSF) – Five Years On (Department of Health 2004) that states Dual Diagnosis as “...the most challenging clinical problem that we face.” The report goes on to suggest that to date there has been little improvement in the areas of commissioning and joint planning for this client group with only 17% of all LITs claiming to have a dual diagnosis strategy. NSF 2004

In 2002 the National Treatment Agency (NTA) for Substance Misuse published Models of Care (MoC) as a framework within which services could look to.. “promote quality, efficiency and effectiveness in drug misuse services in England.” MoC 2002

Within the context of this document it was recommended that for dually diagnosed clients service provision must be based on local prevalence and need. Coupled with this however was a suggested model of service delivery; that of the joint liaison/collaborative approach. Under this model the care of the patient is jointly

managed by substance misuse and mental health services, insuring a dual responsibility by both providers as well as a utilisation of the skills and expertise of each.

Other recommendations identified within MoC for individuals with a dual diagnosis were:

“...services need to have close collaboration with other providers involved in the care of the patients and carers. Those involved in the care of the patient need to identify a named care coordinator...” MoC 2002

“(assessment should)...obtain a comprehensive picture of needs and problems through an ongoing process which is multi-professional and multi-agency in approach....services need to ensure that ongoing assessment and care plans change according to need.” MoC 2002

### National prevalence and other models of service delivery

In the United Kingdom it has been estimated that a third of all psychiatric patients with serious mental illness will have some form of substance misuse problem/history; and within drug and alcohol services up to half of the clients will have some form of mental illness. Alcohol misuse is seen to be the most widely recognised ‘drug of choice’ with up to 40% of those with an alcohol disorder presenting with a concurrent mental health problem. This high incident rate can be contributed to, in part, the closure of the larger psychiatric hospitals and an increase in the number of cheap and varied substances within the community. Being able to compare research undertaken within the UK was, however, seen to be problematic for a number of reasons; namely the ever changing definition of dual diagnosis from region to region, the criteria for mental illness and substance misuse within different areas, the types and availability of certain substances within different regions and finally, that those individuals with complex needs were often perceived to be more ‘troublesome’ and chaotic and so were often deliberately excluded from any research studies.

However, a number of generic findings can be identified with this client group. Increased rates of violence and suicide, criminal and risk taking behaviour, homelessness, non-compliance with medication or treatment and little or no support mechanisms; all amounted to dually diagnosed individuals being some of the most vulnerable and needy persons within society. The resource impact and revolving door issues they posed on all sectors of provision was far greater than for the majority of the remaining population.

Nationally it can also be noted that there are some common ‘gaps’ in service provision and training. Duplication of assessments, disjointed joint working procedures and ad-hoc low quality referral and discharge protocols as well as a lack of knowledge and some subsequent prejudice on the part of staff. Service users and their carers received limited information and perceived current waiting lists and service opening times to be unrealistic and inflexible.

In an attempt to address these issues, and also, for some, in direct response to the Department of Health’s guidance on Dual Diagnosis, it can be noted that other models being taken forward nationally are all seeming to advocate the integrated approach to treatment. Their respective definitions ultimately affected what clients were specifically eligible and the existing provision as well as prevalence

within their own area ultimately affected how the model could look to adopt/develop an integrated service.

## Dissemination of the Needs Assessments and Training Needs Analyses

In order to try and ascertain perceived prevalence within the County a number of needs assessments were disseminated to all appropriate providers of care. These constituted tiers 1-4 substance misuse services (voluntary or statutory), inclusive of those for both the young and older populations, Primary care up to all mental health provision (again both voluntary and statutory) inclusive of those for the young and older populations; as well as housing advisory services, housing providers, social services, drop-in services, direct access hostels, the criminal justice system en masse including the prisons and the anti-social behaviour teams, youth services from schools to employment, advice and advocacy services and the YOTs. Employment services for the mentally ill or ex-offenders were also sourced and service user networks and advocacy groups were asked to contribute. Finally, where they existed, services specific to the needs of women or the ethnic minorities were also approached.

A service user/carer needs assessment was disseminated across the County asking questions around opinions on current provision. Individuals were asked how they felt their current care was being managed, where they felt gaps in provision existed and if they would benefit from more education, support or training around complex needs.

A service provider needs assessment was also given to all the organisations named above. This looked to identify the perceived prevalence within the County and within that the perceived drug of choice and main mental health diagnoses. Services were asked how they currently managed these clients and what problems they encountered. Subsequently they were also asked what joint working took place and how successful it was seen to be. Finally they were asked where they perceived the gaps in provision/treatment lay and how this affected their working day and the care of the individual concerned.

A Training Needs Analysis was also cascaded down to services and the staff contained within. This asked specific questions around training currently received/offered in-house and externally. How appropriate was the training and did new staff received dual diagnosis training as part of their induction. Finally services were asked what training they needed or felt would further enhance their day to day management of clients with complex needs. Clinical training was also identified, where it existed.

All the findings from the three assessments were then split up into the known mental health LIT clusters within the region; that of Central, Eastern and Western. This would allow any geographical differences within the region to be highlighted. The results were also broken down by the different provider 'groups' i.e. housing, the criminal justice system, employment services etc. This would enable us to identify if there were any marked differences between the services themselves in terms of incidence, prevalence, treatment options and training.

## 2. Findings from the Needs Assessments and Training Needs Analyses disseminated County-wide

### Service user/carer feedback

The majority of service users who completed the forms were male, white-British and aged between 25-38. For the Central and Western clusters within the County Heroin was the main drug of choice with Alcohol prevailing in the East. Within all the clusters most service users considered themselves to have a main mental health problem of depression – whether clinical or manic.

The average time with any one agency across the County was 2.58 years with service users perceiving themselves to have 1.6 keyworkers at any one time. In light of this some 65.8% felt their quality of care was good to excellent and only 34.2% felt it was fair to poor. Over half of all service users from the Central and Western clusters felt their needs were being met and only the East, in the majority, were unhappy with their current situation.

The main needs identified as not being met across the County were mental health, housing and the knowledge demonstrated by GP's. Boredom, access to residential rehab and after-care were also identified.

The main gaps in service provision across the County were seen to be support out of hours, access to mental health services and GP knowledge; as well as just having someone available to talk to and/or listen.

Finally over half of all service users across the County felt that they possessed a good personal support network but that their carer would benefit from further education and training around their dual diagnosis. Some 41% County-wide felt that this was the case although support and guidance was identified as opposed to actual training.

### Service provider feedback

The Central cluster appeared to have the highest prevalence across the County, but it is the biggest 'area' and thus more agencies were able to be sourced for information.

County-wide the estimated prevalence was some 33.8%. The most prevailing age range was 25-31 years but 18 years up to and including 52 years were also strongly identified (this could be due to when a person chooses to present to services, when their diagnosis is identified; or it could mean that there may be little correlation between age and the on-set of a dual diagnosis – possibly more reliant on a persons socio-economic status at any one given time).

All three clusters perceived a higher prevalence amongst men, numbering some 75%, with the prevailing ethnic group being that of White-British. Other identified ethnic groups, namely Black British, Black African, Mixed Race, Afro-Caribbean and Mediterranean, only made up some 8% of the total ethnic mix.

The main drug of choice from a providers perspective was Alcohol with Heroin coming in second place although poly-drug use was seen to be common place. The main mental health diagnosis, County-wide, was Schizophrenia although a multitude of diagnoses including depression and anxiety were identified.

Over 61% of all service users appeared to have had some form of criminal justice intervention and dual diagnosis clients en-masse exhibited more risk-taking behaviour than their counterparts comprising mainly of self-harm and attemptive suicide. Over 50% of the reported dual diagnosis cases were not working and all were either residing in rented accommodation, a hostel or were homeless. When asked how the care of these individuals was currently managed by services both integrated and serial care were similarly identified; the main gaps to effective integrated care were seen to be liaison/collaboration with other services as well as specifically accessing the most appropriate treatment for the client at that time. An awareness of available provision and referral procedures/routes as well as a lack of training around this field were also seen to inhibit treatment. Capacity within services to undertake joint assessments, attend all reviews as well as provide adequate support and supervision was identified as a current presenting issue amongst the statutory services; with a 'fear' that should more individuals be expected to be mainstreamed through the statutory providers, there will quite simply not be enough staff to cope with demand. Best practice was also highlighted comprising of multi-disciplinary teams across the County, especially within youth services, shared care schemes with the GPs, some CPA reviews and service user involvement.

## Training Needs Analyses

Over 50% of all providers from the homelessness/housing sector, offenders including prisoners, youth, services for women and older peoples services felt that they were not equipped to work with dual diagnosis clients.

All the services bar mental health cited mental health provision as a challenge to treating these clients and all services including mental health identified a lack of knowledge and appropriate training as another barrier. Personality disorder was also cited as a 'problem', especially amongst the housing providers, as was the threatening behaviour and risk these clients can pose.

When asked what training was currently offered, over 50% of all substance misuse and housing services and over a third of services for offenders claimed to receive none. These providers were specifically from Tier 1, the voluntary sector and the generic agencies, direct access hostels.

When asked who delivered training it would appear that those coming under the remit of the three Trusts were fairly well served; outside of this training was on a very ad-hoc basis, purely down to individual agencies - their resources and the emphasis they placed on providing training specific to mental health, substance misuse and/or dual diagnosis. Access to publications, the internet, a library etc varied within provision depending on whether an agency was voluntary or not, how many staff it had, the resources it had available; but again, those services coming under the remit of the three Trusts were well served.

All providers felt that in the majority of cases most new staff members did not receive dual diagnosis training and the majority of providers also cited a lack of clinical training available.

Consequently when asked what training services felt would be of benefit, all services wanted all training. Points to note, however, are training specific to integrated care pathways, joint working, CPA, risk and risk assessment, substance misuse and mental health awareness and a better working knowledge

of personality disorder. Brief interventions and motivational interviewing were seen to be of benefit to all staff as well as a more in-depth knowledge of local available provision and referral pathways in to treatment.

Providers wanted training made available to as many staff as possible but tiered so as to be appropriate and of value. Coupled with this was the desire for training to be off-site and multi-disciplinary so as to enhance networking amongst agencies/across provision.

The main barriers to accessing any training were seen to be cost and availability of staff.

All services felt strongly that carers and service users would benefit from some form of education or training around this field; delivery could be via group workshops and seminars as well as through leaflets available in surgeries and day centres. This would ensure the relevant information could be disseminated as widely as possible across the County.

### 3. Aims

- To implement an integrated and inclusive model of service delivery, tailored per locality, in accordance with Department of Health good practice guidelines and local prevalence and need; and to utilise/incorporate existing provision and existing and developing staff roles to facilitate change.
- To encourage greater collaboration and joint working between substance misuse and mental health services.
- To encourage multi-agency collaboration and appropriate information sharing across all generic providers of care.
- To ensure all staff across all sectors, who regularly come into contact with this client group, have the appropriate training and support relevant to their individual needs.
- To ensure all individuals coming under the remit of a dual diagnosis receive a service irrespective of where and how they present; how motivated they are to 'change'. Any proposed care plan should commence with/culminate from a thorough assessment of risk.
- To respond to all presenting and ongoing needs of the service user irrespective of cultural diversity, age or geographical location within the County.
- To support and inform both service users and carers throughout the treatment process.

#### 4. Definition of Dual Diagnosis

As mentioned previously the Department of Health guidance recommended a County-wide definition of dual diagnosis; to be agreed by all relevant parties, applicable to the prevalence therein and specific both in terms of diversity and geography to the region at large.

The definition would ultimately direct/dictate much of the structure of the model. Identifying care coordination, integrated care pathways and gate-keeping, as well as agreeing joint working and information sharing protocols, and the appropriate mainstreaming of these clients, would become much more fluid once providers were aware of their responsibilities under the term.

When trying to identify what to include and exclude within any definition, it was noted that since the dual diagnosis guidance was published, a separate document looking at personality disorder alone has since been produced. Personality Disorder – no longer a diagnosis of exclusion, 2003 gave specific recommendations for including and treating such clients. A number of the recommended interventions duplicated those already identified in the dual diagnosis guidance; namely “...people with all forms of personality disorder...subject to compulsion in the same way as those with other forms of mental illness”. This, in turn, should look to the assessment and treatment of personality disorder as forming a routine part of mental health services. This mainstreaming of clients with a personality disorder through mental health mirrored that of a dual diagnosis client and almost negated the possibility of excluding such clients from a definition, even if the diagnosis does not run concurrently with another mental illness. Inter-agency collaboration, joint working and integrated care pathways are to form the mainstay of developments for those with a diagnosis of personality disorder and, although personality disorder itself may need to be defined at a later stage, the ‘treatment’ of these individuals can well be served within the context of a dual diagnosis referral.

#### Provider information

The provider feedback taken from the needs assessments, and from frequent meetings with organisations across the County, seemed to allude to a definition that was very generic and all-encompassing. Mental health was rarely prioritised or so-defined and substance misuse was, normally, automatically taken to include alcohol. What was also apparent was that providers were seemingly unaware as to the ‘boundaries’ of the term, even within mental health and substance misuse provision at Tiers 3 and Secondary care, the definition amongst front-line staff was rarely understood.

When questioned as to why agencies/staff used such definitions reasons given were not specific to any geographical location or provision within the County. Most staff wanted a definition that was all-inclusive and did not serve to alienate the client group any further. A fear of ‘pigeon-holing’ these clients was paramount. However, some agencies were also keen to stress that often dual

diagnosis individuals were so defined for historical reasons; i.e. they had always defined the term as such.

When questioned as to how accurate providers felt their definition to be, most answered in a fairly similar fashion. The majority were unsure as to the accuracy of the term and used it as a 'catch-all'. In the light of little training and information around this client-type staff tended to either tailor the term to meet their treatment provision or, again, apply historical descriptions of the term.

Where staff were happy as to the accuracy of their definition it was generally within a setting of integrated care. It would appear that when a number of agencies were working together, staff seemed comfortable to stand by their notion of a dual diagnosis due to receiving advice and support from other providers; some of whom were clinical. Even in instances where integrated care took place with providers using very generic or different definitions, the concurrent care of the individual was the priority with little onus placed on the definition itself.

## National definitions and their subsequent models

The Department of Health guidance talks of a dual diagnosis in the context of only those individuals with a severe and enduring mental illness and substance misuse; all of whom must be on the CPA and receive a full risk assessment. To include only those with severe mental illness and thus insist they be eligible for CPA is to exclude a vast majority of service users within the County with complex needs. To ensure all have a full risk assessment, as recommended by the Department of Health, is seen to be correct but of equal importance to the 'undiagnosed' who pose a potential threat not only to themselves but other service users and staff alike.

Two main strands of thought seemed to prevail when looking at what definitions were being taken forward across the country; the specific and the all-inclusive.

The definitions that were seen to be very specific amounted to little or no variation from the Department of Health's description. Only those individuals with severe and enduring mental illness were to receive a service under the term and often personality disorder was not included. In some instances the voluntary sector substance misuse services were not to receive the full benefit of the end-model; namely the training and/or the inclusion on care plans and any joint working to come out of these. The voluntary sector also make up a large proportion of the wider provider groups; namely housing, employment and social support networks; as well as some criminal justice interventions.

When looking to engage clients with a dual diagnosis, it is recommended that meeting immediate and presenting need is the key to long-term engagement; stabilisation/reduction of substance misuse as well as compliance with medication may well be long-term goals. Even in examples of best practice cessation and total mental well-being may never be realised. By ignoring the wider providers and the specific providers within the voluntary sector the definition/model may well be missing out on opportunities of engagement as well as valuable input into a persons physical and mental state on a daily basis. Coupled with this, agencies whose primary remit is to look at mental health or substance misuse are having to deal with other factors involved in the care of the individual; the staff concerned may well be in-experienced in dealing with these resulting in saturation of work-

loads and a possible negative treatment episode on the part of the client. Duplication of data and the 'missing out' of valuable information from other providers may also be commonplace.

To only include those with severe and enduring mental illness is to deliberately exclude the rest. Those who are undiagnosed or whose dependency is so chaotic as to make a diagnosis impossible are as hard to engage as those already mainstreamed through mental health, and quite possibly harder to retain in treatment. The resource implications on health, the criminal justice system and housing providers are great and whilst the 'severe and enduring' dual diagnosis clients are thus receiving a service, the remainder are still impacting severely on primary care and statutory and voluntary providers alike.

The decision to exclude Personality Disorder has the same repercussions as already mentioned. Coupled with this, however, is the need to now look at provision for this client group regardless, in light of new strategic documents being produced.

The positive elements of having such a ring-fenced definition were also taken in consideration. When looking at the Department of Health's take on the term as well as those models that chose to implement this in full, or part, it did mean that the severely mentally ill do finally receive a service that best fits their complex needs and no longer allows for providers to negate responsibility to these clients en-masse. The integrated approach recommended does seem to work in practice and the fact that only certain providers were included under the model made the whole process that much easier. By placing such rigid boundaries around the definition allowed for a greater ease of joint working and in identifying care pathways due to the number of providers involved in the care plan being that much smaller. The training requirements of the scaled-down workforce are obviously less allowing for more in-depth training to be disseminated down. This has implications on time, resources and the availability of staff, which, were the definition all-inclusive, would impact greatly on all providers. Finally there could be no argument as to where care coordination would sit as the definition only allows for those on the CPA; therefore in the majority of cases mental health would have to take the lead.

The all-inclusive definitions as taken forward by a number of areas across the country (and also, interestingly, highlighted within the Department of Health's guidance as examples of best practice) did seem to be much more in-keeping with feedback from local providers at large.

By extending the definition to allow for as many clients as possible to be engaged services should be able to manage these individuals better providing the definition is backed up with the appropriate formalised protocols and training. Even those clients who are 'un-diagnosable' would receive a service and should no longer be excluded on the grounds of their chaotic and seemingly untreatable lifestyles.

By including all clients with complex needs although not necessarily insisting they be eligible for CPA would mean that they all receive a thorough risk assessment and all services including primary care and tier 1 should be much more aware of whom they are actually dealing with.

In instances where identifying the primary and secondary presenting diagnosis is not feasible, and therefore nominating the most appropriate care coordinator is problematic, it should be possible to either go 'up' the line management within the model until a decision can be reached; or, revert back to Department of Health

guidance and allow mental health services to take the lead until such a time as either a diagnosis can be reached or the mental/physical state of the individual allows for care coordination to change.

Training would need to be disseminated down to a much wider provider base and may also need to be more diverse in terms of the staff requiring such training and the broader range of mental health problems coming under the definition.

By allowing a wider range of providers to be involved in the care plan of the individual, staff should be able to work within the remit of their own jobs and not have to take on 'other' work they are not skilled to do and/or that saturates their case-loads. More dually diagnosed clients should receive a multi-agency package of care that looks to meet all their needs as and when they present; as opposed to 1 or 2 clients taking up 100% of a single staff members time.

There are some structures that would need to up-held, however, in order for the all-inclusive definition and the model to 'work'. An opportunity would still exist for agencies to 'pass the buck' or relinquish responsibility due to the vague nature of the definition. Care coordination must be backed up by formalised joint working and information sharing protocols or services may see little change in delivery of care for this client group. A greater emphasis must be put on all providers to ensure they view dual diagnosis as 'every-ones problem' irrespective of whom the care coordinator is. They will ultimately be responsible for ensuring that the definition and the subsequent model are upheld. Integrated care requires day-to-day management to ensure joint assessments are taking place, reviews are held regularly and with all relevant providers; and training is being received and delivered as per identified need.

The cost and time factors of having such a catch-all definition are slightly higher due to the increased number of providers/staff involved in care and the training, assessment and overall joint working required.

## Conclusion

Upon taking all research into account; namely Department of Health recommendations, other definitions across the country and County feedback/preference as well as prevalence it has been decided to look to an all-encompassing definition and subsequent model of service delivery.

The definition of dual diagnosis within Norfolk, as approved by all relevant bodies, is as follows:

### **Vision Statement**

#### Dual Diagnosis:

"An individual who presents with co-existing mental health (and/or Personality Disorder) and substance misuse problems (drugs and/or alcohol)."

### **Partnership Statement**

Norfolk DAAT and LIT's support the implementation of provision for this client group using the Integrated model of service delivery approach. Integrated care is taken to mean the concurrent provision of both psychiatric and substance misuse services. These services are to be provided in partnership with other organisations to meet the presenting and ongoing needs of the individual.

## 5. The Inclusive Model of Integrated Care

Please see Appendix 1

The recommendations made within the document are for the benefit of all providers and specific groups as identified throughout the County and the Department of Health Guidance. All providers are taken to mean both the voluntary and statutory sectors inclusive of any generic services who regularly come in to contact with dually diagnosed individuals. Specific groups are taken to mean those identified by the Department of Health in their guidance document; namely the young, homeless, ethnic minorities, offenders including prisoners, women and older peoples services.

In making the recommendations contained within the model it is in no way assumed that some services do not already provide this type of treatment provision. Indeed there are some excellent examples of best practice currently operating within the County. For those organisations the expectation is that treatment provision should continue as normal although there may be some elements/recommendations contained within that may further enhance their practice.

When looking at the proposed model it is important to note how each of the components feed into and relate to each other. Without all the elements being taken forward no one single element can be realised in full. This in turn would mean that the inclusive definition of dual diagnosis will fail to be inclusive without all the facets of integrated care being promoted and implemented by providers and backed up by a comprehensive training strategy.

### Care planning

Any Tier 1 or generic provider of treatment should look to identify substance misuse and/or mental health issues as part of their own in-house assessment procedures. This will allow for more individuals to be mainstreamed via the gatekeeping route. This does not necessarily mean that all individuals who are deemed to have dual needs will want to be referred on for further treatment; it does however allow for more individuals to be identified and in doing so, be offered ongoing and appropriate interventions. It will also enable more of the generic providers and their staff to be supported by specialist services, make appropriate referrals and, due to the risk assessment offered at the gatekeeping stage, become aware of the risks involved with any particular individual.

There should be clear eligibility criteria for both statutory substance misuse and mental health services, accessible by all. The needs assessments identified a lack of understanding around the perceived thresholds for accessing statutory services. Even some primary care staff, including GP's asked for better clarity in this area. If primary care are unaware as to the eligibility criteria, is it not surprising that the voluntary sector and the generic services en-masse, may also be confused. By defining the thresholds, this should again allow services to make only appropriate referrals in to other provision. Coupled with this will also be the

clarity amongst the statutory services around whom is best placed to then care coordinate.

Confusion around what provision was actually available in-County and within locality was also paramount within the needs assessments. A large number of all providers were unaware as to the wealth of provision that does currently exist and therefore opportunities were being missed on accessing other interventions or support. Within the County there are two main service directories, a directory for substance misuse and the Heron directory and database developed within the Norfolk and Waveney Mental Healthcare Trust. It may be appropriate to merely include any other provision specific to the field of dual diagnosis within either or both of these directories. Updating these regularly would be necessary and ensuring that all providers are aware of their existence would also be crucial.

### *Gatekeeping*

A shift in the cultural attitudes of staff is necessary in order to effectively retain dual diagnosis clients in treatment and prevent them from being excluded and/or 'bounced' from/between services. Staff must look to respond to the presenting need/s of the individual and must also recognise that dual diagnosis is commonplace and the responsibility of all providers.

Any suspected Dual Diagnosis referral made via any Tier 1 or generic provider of treatment; or indeed a self-referral to Primary Care or Tier 2 should automatically receive a full risk assessment and/or triage. Either mental health or substance misuse services can do this individually, or alternatively they may choose/request a joint assessment if felt appropriate. The statutory providers should commit to providing a prompt response for joint assessments. This will facilitate and enhance joint working between agencies and ensure the client receives an immediate service, hence helping keep them engaged, as well as moving on from past accounts of 'bouncing' the client between services. As already mentioned dual diagnosis individuals are more vulnerable than their counterparts and more susceptible to risk-taking behaviour. By responding quickly to requests for joint assessments once a dual diagnosis is suspected, services are therefore working within best practice guidelines and ensuring the model looks towards engagement and retention from the outset.

If undertaking individual assessment, each agency must consider the presence of both substance misuse and mental health issues as to do otherwise may result in misdiagnosis. If both elements are found to be present further exploration into the severity of each, and the association between the two needs to be undertaken as well as the implications on the holistic well-being of the individual, their housing needs, support networks, physical state etc. Guidance, support and joint working with other agencies may be required at this stage in order to achieve an accurate representation of presenting need and diagnosis. If a Dual Diagnosis is not suspected the individual concerned will either remain under the care of the relevant team or be referred back to their referring body with support and guidance.

Where the assessment is conducted jointly by both agencies the use of a joint screening and assessment tool should become commonplace. Coupled with this should be the use of a common assessment tool to allow as many services as possible to become familiar with and contribute to the assessment and

subsequent care planning process. The Models of Care referral and assessment forms are known and utilised by many services and a large number of staff from a wealth of provision are already trained to use the documents. To produce yet another assessment tool specifically for dual diagnosis individuals would not be well received by agencies and may result in duplication and multiple assessments on the part of the client. It may be appropriate, however, to suggest that for dually diagnosed individuals further information may need to be obtained and 'attached' to the documents. Due to the generic nature of the forms, certain settings may require more detailed information in order for staff to accurately identify and manage any issues arising. For example, the addition of a form for use in in-patient settings has already been suggested, as has an additional form for prison staff, to ensure that staff are all asking appropriate questions and retrieving the information necessary for their needs. These forms could quite literally 'bolt-on' to the existing documents.

The Models of Care forms are due to be reviewed in time, to ensure they are still relevant and working well. Now there is a county agreed definition of dual diagnosis it will be possible to develop the forms to incorporate more detailed questions. This will also be useful in terms of auditing and data collection. It may be possible at the review stage to ascertain the possibility of incorporating the joint screening process onto the forms thereby, once again, negating the possibility of multiple assessments and duplication.

If a Dual Diagnosis is suspected the gatekeeping role held by Tiers 2 and Primary Care will commence.

Because of the wealth of provision within Tier 1 it is not feasible for these services to be expected to provide effective triage and subsequent care coordination and care planning for these clients.

Primary Care, however, should be a highly appropriate arena for individuals to receive the clinical screening and assessment within which to then identify whether multiple diagnoses are prevalent.

All staff within Primary Care and Tiers 2 upwards will need to be supported in this role through the appropriate training and supervision.

It is also feasible to expect staff within these organisations to be able to make the appropriate referrals into other services if necessary and to identify whom should care coordinate at any one time; and what other agencies or individuals need to be included on the care plan.

#### *Care coordination and protocols*

Once, via the initial assessment, a dual diagnosis is confirmed the role of care coordinator should become apparent.

This is where the definition will need to take a three-fold approach, although due to the statutory responsibilities under Health it is considered only appropriate at this time that all care coordination must ultimately sit with the statutory services.

The voluntary sector are not necessarily regulated in this way and in the initial implementation of the model it is imperative that care coordination can be so regulated.

To summarise, for those clients found to have a diagnosed mental illness and be eligible for CPA, care coordination will sit initially with mental health services.

For those clients whose substance misuse is deemed to be the primary issue, substance misuse will take the lead.

And finally for the hard to diagnose or seemingly un-diagnosable, it may be necessary for both agencies to jointly take on this responsibility until such a time as a primary and secondary diagnosis can be found.

### Definition vs. Care Coordination

	Recreational or low substance and/or alcohol use	Dependent or high substance and/or alcohol use
Severe and enduring mental illness – diagnosed	C/C: Mental health Input: Substance misuse	C/C: Mental health Input: Substance misuse
Mild to moderate mental illness – diagnosed	C/C: Mental health Input: Substance misuse	C/C: Substance misuse Input: Mental health
'Hard to diagnose' / 'undiagnosable' / PD	C/C: Mental Health C/C: Substance misuse	C/C: Mental Health C/C: Substance misuse

Under CPA there may only be one care-coordinator but in the case of those clients who do not meet the mental health thresholds and yet are still deemed to be a dual diagnosis; they should still be offered interventions by both services under a single care plan. For those deemed to have a Personality Disorder further structures/protocols should then be implemented. (Please see section below on Personality Disorder)

Any client considered to be a dual diagnosis should receive a full risk assessment irrespective of their eligibility for CPA. This will enable all services to be aware of whom they are actually dealing with; highly important when reverting back to Tier 1 and the more generic agencies whose staff often encounter the more chaotic of these clients.

The following recommended protocols incorporate some of the information already discussed:

- Care coordination must sit with either statutory mental health or substance misuse services. The newly integrated mental healthcare trusts must therefore hold care coordination at this time.
- Where an agreement cannot be reached on care coordinator either the management structure of the model may be imposed – going 'up' the line of management until a decision is reached; or, alternatively substance misuse and mental health may choose to jointly care coordinate until such a time as the appropriate care coordinator can be identified. There should still remain one care plan.
- Clinical governance protocols regarding dual diagnosis need to be formulated or adjusted to be inclusive of:
  - Clear care coordination guidelines for services
  - Substance misuse on In-patient Units – specific guidelines may be necessary
  - Shared treatment protocols between the statutory services and the non-statutory providers
- Key-workers are as accountable for overall provision as the care coordinator

- The care plan must reflect the presenting need and then be longitudinal and open to revision. Care coordination may need to change if a diagnosis becomes apparent or changes. Key workers may 'dip' in and out of the care plan as appropriate
- All dual diagnosis individuals must receive a full risk assessment – joint if necessary – irrespective of eligibility for CPA
- Joint screening and assessment tools need to become mainstream for this client group; incorporating Models of Care forms where possible.
- The care plan must be reviewed regularly with all key-workers invited to attend. Correspondence/updates via email/letter/fax is appropriate if unable to attend in person
- Questions that need to be asked at each review:  
 What does the service user want?  
 How much support do their carers need?  
 How many providers are currently involved in the care plan – whom do we invite to form the integrated care plan and subsequent integrated care pathway?  
 How often do we need to review?

### *Care plan*

Please see Appendix 2

Out of the nominated care coordinator should then follow the care plan.

This should look to include all appropriate agencies at all times with identified key workers from these agencies being invited to all reviews alongside the service user themselves.

Although the care plan will have the aforementioned care coordinator it is important to stress that a dual diagnosis client is the responsibility of all the parties involved and no one agency should be expected to work in isolation with this individual or make the majority of all decisions.

It is recognised that by promoting joint working there may be the concern that staff will be too taken up with reviews and CPA meetings to fulfil the other remits within their posts. It is perfectly acceptable, as does happen under existing CPA, for reports to be sent through in lieu of a staff member being unable to attend; providing that staff member takes it upon themselves to follow-up on the progress of the meeting and be aware of any subsequent changes to the care plan. It is also important to identify how daunting such reviews can be for the service user. Clients themselves may have negative experiences of previous reviews, may be unfamiliar and/or untrusting of some staff attending or may not wish for aspects of their personal history to be discussed in front of certain agency representatives. It may be appropriate for the review to take place with the service user and their care coordinator alone providing the necessary documents are sourced from the other keyworkers prior to review, the keyworkers are kept informed of progress post-review, and the service user is fully aware of the intention to update other individuals upon any changes made to the care plan.

Care coordination and the subsequent care plan, as previously mentioned, will need to be longitudinal and open to review and revision at any time. It is vital that staff attitudes are realistic as to the treatment approaches surrounding this client group and the need to change and adapt, should the clients motivation and/or engagement wane. The Department of Health's Dual Diagnosis document recommends the following stages of treatment for dually diagnosed individuals:

**Engagement:** The development and maintenance of a therapeutic alliance between staff and client. Interaction needs to be on a non-confrontational and empathic basis with a commitment to meeting immediate and presenting need. Cessation may not be an option at this, or indeed any stage.

**Motivation:** Motivational Interviewing approaches should be adopted by front-line staff, with a view to encouraging change in the individual over a period of time.

**Active treatment:** Although the initial care plan should look to identify with the client and with their expectations/goals of treatment, it may take a prolonged period of time or may indeed need to change over time as the client wishes. Active treatment should look to address all the issues presenting, both substance misuse, and mental health although it may be realistic to look to harm reduction/minimisation and stabilisation techniques in the first instance. Staged interventions, motivational interventions, individual counselling and social support interventions are all recognised as effective treatment for dually diagnosed clients.

**Relapse Prevention:** If the client does realise a stage of reduction, abstinence or stabilisation the introduction of relapse prevention techniques are vital in order to encourage the individual to address or prevent future relapse.

The Dual Diagnosis Good Practice Guide Department of Health 2002

It would be unrealistic to expect a dually diagnosed individual to pass through the treatment stages seamlessly and fluidly. Relapse and disengagement are common amongst these individuals. Coupled with this is the likelihood of the individual being unable or unwilling to address their dual issues, that of substance use and mental illness, in the same way at the same time. It is with this in mind that the care plan and the providers must remain flexible and adaptive to any presenting or changing need.

Finally, it is recommended that from the outset the care plan should contain a discharge strategy/aftercare policy. Formalising this may not be necessary as it is important to treat each case on its own merits but such a protocol should be discussed at the outset and formulated if appropriate; again being open to revision and change at all times. Aftercare for this client group is seemingly difficult and the needs assessment identified a dearth of available and appropriate provision post-treatment. It is vital, therefore to look at the long-term options in terms of housing, support and possibly employment as well as immediate response should the individual's physical and/or mental health deteriorate or their substance/alcohol use become problematic. It is not acceptable to look at aftercare towards the end of the treatment 'phase' as sourcing and securing available and appropriate provision for dual diagnosis individuals can be a lengthy and costly process.

### *Integrated Care Pathways*

Please see Appendix 3

Once a care coordinator and care plan has been identified the subsequent integrated care pathway will follow.

This cannot possibly be expected to function smoothly and effectively without all agencies being committed and, where possible, signed up to joint working and information sharing. The recommended integrated care pathway ensures that all

agencies at any one time are feeding back into the care plan; and that appropriate decisions on treatment or interventions are as a direct result of the care planning process. By allowing all agencies involved to actively participate in a single care plan no staff member should feel isolated or be left with the bulk of the work. Coupled with this the immediate needs of the service user should be able to be addressed and all agencies will be able to give appropriate and relevant information as and when it arises.

### *Personality Disorder*

Due to the decision to incorporate personality disorder into the County definition of Dual Diagnosis; these individuals should now be mainstreamed in the same way as recommended under the model.

Coupled with this, however, and in light of the fact that historically individuals with a personality disorder are not deemed to meet the thresholds of mental health, it is also appropriate to recommend an addition/bolt-on to the care plan of such an individual.

For clients who present with a personality disorder the subsequent care plan should contain within it in a Crisis Management Plan that all parties involved are aware of, agree to and can access at any time. This is to ensure that the client is able, in times of perceived/actual crisis, to access care and help reduce the inappropriate use of primary care and the emergency services. The Plan should be tailored to meet individual need but it is also recommended that:

- A named contact be sited both during and out of hours; this does not necessarily have to be the care coordinator
- A list of current medication and current substance use
- A copy of the signed consent form
- A out of hours information sharing protocol

Where the client has a concurrent mental health diagnosis, which would make them eligible for enhanced CPA, the identification of a Crisis Management Plan may not be necessary although it is important to take each case on its own merits and use all available protocols and approaches if appropriate.

### Data collection

“It is recommended...that local services...agree improved data collection methods with partner organisations for future needs assessment.”

The Dual Diagnosis Good Practice Guide Department of Health 2002

### *Auditing/accountability*

All providers will undoubtedly have their own minimum data set requirements requiring set information to be retrieved and retained for future auditing purposes. To date no in-depth data is known to be held specifically on dual diagnosis by any provider organisation. This may be due to their having been no County agreed definition within which to gauge what data was to be retained under the term.

The minimum data set requirements for the National Treatment Agency (NTA) requires only level 3 and 4 data to be retained in regards to this client group:

Level 3: Recommended core data for clinical data sets. Should enable the client to be tracked through care pathways and form basis for a full clinical record consistent with Models of Care.

Level 4: Suggested format for data items related to local clinical records and research. Represents information that clinical teams may wish to define within local clinical records. Included within the data set to ensure consistency and comparability of non-core data between providers to enable data transfer between clinical information systems for research.

Within the NTA minimum data set this translates into the question:

“Dual diagnosis:

Ongoing treatment with m/h service	Y/N	(Level 3)*
Clinical diagnosis (psychiatry use only)	ICD 0 code	(Level 4)**”

*\*Minimum data set requires Level 3 question only*

*\*\*Recommended data set requires Level 3 and Level 4 questions*

*Both questions to be raised at initial assessment stage*

Reference: National Treatment Agency Minimum Data Set 2003

The minimum data set requirements under mental health allude to dual diagnosis data but there seems to be no specific questions or codes assigned:

“(CPA information system often has most clinical information about each patient and usually serves as the host system for creating the Unique Patient Identifier. ID No’s assigned to a patient from other systems will need to be linked to the UPI. No patient must have more than 1 UPI).”

CPA questions are included in the Mental Health Minimum Data Set and descriptions of each type are given which include substance misuse:

“Standard Characteristics of person on CPA inc:  
They require only low-key support from more than 1 agency or discipline.

Enhanced Characteristics of person on CPA inc:  
They are more likely to have m/h problems co-existing with other problems such as substance misuse.”

“Patients Diagnosis

Additional diagnoses for patients with either short or long-term involvement with services could include, eg diagnosis of substance misuse in the context of a mental illness, which may be transient. The RMO or doctor responsible for treatment should confirm or amend the diagnosis at each case review. Up to six ICD 0 diagnoses may be entered at any one time.”

“Non-NHS Residential Care Indicator

Data-set requires an entry indicating whether the patient care plan includes time in non-NHS residential care; to include residential drug and alcohol treatment and rehabilitation programmes run outside the NHS.”

Referral Source

*The only appropriate codes to give in relation to dual diagnosis may be:*

“Other clinical speciality” 07

“Other” 13

“GP” 00

“Self” 01

“LA Social Services” 02

“A&E Department” 03”

Clinical Team

*Team classification groups Include:*

“Substance Misuse Team” 03

Reference: Mental Health Minimum Data Set 2004

The fact that even specific substance misuse and mental health providers are not obliged to specifically retain data on dual diagnosis makes long term auditing a problem. With that in mind it is recommended that each individual agency across all provision retain data on dual diagnosis outside of their own minimum data set requirements. It is imperative that data collection start at the gatekeeping threshold; however all providers who come into contact with this client group would benefit from retaining relevant information. This will allow for the care pathway of that client to be tracked upon immediate point of contact with any service and on into the relevant agencies as identified within the care plan.

Recommended data to be held/retained should also be, where possible, agreed by all relevant agencies so that there is a generic baseline of information available for auditing and/or accountability purposes. Recommendations as to the level of information required should allude to:

Age, ethnicity, gender, residential status, criminal justice history/status, drug/s of choice, main mental health issue/s and whether or not this has been diagnosed, number and type of agencies presently involved in care, treatment interventions – past or present, and whether this individual is a new referral or known to services. If known, how many times has this person presented previously. Outside of this agencies should decide what other information is appropriate to retain in light of the service they provide.

When looking to retain data outside of the recommended requirements, agencies should allude to the County definition of dual diagnosis as a baseline for inclusion and retention of data, and individuals, under the term.

#### *Information sharing/confidentiality*

Providers need to be encouraged and allowed to share appropriate information if integrated care is to be realised in full. None of the recommendations under the model can be achieved in their entirety if agencies are unable or unwilling to release information to other providers, especially out of sector. Each agency has its own confidentiality policies to which all staff must sign up to. That said, in the majority, most confidentiality and/or information sharing protocols are similar in style and content and all abide by the guidelines as set out in the Data Protection Act 1998, the Caldicott Committee 1997 and the Crime and Disorder Act 1998.

In addition to these there are some County information sharing policies already in existence, namely the Norfolk Data Sharing Protocol and the Mental Health Services in Norfolk Protocol. There are also some specific protocols drawn up by a few voluntary providers to ensure ease of information sharing amongst the voluntary and statutory sector, an Information Exchange Protocol for registered social landlords, and the police are looking at a data sharing partnership, still being devised, in line with the requirements under the Criminal Justice Intervention Programme, the Crime and Disorder Partnership, and the Prolific and Other Priority Offenders strategy. Finally there are also protocols around seconded staff, or staff working on a sessional basis and their accountability and information sharing procedures.

To recommend an information sharing protocol specifically for dually diagnosed individuals is possible but providers have already alluded to the ever increasing 'mass' of paperwork needed to work with clients and the confusion that arises from so many similar documents. Instead and where possible, agencies should look to be included on existing protocols whether they be county or locality specific. It is important in respect to these clients that out of hours access to information be formalised and if necessary this could be built into the crisis management plan and/or care plan; or could be a 'bolt-on' to any existing protocol. By formalising all information sharing, and joint working, agencies will be able to revert to these protocols should collaboration break down and new staff should be able to function effectively within this arena. Using the common referral, assessment and consent forms where possible, as devised under Models of Care, can also alleviate issues of consent as well as joint working and information sharing. It is imperative that agencies from the gatekeeping threshold upwards formalise information sharing and confidentiality policies but, again, all agencies who regularly come into contact with dual diagnosis individuals should look to be included.

### *Joint working*

The necessity for seamless joint working amongst agencies both within sector and across provision is vital for the effective mainstreaming of dual diagnosis individuals. One of the main issues identified within the needs assessments was the lack of joint working between services and how time-consuming and frustrating it can be for providers, as well as detrimental to any interventions offered to the client. As previously mentioned, by formalising any appropriate joint working amongst agencies the protocols act as a safeguard whenever issues arise and all staff, including new staff, are able to plan a fluid and seamless care pathway; as well as source external advice, guidance and intervention when appropriate. It is therefore recommended that all agencies, from the gatekeeping threshold upwards in the first instance, should look to formalise any current joint working with external providers; or where there are currently issues with other providers, protocols should be devised between the agencies concerned to alleviate this. The recommendations do extend to the wider provider groups as it is vital, if they are to be included on care plans, that they have the guidelines in place to allow them to effectively work within this arena. Protocols should look to be generic as well as locality specific.

## Training strategy

All training must be made available to all services; statutory or independent, Tiers 1 and Primary Care upwards, as well as generic providers of care, carer support services. To support staff to implement the training received there should be identifiable clinical supervision regularly available where required.

One or more staff within statutory mental health and statutory substance misuse services should develop a specialism in dual diagnosis with service level agreements in place to allow skills and knowledge available at all times to all providers. It is recommended, however, that the other providers of care from Tiers 2 and Primary Care upwards should also look to so identify an individual to become a Specialist within this field, thereby acting as a resource within their own organisations as well as out of sector. The role of Specialist within each agency may then need to adopt a 2-tiered approach. Longitudinally it would be more appropriate for some of the Specialists to go on to become Champions. The differences between the two roles would be:

**Specialist:** to act as a resource both within and out of sector. It is recommended that these individuals be offered training up to the accredited course, that of Certificate level status, although for some agencies this may not be necessary or feasible, alternatively some staff may be qualified/experienced beyond this.

**Champion:** To be able to offer clinical supervision, consultation and possibly joint assessments, as well as performing a training and resource role when appropriate. In order for such an individual to be able to perform these functions effectively, they should be offered a higher level of accredited learning. It is envisaged that these individuals would reside within statutory mental health and substance misuse, or indeed any relevant clinical setting, in the first instance.

During the initial stages of implementation the role of Specialist and a mass Awareness Raising must take priority. Only after the majority of staff receive training on any level will it then be possible to identify where the Champions would be most appropriately placed within the wider sectors of provision. Although it is not the expectation that only a few designated members of staff be able to conduct joint assessments, some services might feel that having such an identified individual may be of more benefit. To allow these individual to hold case-loads in dual diagnosis would not be beneficial however, as this would result in a saturation of their time and may lead to a cliché of staff as opposed to an enhanced experienced workforce.

The notion of further training some staff may be of considerable relevance to practitioners and other medical staff. Again, only once the initial wave of training has begun will it be possible to gauge the uptake from and relevance to specific clinical teams/settings.

Due to the decision to 'Gatekeep' for these individuals at Tier 2 and Primary Care, all agencies from here on upwards should nominate a specified staff member to coordinate training and ensure its longevity. If necessary, due to staff availability/cost/availability of places either this specific staff member or an appropriate other should be nominated to attend external conferences etc and then feedback. However, due to the size of some agencies and/or their county-wide remit, the costs involved in ensuring all staff are appropriately trained may be considerable. Coupled with this is the need to ensure the ongoing and rolling

requirements of any training received. It is with this in mind that it may be appropriate for the identified Training Coordinator to attend a 'Train the Trainers' course/s so that they may be then responsible for effectively disseminating the information down to their own staff. This will be more cost-efficient, ensure the personal development of that staff member and allow for more agencies to access training due to only one or two members of staff from each agency needing to attend at any one time. To accredit this course would provide the staff member with a skill that is transferable across provision/out of provision. (However this may then exclude some individuals who do not have the required experience/qualification needed to enrol). There may be cases whereby nominating such a coordinator may not be feasible for organisations, whether from Tier 2 or Primary care upwards. This could either be where an agency is so large that the role would need to be a full-time post thereby posing a resource issue; or where an agency is so small that such a coordinator is not necessary. In such instances it is recommended that these agencies either encourage one staff member to develop a specialism as already recommended to act as a resource within their organisation with clear links made with other services to ensure the expertise is available should they require it. Or, where the agency is large or has many different teams/sectors of provision; that these individual teams each allow one staff member to develop a specialism as discussed.

Locality-based Lead Clinicians should be easily identifiable by all. The Management structure of the Model should encompass the Leads within the Training strategy/component – the Network of Specialists, the Champions, the Clinical Leads and to whom these are all accountable. All Providers should be able to see how the line of accountability is structured and whom is the most appropriate committee/lead to contact at any one time.

It is also recommended that various Audit tools are in place to ascertain qualitative and quantitative data pre and post training. The numbers and range of staff/individuals accessing the Awareness Raising course, evaluation forms to gauge feedback on training received, qualitative data on client feedback and treatment approaches post training, data retained on secondments/shadowing and the value thereof, numbers and range of staff accessing and/or completing the accredited course, and the numbers of staff attending the train the trainers course coupled with the numbers within their organisations they then train. Part of the remit under the Department of Health's guidance is to ensure that all staff receive appropriate training tiered to the level of need. It is imperative therefore that an audit is carried out regularly to ascertain that not only are the appropriate numbers of staff being so trained, but that it is seen to be of value and improves on long-term engagement and retention for clients and multi-agency collaboration and case-management for services. Coupled with this is the need to retain and improve on data collection methods for the future. The overarching model looks at collating data with regards to actual provision and prevalence for this client group; the training should ensure that not only are staff equipped with the skills within which to collect this data but that they themselves are also accounted for and 'measured' under the strategy.

All organisations should be responsible for ensuring staff have access to the internet/library/periodicals, if necessary with the help of the statutory organisations and/or the Trusts. Local Learning Centres should be identified and the smaller providers and those from Tier 1 should ensure their staff utilise these regularly. The Network, to be discussed, could address/identify issues around

utilisation of learning facilities and encourage other agencies to come and 'share' their resources where appropriate.

Services must be aware that for this client group training solely around substance misuse and mental health is not enough; housing, CJS, Youth services, Employment organisations and support networks all have a vital role to play and all other organisations, statutory or independent, should ensure they have a basic knowledge and links within each to ensure collaborative working is possible.

Secondments/shadowing should be made available by locality; length and between which providers is down to individual services themselves. In the case of services with a county-wide brief; the secondments/shadowing can extend beyond the immediate locality as appropriate. Another option to consider may be offering a rotational post/s amongst services, thereby negating the need to back-fill. This would involve a large amount of planning, cooperation and multi-agency working both in and out of sector but would also allow for more staff to receive quite in-depth training/acquisitive learning in different fields. Any in-house training should be extended (by 1 or 2 places) to other organisations within that locality and must be a reciprocal agreement.

Leaflets should be made available in all services – day centres, surgeries, hostels, community drug and alcohol teams (CDATs), community mental health teams (CMHT's), in-patient settings, employment services etc; detailing the term Dual Diagnosis and whom to contact, how to refer if such a diagnosis is suspected. These will need to relate to the immediate provision within that locality; as well as referring to County services if needs be. And finally resource packs should be made available to all services relating to the Definition, referral pathways and care coordination protocols under the term, local provision and the identified Specialists (or Champions) within each sector.

### *Dual Diagnosis Network*

To encourage multi-agency working, the sharing of expertise and best practice the identified training coordinator/specialists/champion within each agency should form a county-wide (not locality specific) network to meet approximately four times a year. Representatives from the Drug and Alcohol Action Team (DAAT) and the Trusts should also be present, service-user representation and support/carer support representation; as well as possibly representatives from the main local training providers. The purpose of the meetings would be to:

1. Provide all other agencies with a break-down of all in-house training being provided over the next 3 months by all the organisations present with a view to offering 1-2 places to these other providers,
2. Identify nominees for the next DD course/s and agree provisional numbers from each agency (this will also give organisations enough notice to release staff and organise appropriate cover),
3. Highlight any conferences, courses, trainers both within the county and nationally that may be relevant to the other agencies,
4. Discuss informally any new research that has come to light, periodicals or articles that may be of interest, as well as any changes in the prevalence or provision for this client group within the county,
5. Discuss and propose any appropriate secondments/shadowing/rotational posts between agencies as appropriate,

6. Discuss the training received so far, taking into account feedback from staff/organisations and the uptake. Identify any issues with the strategy/package of training that may need to be amended,
7. Highlight best practice amongst the network, where secondments/shadowing has seen to be beneficial, and where the training received has resulted in better collaborative working and an understanding and managing of these clients etc,
8. Provide qualitative and quantitative data on numbers and range of staff accessing training from each agency, for the purposes of measurable data collection and audit,
9. Address issues around available library resources, internet and periodicals etc, with a view to identifying agencies who have limited access and thus 'sharing' resources where possible,
10. The minutes of each meeting could culminate in a brief newsletter for all members (to disseminate amongst their own organisations) summarising all of the above.

The establishment of such a network would almost be integral to the continuation of the strategy and the multi-agency working that must come with it. By ensuring that all members meet regularly throughout the year the training and the other elements contained within the strategy would always be up-to-date, any identified 'problems' could be addressed immediately and the coordinators/specialists/champions would be supported in their individual roles. Coupled with this could be the support and guidance of national agencies such as NIMHE, as well as close working and support from the DAAT and the Trusts. This would be highly beneficial to the more generic providers of care and the voluntary sector and encourage the county organisations as a whole to work closer with the statutory sector and each other; both within their own provision and, more importantly, across provision.

The network could also play an important role in the oval audit/review of the strategy leaving it transparent and flexible thereby adapting/updating on developments in the field, changes in prevalence and the emergence of other/additional needs for these clients. Also this would enable the strategy to be accountable at all times, address components of it that are seen to be failing as well as identify areas within it that can be deemed as best practice.

### *Training Courses*

In addition to the above the DAAT, the PCTs and the Trusts should ensure a County wide training package:

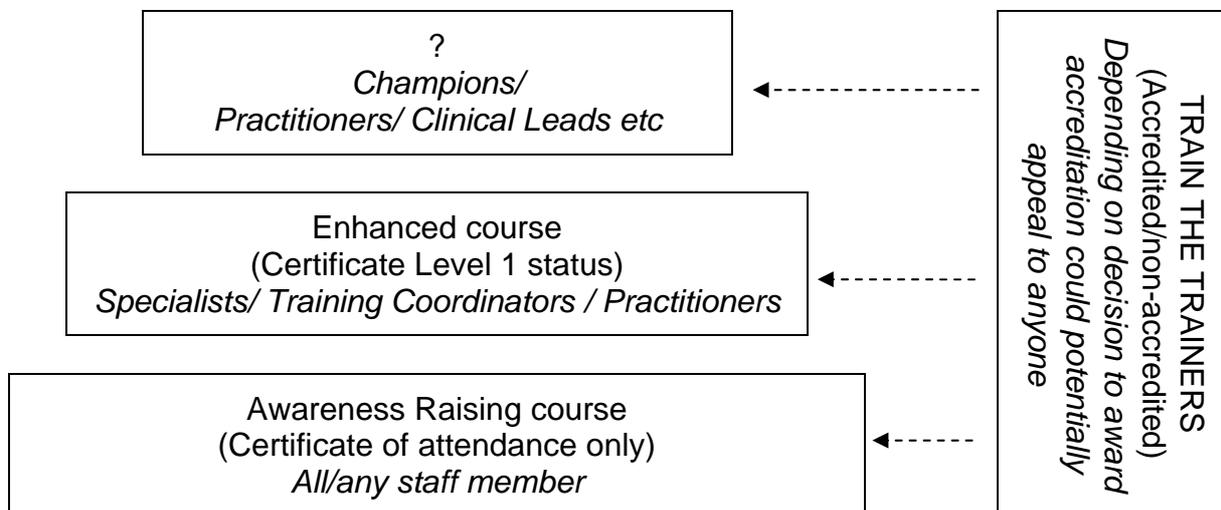
- A 1 day Awareness Raising course. This will not be an accredited course but will look to appeal to all staff with varying levels of expertise. The main aims of the course will be to raise awareness within this field and enhance multi-agency networking due to the multi-disciplinary attendance and off-site location.
- A modular course consisting of 4 or 5 separate components; 1 every month. To ensure the staff member accessing the course/s retains the information at each stage there should be the opportunity for Reflective Learning Portfolio's and study groups in-between each course day.

The course would provide 30 credits in line with a Certificate, Level 1, status.

- A Train the Trainers course, running alongside the aforementioned 2 courses. As previously mentioned this will facilitate sustainability and enhance the personal development of the nominated staff member.
- As previously mentioned a further 'tier' of training may need consideration for the future. Allowing some staff the opportunity to enhance their knowledge and so become 'Champions' within this field may be of benefit especially within clinical and/or statutory settings.

The possibility of bringing in an outside consultant for all or specific parts of the training should be considered.

The table below gives an idea of how, long-term, the training course/s may be structured thereby allowing the training to appeal, and be of relevance, to any/all staff:



The strategy does need, however, to be realistic and sympathetic to the main barriers in receiving training, as identified in the training needs analyses. These are cost and release of staff as well as having the training available locally. With this in mind it would be appropriate to base the off-site course Awareness Raising course at different venues depending on the locality accessing it. The costs could also be greatly reduced by nominating one or two staff members only as already discussed. The training needs analysis also identified a lack of appropriate training for the Carers of service users. It would be appropriate and beneficial if the Awareness Raising course were to be offered to Carers, as well as some Service Users if considered appropriate. To offer the further levels of training to these groups may also be of benefit.

Finally with regards to the release of staff, it is widely recognised that the majority of staff have high case-loads and that at one time or another most organisations will have absenteeism thereby, again, making it hard to allow staff time out to access the training. With this in mind that strategy would also look to recommend/devise training packs that can be easily disseminated down to staff. Having an external trainer come on-site to deliver these training packs, where necessary, would also be appropriate although this does not enhance multi-

agency networking and should thus be the exception and not the norm. The training packs would relate to the Awareness Raising course only and it would still be the recommendation that a nominated staff member go on to become one of the aforementioned Specialists.

All appropriate new staff should receive the Dual Diagnosis training as part of their induction/part of their first year of employment. This should become mainstream within all agencies where there is a prevalence.

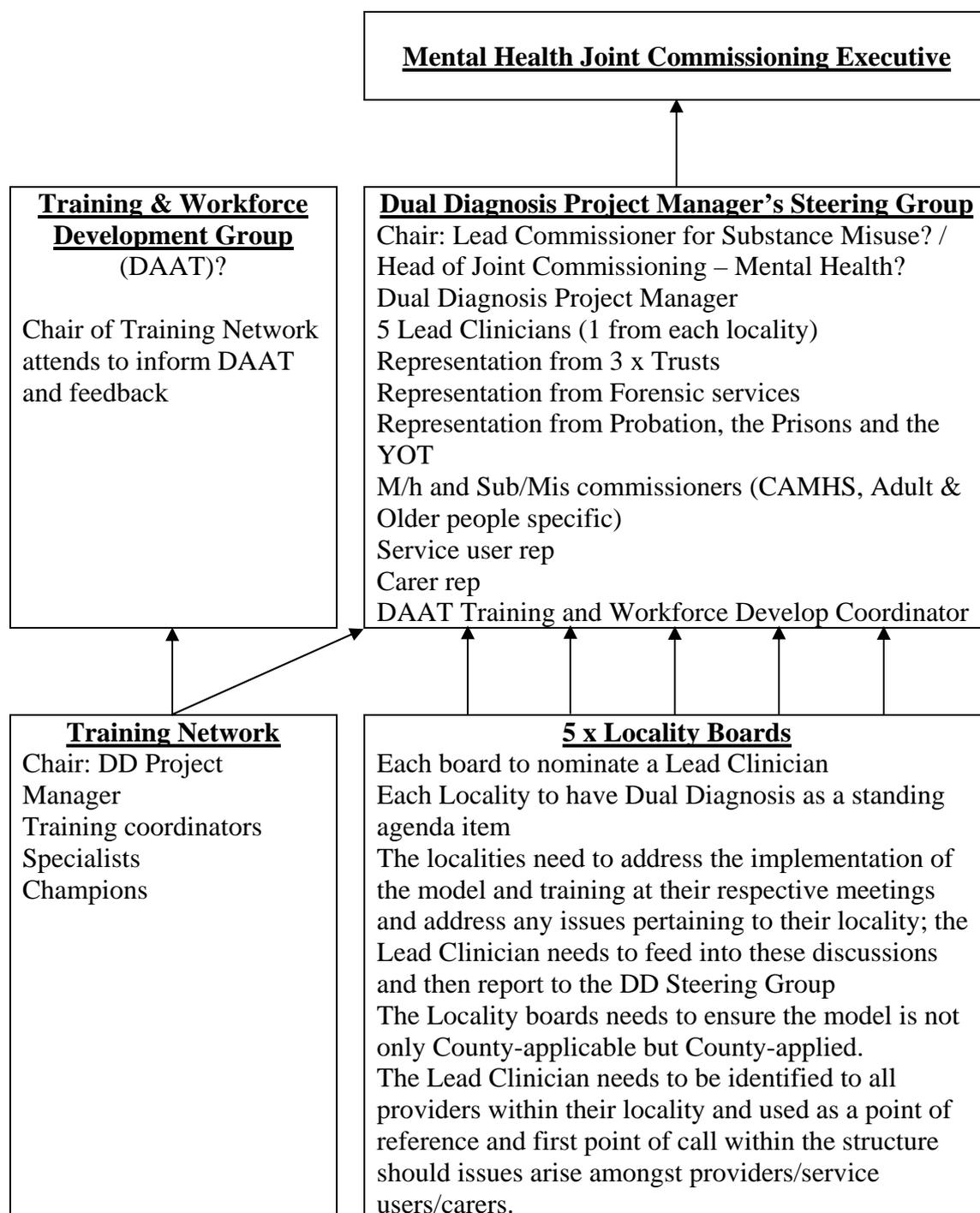
Finally a pool of possible facilitators would need to be identified, both in-county and externally; to enable the DAAT and the Trusts to commission the best and most appropriate training relevant to the changing needs of the providers over time.

### Management structure

(please see overleaf)

The management structure will be the line of accountability by which the model can be implemented long-term. All appropriate provider groups need to be represented and have clear clinical and strategic governance. The structure should not be formulated out of goodwill, but should be longitudinal with all groups and representatives aware of their position within the structure and to whom they themselves are accountable; similarly all providers on the ground need to be aware of the management structure and of whom to contact at any one time.

## Dual Diagnosis Management Structure



### Service users

In order to address the identified 'gaps' in service provision both from a Provider and service user and carer perspective the role of the Primary Care Mental Health Link/Gateway and Graduate Workers have been brought under the umbrella of the Model.

Within Norfolk these workers are based within primary care with their remit in line with strategic requirements. Link Workers within the region do not, however work 7 days a week or are on call 24 hours a day.

The Enhanced Depression Contract, to constitute a depression register, access to psychological therapies and self-help material, is currently being piloted in the City amongst 1 Link Worker and 6 Graduate Workers within 3 GP practices for 12 months.

County wide, and to best utilise their location within a primary care setting, the Link and Graduate Workers remit incorporates a fundamental sign-posting role within all surgeries, not only for GPs and staff contained within but also for service users and their carers. Link Workers can refer directly into secondary care and tier 2 substance misuse services and thus can also be seen as effective liaison between primary and secondary care as well as from Tiers 1 upwards. Allowing these workers to refer directly into Tier 3 may also be of benefit but it may be more viable, should substance misuse intervention be required, to allow this role be performed via Tier 2 thereby ensuring substance misuse providers are kept in the 'loop' at all times. The Link Workers are able and trained to use the Models of Care referral and assessment forms when referring into substance misuse so multiple assessments are avoided.

Both the Graduate and Link Workers already receive effective training so as to act as a point of advice, information and guidance to the service users/carers and also, again, to the GPs and the staff within the surgeries thereby ensuring staff within primary care settings have an immediate point of reference. On top of this enhanced training should be given specific to Dual Diagnosis so that primary care staff en-masse have a named person within their organisation whom they can contact for advice and guidance. Primary care staff and the Workers themselves should then feel much more able to work/manage these clients.

Training should incorporate mental health and substance misuse awareness, use of CPA and enhanced CPA, identification of risk, knowledge of formal joint working and information sharing protocols between relevant agencies as well as a working knowledge of eligibility and service thresholds. Coupled with this should be an awareness of available provision across all sectors County-wide thereby enabling effective sign-posting when needed. Again it is not assumed that this training is not already offered to some extent but it is of vital importance to ensure that top-up training is provided where needed as care pathways and care coordination can greatly alter once an individual is deemed a Dual Diagnosis.

All of this may be achieved without the Link Workers having to hold any Dual Diagnosis caseloads. The Graduate Workers would still be able to offer group interventions to these clients as per identified need, but would not be accountable under a care plan or be required to key-work.

Both Workers would not even be required to co-work as upon identification of multiple needs their role would be to sign-post on or in to more suitable provision. However, it is envisaged that gatekeeping for these individuals commences in Primary Care so it may be necessary for the Link Worker to undertake the initial risk assessment and/or triage. The clinical nature of their work would enable

them to undertake the role as appropriate and it is already the case that the Link Workers are being utilised for assessment purposes in some surgeries. The option of undertaking a joint assessment with substance misuse should also be considered and the links made with these services, as already identified within the Link Workers/Graduate Workers initial remit, should ensure that this is seamless. Once an individual is deemed a Dual Diagnosis, however, it would still be beneficial in some circumstances if some of the services offered by the Workers could be utilised as appropriate. The group work undertaken by the Graduate Workers and the interventions offered under the Enhanced Depression Contract would be of benefit. This type of brief intervention work is known to be beneficial especially in the first instances of psychosis and substance misuse. The Department of Health, as previously mentioned, recommends mainstreaming these clients through mental health. This would therefore be an ideal opportunity to offer time limited interventions in primary care settings. If the Enhanced Depression Contract were to receive approval county-wide the incorporation of dually diagnosed clients under the Contract from the outset would ensure this duty of care becomes commonplace practice and does not 'fall by the wayside'. It would also enable the long-term inclusion of these clients under mental health. Data collection upon initial diagnosis can also begin here. It is recommended that new and improved methods of collating data on Dual Diagnosis clients be devised. First instances of psychosis culminating in an assessment and subsequent diagnosis can thus be recorded. If needs be the client could then be 'tracked' through the system using the generic Models of Care referral and assessment forms, CPA if appropriate and the single care plan.

Within Norfolk the Support, Time and Recovery Workers (STR) posts currently encompass some 20% ex-service users. The remit is CAMHS up to and including Older Peoples Services with the criteria/eligibility for appointment to such a Worker being dependant on the referral criteria of the service they are 'in'. There are however, no self-referrals taking place. STR Workers are to be included on all Care Plans and do carry case-loads with no set time-limit within which to work with an individual. By identifying support for service users through most, if not all, mental health provision the 'gap' as identified by the needs assessment can be further addressed. It is also a possibility that these individuals may be deployed anywhere there is seen to be an identified need and so it may be the case that primary care, in-patient services, the criminal justice system and, in fact, any statutory or voluntary provider could request and appoint such a member of staff.

By incorporating these posts within the model another vehicle will be identified within which to ensure such support; as well as ensuring the Workers themselves receive the appropriate training and supervision around Dual Diagnosis. It is envisaged that such staff will undoubtedly encounter these individuals in their day to day working and therefore the model needs to be seen to respond to their training and support needs.

The generic training received by the Workers encompasses any appropriate and/or identified in-house training as well as Vocationally Related Qualifications in accordance with a model devised by the Workforce Development Confederation. It is apparent, however, that training specifically relevant to Dual Diagnosis would be of benefit and so it is recommended that the Dual Diagnosis courses devised under the Training Strategy be made available to the individuals appointed to

these posts. The extent of knowledge they may require/need and consequently the 'level' of training they access is the decision of the Worker themselves and their line manager/organisation.

### Carers

A major 'gap' as identified through both the provider and service user needs assessments was the lack of support and/or training for the carers of service users. It is therefore felt appropriate to recommend and identify the Carer Support Workers as an opportunity to address some of the problem; and also to encourage carers of dually diagnosed individuals to attend the Awareness Raising course within the training strategy. It is also felt beneficial that, where not already being considered or in practice, the statutory substance misuse and mental health services form Carer Support Groups and/or identify where within their locality those groups may already exist. Once up and running these could be largely self-supporting and therefore would require little 'management' on the part of the provider. Identifying a location/room out of hours may be required and some administration in the form of leaflets and flyers may also be necessary, although if the facilities were to be provided the group themselves could be responsible for actually completing the necessary work. It would obviously be of benefit if the voluntary sector were to follow suit but in the first instance it is imperative the statutory services are seen to be pro-active in this area.

The Carer Support Workers (CSWs) accept all types of referral with the only eligibility being that the cared for person must be over the age of 18 and with a severe and enduring mental illness (preferably diagnosed). Learning disabilities or Parkinsons disease are not classed as 'mental health problems' for the purposes of these posts although Personality Disorder is accepted. A carer of someone with Dual Diagnosis would therefore be permitted although an individual whose presenting problem is their mental health would receive priority over a Dual Diagnosis individual whose substance misuse or drug-induced psychosis is the presenting issue for their carer.

The Workers do hold case-loads, not time limited, and, although no formal counselling is available, one-to-one work, group work, advice, information and support are the mainstay of the job. Some advocacy is also undertaken as well as the possibility of supporting any referrals back to primary care or on into secondary services.

Training on offer to the CSWs is dependent on identified need by the individual themselves. Upon appointment to the post neither clinical expertise or training is required. It would therefore be of benefit if the CSW's could be allowed access to the Awareness Raising Course in the first instance. Allowing 1 CSW per locality to become a specialist would also be of benefit, however en-masse these Workers do not require any form of in-depth training.

Currently there is a GP pilot scheme within the Central cluster whereby the CSW's are based within the GP surgeries themselves. 12 months initial funding has been set aside for this. If this does prove to be a success, it would be prudent to link-up both the CSWs and the Graduate and Link Workers; facilitating joint working and assisting primary care in retaining and managing individuals and, where possible, negating the need to refer on to secondary care.

It may also be appropriate for a CSW to be so identified on any care plan; thereby meeting presenting need if identified and also looking holistically at the individuals overall well-being and that of their carer/s.

The needs assessments identified, not only the need to offer specific training and support to carers of dually diagnosed individuals but also to raise awareness of available provision and referral pathways. With this in mind it would be appropriate to recommend that the directory of services be made available to such carers. The aforementioned directory for substance misuse services and the Heron directory and database should look to include any other appropriate contacts relevant to dual diagnosis, if not already present. These directories should be made available in primary care services in the first instance, with a view to all services having such a directory/s for the benefit of staff, service users and carers.

Coupled with this should be the formulation of leaflets detailing whom to contact or how to refer if a dual diagnosis is suspected. Information around the aforementioned carer support groups and basic information around dual diagnosis itself should also be included. Again these leaflets should be made available in all day centres and primary care settings in the first instance.

## 6. Summary of recommendations

### Care planning:

- All Tier1 or generic providers of treatment should include questions around substance misuse and mental health as part of their own in-house assessment procedures.
- There should be clear eligibility criteria for statutory substance misuse and mental health services.
- A directory of service provision should be made available to any provider or interested party. Incorporating this onto existing directories may be more appropriate.
- All staff must recognise that dual diagnosis is commonplace and the responsibility of all providers.
- Agencies need to be committed and, where possible, signed up to joint working and information sharing.
- Gatekeeping commences at Tier 2 and Primary Care.
- All staff within Primary Care and Tiers 2 upwards will need to be supported through appropriate training and supervision.
- Any suspected dual diagnosis referral to Primary care or Tiers 2 upwards should automatically receive a full risk assessment.
- Joint screening and assessment tools need to become mainstream for this client group. Requests for a joint assessment should be met promptly by the other agency.
- Staff must look to respond to the presenting needs of the individual. The care plan should reflect this need and then be longitudinal and open to revision. Care plans should consider discharge/aftercare provision from the outset.
- Care coordination must sit with the statutory services.
- Clinical governance guidelines may need to be developed in regards to dual diagnosis.
- Where an agreement cannot be reached upon the appropriate care coordinator the management structure of the model may be imposed, or alternatively, statutory mental health and substance misuse services may choose to jointly care coordinate. There should still remain one care plan.
- Treatment should be based around, engagement, motivation, harm reduction/minimisation and relapse prevention in the first instance.
- Personality Disorder is to be mainstreamed and integrated under the model.
- For clients who present with a Personality Disorder, the care plan should contain a Crisis Management Plan.

### Data collection:

- All agencies should not look to retain data on dual diagnosis outside of any minimum data set requirements they may already have.
- A generic baseline of information should be agreed by all agencies to ensure ease of auditing/accountability.
- All providers should look to be included on any existing/developing information sharing and confidentiality protocols within their locality and, where possible, County-wide.
- Out of hours access to information needs to be formalised.

- It is recommended that all agencies formalise any current or future joint working with external providers. Protocols should be generic as well as, where possible, locality specific or County-wide if appropriate.

#### Training strategy:

- All training must be made available to all services.
- Clinical supervision should be made available to all appropriate staff.
- One or more staff from all agencies should develop a specialism in dual diagnosis.
- Longitudinally, and where appropriate, services should look to further develop some Specialists by allowing them to become Champions, with a higher degree of acquired/accredited learning.
- Agencies from the gatekeeping threshold upwards should nominate a Training Coordinator to ensure longevity.
- Agencies should look to allow a staff member to attend a Train the Trainers course to keep costs down, ease problems around release of staff and ensure sustainability for the training strategy.
- Locality-based lead clinicians should be easily identifiable by all.
- Audit tools should be devised to ascertain qualitative and quantitative data pre and post-training.
- All staff should have access to the internet/library/periodicals, utilising the statutory services if necessary.
- Secondments/shadowing/rotational posts should be made available by locality.
- All in-house training should be offered, on a reciprocal agreement, by 1-2 places to other providers.
- Leaflets detailing the term dual diagnosis and how to refer, should be made available to service users and carers in all Primary Care settings upwards.
- Resource Packs should be made available to all services detailing the term dual diagnosis and the protocols and care coordination pathways under the term.
- The identified Training Coordinators/Specialists/Champions should form a county-wide Dual Diagnosis Network to aid implementation and auditing, and facilitate multi-agency networking.
- A county-wide training package should be implemented in the first instance.
- Appropriate carers and service users should be encouraged to attend training.
- The Awareness Raising course could be put into a training pack for services unable to release staff. This should only be in exceptional circumstances.
- All appropriate new staff should receive dual diagnosis training as part of their first year of employment/induction.
- A pool of facilitators will need to be identified to enable effective and good quality commissioning of trainers.

#### Service users

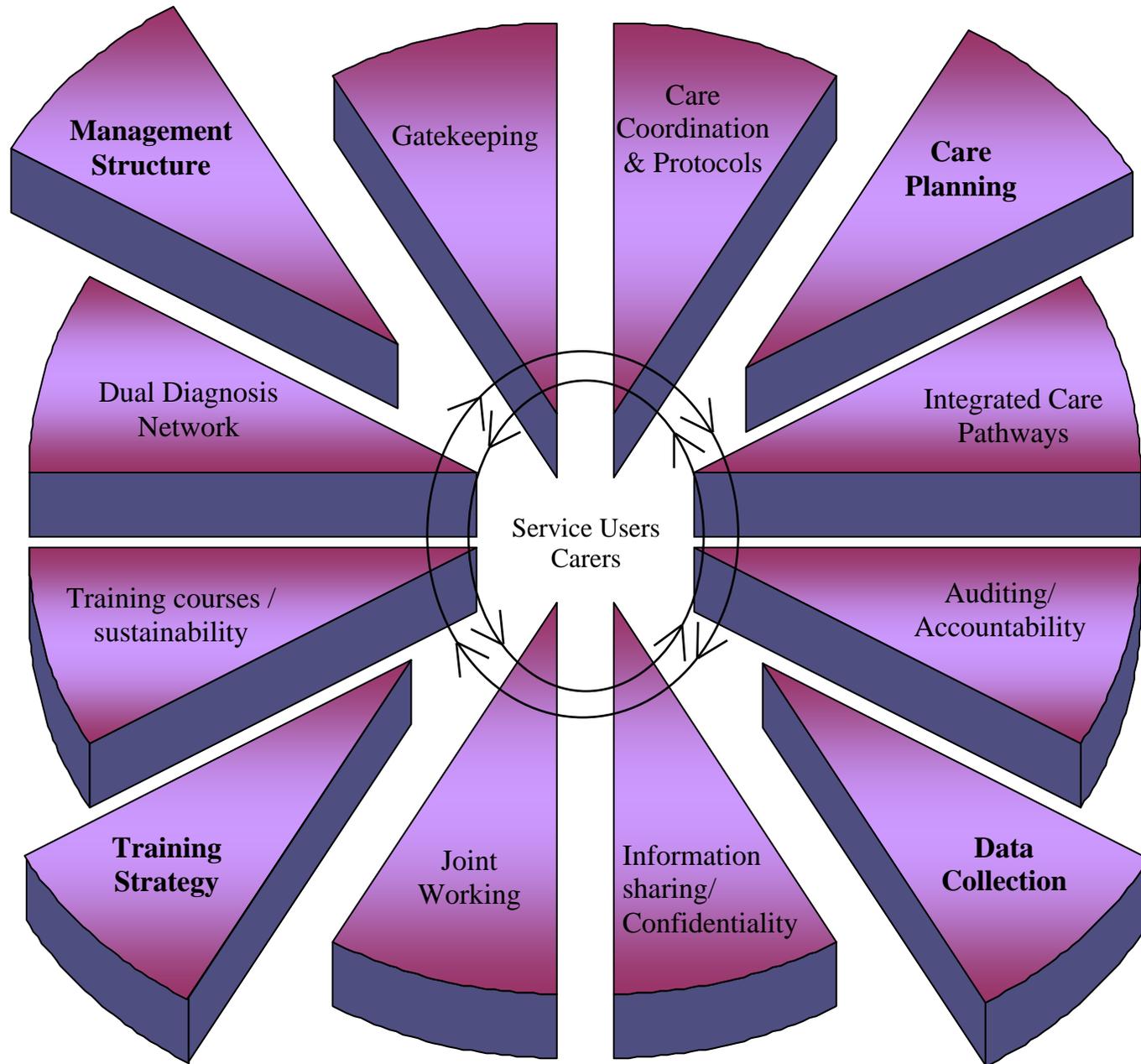
- Link and Graduate Workers should receive training in dual diagnosis. All 'levels' of training should be made available as per identified need.
- Link and Graduate Workers should be utilised as a sign-posting and resource role around dual diagnosis for staff and service users in primary care.
- Link and Graduate Workers should not hold dual diagnosis caseloads.

- Link Workers may be able to undertake initial assessment/joint assessment of suspected dual diagnosis individuals within primary care.
- The group work offered by the Graduate Workers should be made available to dually diagnosed clients where possible.
- Support, Time and Recovery Workers should receive training in dual diagnosis. All 'levels' of training should be made available as per identified need.

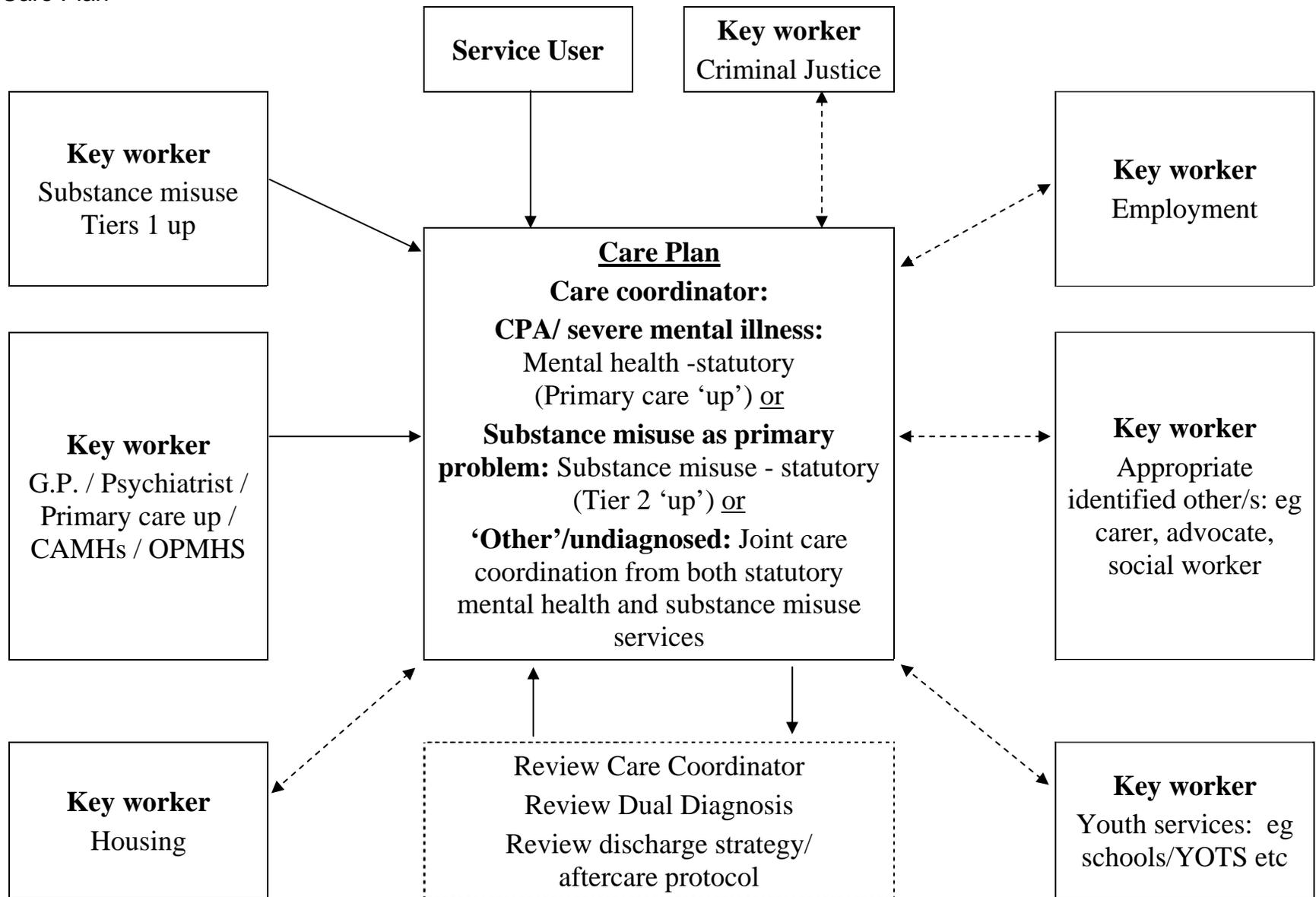
#### Carers

- Carer Support Workers should receive dual diagnosis training. All levels of training should be made available as per identified need.
- Carers should be allowed to access the Awareness Raising training in the first instance.
- Where not already in existence, the statutory services should look to form carer support groups within their localities. The voluntary sector should also be encouraged to identify existing groups or formulate them, working collaboratively with the statutory providers.
- Carer Support Workers should be included on care plans where appropriate.
- A directory of services should be made available in primary care settings.
- Leaflets detailing whom to contact and/or how to refer should be displayed in primary care settings.

7. Appendices Appendix 1: Model

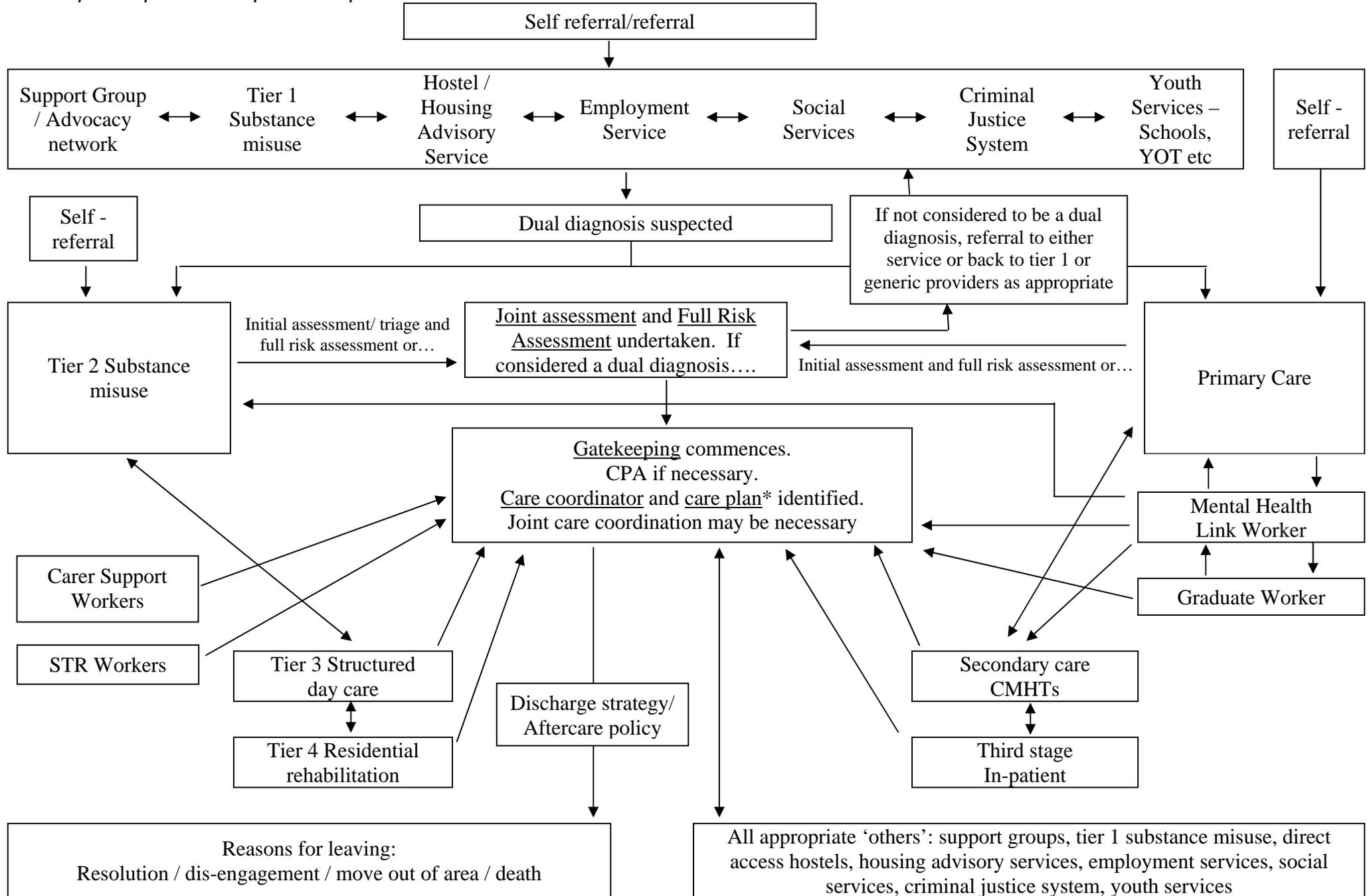


Appendix 2 Care Plan



Appendix 3 Dual Diagnosis Integrated Care Pathway

\* see separate process map for care plan



## 8. References/list of contributing agencies

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#### List of contributing agencies

Without the help, guidance and assistance of all the agencies mentioned, none of the recommendations could have been realised nor could the developing model have obtained overall approval.

ADAPT – CARAT teams, Norfolk  
ADAPT – Community Link  
ADAPT – Prison Resettlement Worker  
ADAPT – The Diana, Princess of Wales Treatment Centre  
Addaction – Thetford  
Adult Mental Health Services – Kings Lynn  
Advocacy Project – Kings Lynn  
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John Boag House – Norwich  
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Locality boards – Northern, Southern, Eastern, Western and Central  
Mancroft Advisory Project – Norwich  
Matthew Project Youth Service (T2) – Norfolk  
Mental Health Services for Older People – Norfolk  
Mentally Disordered Offenders – Norwich  
Meridian East – Norfolk  
Methodone Alliance Drug Treatment Advocacy – Norwich  
MIND – Norfolk  
NORCAS – Counselling, Norfolk  
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NORCAS – Training and Development – Norfolk  
Norfolk ACCRO  
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Norfolk DAAT  
Norfolk Mental Health Advocacy Project – Great Yarmouth  
North Norfolk CMHT  
North Norfolk PCT  
Norwich City Social Services  
Norwich CMHT  
Norwich PCT  
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Pedders Way Housing Association – Dereham  
Pottergate ARC – Norwich  
Probation – Great Yarmouth

Probation – Kings Lynn  
Probation – Norwich  
Project 91 – Norfolk  
Project Shop – Cromer, North Norfolk  
Purfleet Trust Resettlement Project – Kings Lynn  
Rethink Severe Mental Illness – Norfolk  
Ripley Project – Norwich  
Rural Advice Project – North Norfolk  
Self-Harm Team, Norfolk & Norwich University Hospital  
Shelter – Norfolk  
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Social Services – Great Yarmouth  
Social Services – Kings Lynn  
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The Youth Offending Team – Kings Lynn  
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West Suffolk Drug Advisory Service  
Winston Court Hostel, Norwich  
Yesu, Sheringham

YMCA, Norfolk