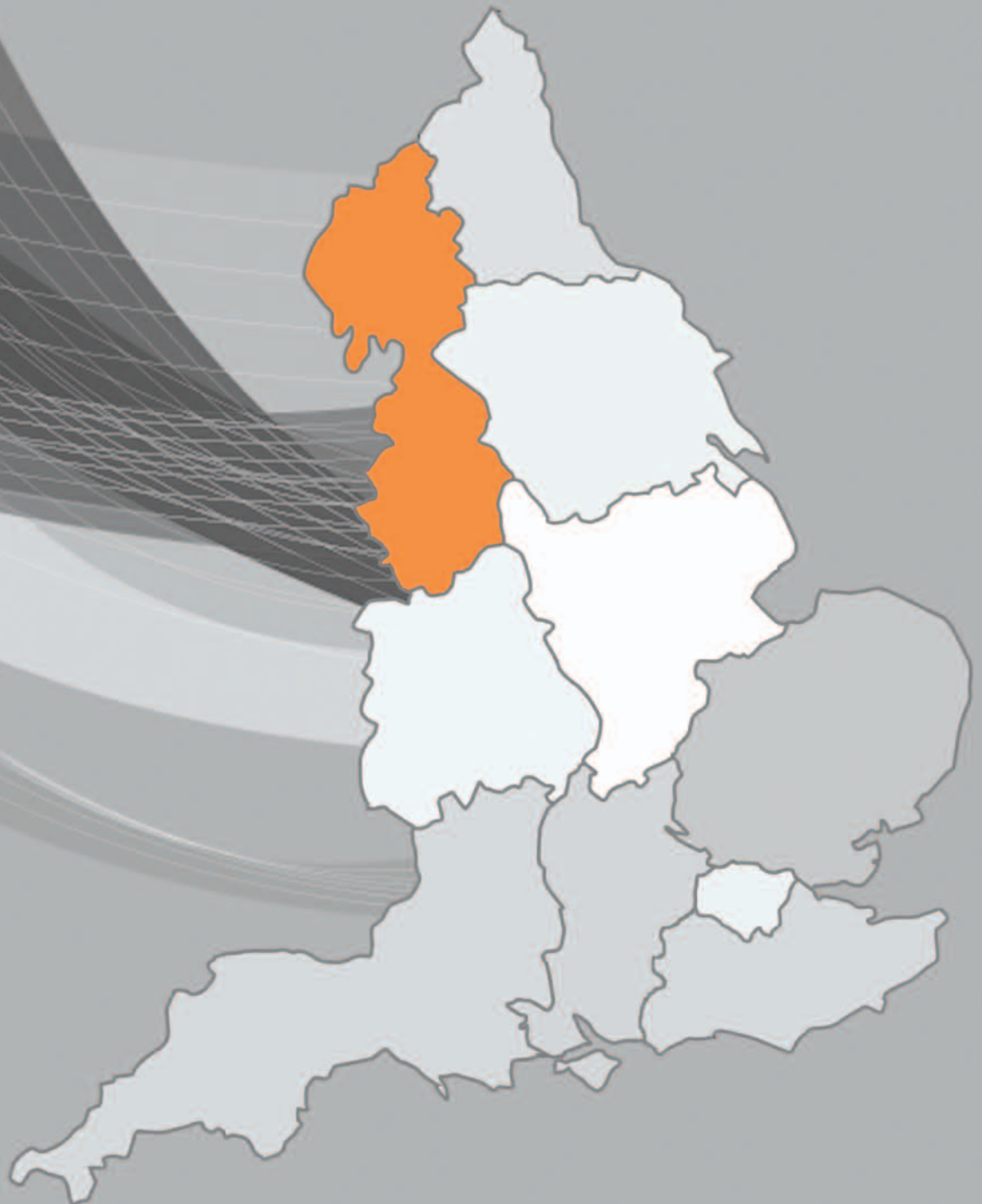


National Institute for
Mental Health in England

Dual Diagnosis

Themed Review Report 2006/07
SHA Regional Reports North West



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Foreword



It is everyone's business to provide good quality services for people with mental health and substance misuse difficulties. The management of people with dual diagnosis (DD) remains an area of concern and one of high priority for mental health policy and within clinical practice. This was highlighted in the *NSF – 5 years On* document (DH 2004) where I restated that dual diagnosis remained one of the biggest challenges for mental health service providers.

Providing appropriate information and support for carer's, family members and friends of service users is an important aspect of the services we provide, and must be given the priority it deserves.

Due to the complexity of physical, social, psychological and other issues associated with this condition, it makes detection, assessment, treatment and the provision of good quality care even more challenging.

The information in this report has been collected from across the country, and thanks to the high response rate, we now have a much clearer picture of areas around the country where service users, carers commissioners and providers are working together and driving up the quality of care locally. We are also aware of areas that may require more support and guidance so as to improve local dual diagnosis services.

It is clear that there is a long way to go to genuinely meet the complex and changing needs of people with dual diagnosis. But I commend this report as a valuable step on the road to achieving choice and real quality of life improvements for service users, carers and their families, and a way forward for service providers to be more confident and competent in providing these services.

A handwritten signature in black ink that reads "Louis Appleby". The signature is written in a cursive, flowing style.

Louis Appleby, *National Director for Mental Health*

Introduction

This regional report focusing on the North West SHA area highlights some of the key quantitative data derived from the Dual Diagnosis Themed Review Report (DH & CSIP 2008), undertaken as part of the Department of Health's annual assessment of progress (autumn assessments).

The intention is to offer key stakeholders involved in the commissioning and strategic developmental process, for the provision of dual diagnosis services, an opportunity to reflect on and provide regional interpretation of the data, and to help set the local agenda in prioritising areas that may require further support.

Other data derived from recent Health Care Commission reports, the Office for National Statistics and others, is included as additional information to help set the context for discussions. It may also help to highlight areas of positive practice that can be shared across the region. Other key organisations, providers, service users, carers and significant local groups will bring their own data and experiences to the table. It is intended that this series of documents provides a helpful start in that process, and in responding to the recommendations that come from the Themed Review.

Recommendations

Modern, effective provision for people experiencing dual diagnosis benefits from the following features:

- 1 There is clear designated local responsibility for the strategic development of dual diagnosis services. Ideally this should be a named individual who supports a forum for decision making.
- 2 The Joint Strategic Needs Assessment can be a useful process to help raise dual diagnosis issues. Data can contribute to the development of a clear local definition of the target population for services. If the local definition covers only those with severe mental illness plus substance abuse, then the needs of those with less severe mental illness also need to be considered. Clinical and Needs Assessments across the whole age range (including the needs of older people) will provide a more comprehensive service response.
- 3 Sensitive and appropriate collection of the views of users as part of needs assessment, strategy development and quality monitoring, to understand satisfaction with services and unmet needs.
- 4 Workforce capabilities are strengthened through employing resources such as, 'the Dual Diagnosis Capability Framework and the 10 ESC Dual Diagnosis modules'.
- 5 Joint stakeholder ownership of local strategies, in which the development and training needs (including local health promotion activities) of staff working with dual diagnosis service users are addressed.
- 6 Assessment and care coordination includes substance misuse problems and physical health care needs.
- 7 The effective recording of user defined outcomes leading to a local outcomes framework for dual diagnosis.

Themed Review 06/07 data

Question 1

Is there a local definition of dual diagnosis, which clarifies the treatment population for services?

Results

AREA	YES %/Number	NO
North West	85% (17)	15%
National Data	90%	10%

Is it in place or being implemented?

Results

AREA	In place/ Being implemented	Under consultation/ Review/ Further development	Neither
North West	60% (12)	20%	20%
National Data	In Place	Consultation/Dev	Neither
	79%	12.5%	8.5%

Question 2

Is any local definition agreed between agencies and drug and alcohol teams/ mental health commissioners?

Results

AREA	YES %/Number	NO
North West	75% (15)	25%
National Data	79%	21%

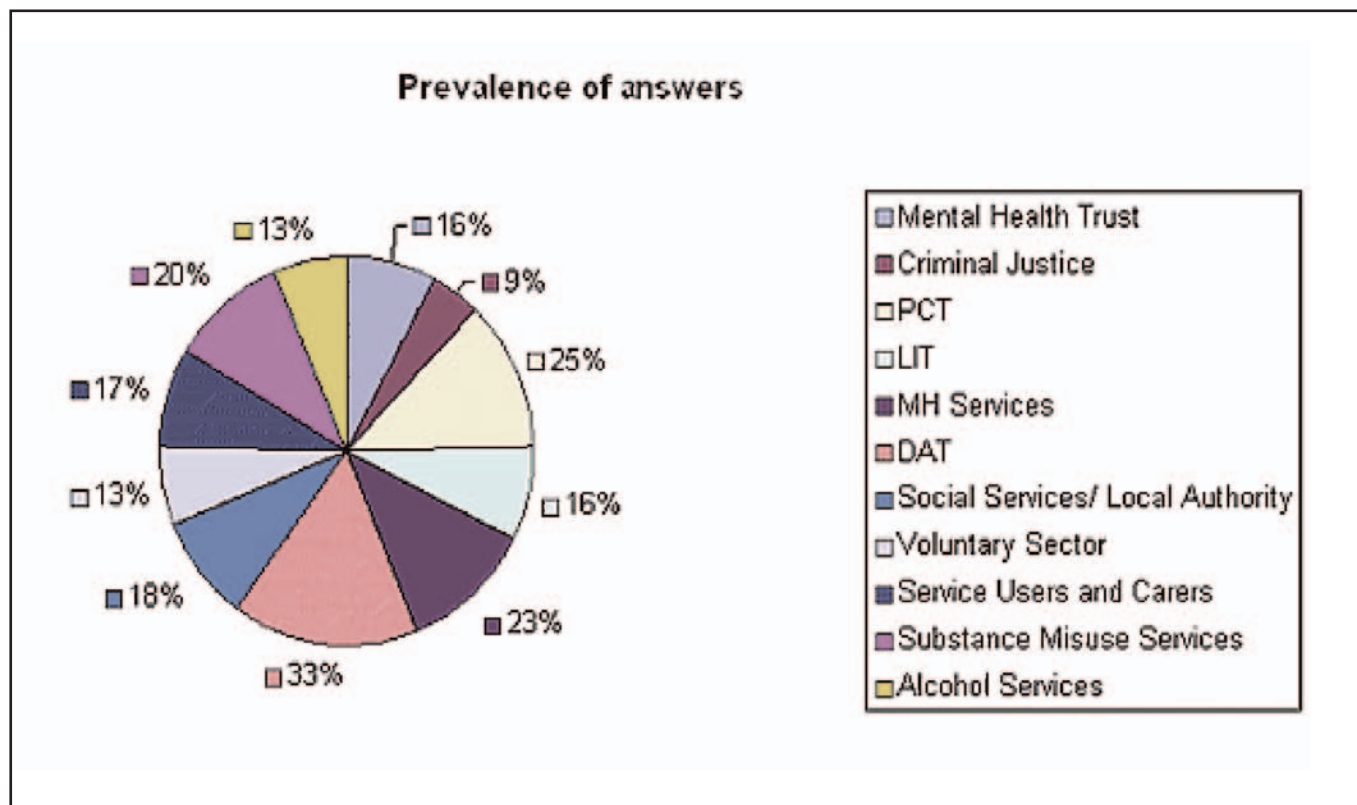
Question 3

Is there an agreed local strategy? Which key stakeholders have this been agreed with?

Results

AREA	YES %/Number	NO	In development/Consultation/Draft form
North West	75% (15)	5%	20%
National Data	60%	12%	28%

The following table illustrates the prevalence of answers indicating which key stakeholders the local strategy has been agreed with.



We can correlate the information on the previous page directly with data collected from the 2005 self-assessment paper (2005 Mental Health Strategies), which indicated that:

Results

	Answer	No of LIT's	Percentage of LIT's
RED	There is no local dual diagnosis strategy and action plan	15	9%
AMBER	There is a local strategy and action plan but links between treatment and criminal justice services are inadequate or ineffective	68	39%
GREEN	There is a local strategy and action plan with effective links between treatment and criminal justice services	90	52%

Question 9

Is there a system in place to measure how many people used the services in the past six months?

Results

AREA	YES	NO
North West	60% (12)	40%
National Data	61%	39%

Has there been any local needs assessment? Is this information available?

Results

AREA	YES	NO	Under Development	NO Data
North West	43%	33%	19%	5%
National Data	63%	21%	8%	8%

Of those answering YES (A local needs assessment has been made), the following table indicates strategic health authority areas where documentation to support the assessment was entered as being readily available.

AREA	Data Collected	Data Available
North West	43% (9)	33%

Question 10

Are there any age restrictions on dual diagnosis services?

Results

AREA	YES	NO
North West	25% (5)	75%
National Data	31%	69%

Question 11

Are there any specialist dual diagnosis provisions for older people with mental health, including provisions for alcohol-related cognitive impairment?

Results

AREA	YES	NO
North West	25% (5)	75%
National Data	26%	74%

Question 12

What financial impact on mental health services are people with dual diagnosis having?

Scale from 1 to 4: 1 = very severe, 2 = quite severe, 3 = some impact, 4 = little impact.

Results

AREA	Very Severe	Quite Severe	Some Impact	Little Impact
North West	45%	40%	15%	0
National Data	22%	43%	33%	2%

Question 14

Is evidence being collated to show that dual diagnosis users are satisfied with service provision?

Results

AREA	YES	NO
North West	25% (5)	75%
National Data	42%	58%

We can now look at correlating this data with the information gathered from part 2 of question 9, which asked: "Has there been any local needs assessment?" The percentages of YES answers from that question have been tabled below alongside positive responses from question 14.

AREA	YES – A needs assessment has taken place	Evidence on user satisfaction is being collated
North West	43%	25%

Question 15

Do risk assessment tools in the care plan pick up the additional risks of substance misuse? Are their appropriate steps to address the risks in this context?

Results

AREA	YES	In Development	Unsure/Unanswered	NO
North West	90% (18)	5%	5%	0
National Data	93%	5%	2%	

Question 19b

Has an assessment been made of training needs?

Results

AREA	YES	NO	Under Development/Review	Unanswered
North West	55% (11)	10%	15%	20%
National Data	49%	11%	10%	30%

Question 19c

Are training needs monitored for the future?

Results

AREA	YES	NO	Under Development/Review	Unanswered
North West	62% (12)	6%	24%	8%
National Data	57%	5%	20%	18%

Question 20

Does a training strategy exist to equip staff with the capabilities required to deliver care and treatment to people with dual diagnosis?

Results

AREA	YES	NO	UNDER DEVELOPMENT
North West	50% (10)	35%	15%
National Data	43%	31%	26%

Acute In-patient mental health service review – Annual Health Check 2006/07

A key aim of mental health care in England in recent years has been to support people to live more independent lives through better care and treatment in the community. One of the concerns arising from the emphasis placed on strengthening community services is that acute inpatient services have not always received the attention needed. The Mental health policy implementation guide for adult acute inpatient care provision (Department of Health, 2002), and other policy guidance published since then, has sought to encourage improvement in inpatient services. The five-year review of the National Service Framework highlighted the need for continued improvement in this area and the Healthcare Commission identified it as a priority on which to focus a service review.

The service review assessed the quality and safety of care given by NHS providers of acute inpatient mental health wards (sometimes called acute admission wards) and psychiatric intensive care units in England. We gave all mental health provider trusts a score, as part of our annual health check for 2006/2007.

Question 2.2.1: Physical health checks on admission

The overall trust, criteria and questions are scored on a 1-4 scale as follows:

- Level 1 (*weak*): performance that does not meet minimum requirements or the reasonable expectations of patients and the public.
- Level 2 (*fair*): performance that meets minimum requirements and the reasonable expectations of patients and the public.

- Level 3 (*good*): performance that goes beyond minimum requirements and the reasonable expectations of patients and the public.
- Level 4 (*excellent*): performance that goes well beyond minimum requirements and the reasonable expectations of patients and the public.

Total number of mental health providers assessed = 69

Regional number of assessments = 8

5 Boroughs Partnership NHS Trust	2
Bolton, Salford and Trafford Mental Health NHS Trust	3
Cheshire and Wirral Partnership NHS Foundation Trust	3
Cumbria Partnership NHS Foundation Trust	2
Lancashire Care NHS Trust	1
Manchester Mental Health and Social Care Trust	1
Mersey Care NHS Trust	1
Pennine Care NHS Trust	2

Question 2.2.2: Health promotion activities

Mental health staff need to be competent in intervening in drug and alcohol use as an integral part of providing treatment and care. This might be by offering drug and alcohol treatment and prevention as a separate programme within mental health services, delivered by specialist staff (DH 2006b).

Total number of mental health providers assessed = 69

Regional number of assessments = 8

5 Boroughs Partnership NHS Trust	2
Bolton, Salford and Trafford Mental Health NHS Trust	2
Cheshire and Wirral Partnership NHS Foundation Trust	2
Cumbria Partnership NHS Foundation Trust	4
Lancashire Care NHS Trust	2
Manchester Mental Health and Social Care Trust	1
Mersey Care NHS Trust	1
Pennine Care NHS Trust	4

Question 2.4.1: Specialist team support for specific service user groups

There should be access to specialist support for dual diagnosis (DH 2006b), people with personality disorders (DH 2003d; NIMHE 2003a;), older people's mental health services (DH and CSIP 2005), learning disabilities services (DH 2005b), child and adolescent mental health services (RCP 2002a), and perinatal care (NICE 2007).

Total number of mental health providers assessed = 69

Regional number of assessments = 8

5 Boroughs Partnership NHS Trust	2
Bolton, Salford and Trafford Mental Health NHS Trust	2
Cheshire and Wirral Partnership NHS Foundation Trust	1
Cumbria Partnership NHS Foundation Trust	1
Lancashire Care NHS Trust	1
Manchester Mental Health and Social Care Trust	1
Mersey Care NHS Trust	4
Pennine Care NHS Trust	2

Question 4.2.3: Staff training in dealing with service users who use alcohol or drugs

Substance misuse is a wide spread problem within acute inpatient units and psychiatric intensive care units. Inpatient staff have generally received little training in the area of dual diagnosis. Training should be available to all staff who routinely come into contact with people with a dual diagnosis, and must include medical as well as nursing, social work, psychology, occupational therapy and non-professionally qualified staff. This should include theoretical and skills based training, based upon an audit of the team's training needs.

The core training needs for individuals working with people with dual diagnosis may include:

- knowledge of dual diagnosis
- drug and alcohol awareness
- assessment skills for substance misuse
- knowledge of the management of substance misuse problems
- relapse prevention for substance misuse.

(DH 2002c).

The Chief Nursing Officer's report into mental health nursing (DH 2006c) recommends the need for improved training for mental health nurses in substance misuse management, both pre and post registration.

Total number of mental health providers assessed = 69

Regional number of assessments = 8

5 Boroughs Partnership NHS Trust	1
Bolton, Salford and Trafford Mental Health NHS Trust	1
Cheshire and Wirral Partnership NHS Foundation Trust	1
Cumbria Partnership NHS Foundation Trust	1
Lancashire Care NHS Trust	1
Manchester Mental Health and Social Care Trust	1
Mersey Care NHS Trust	1
Pennine Care NHS Trust	1

Question 4.2.5: Range of risk assessments

Patterns of substance misuse

Assessment of all individuals with mental health problems should actively consider the potential of substance misuse. Specialist assessments should be undertaken to determine the nature and severity of substance misuse and mental health problems, including an assessment of the service user's patterns of substance misuse, and treatment history (DH 2002c).

Total number of mental health providers assessed = 69

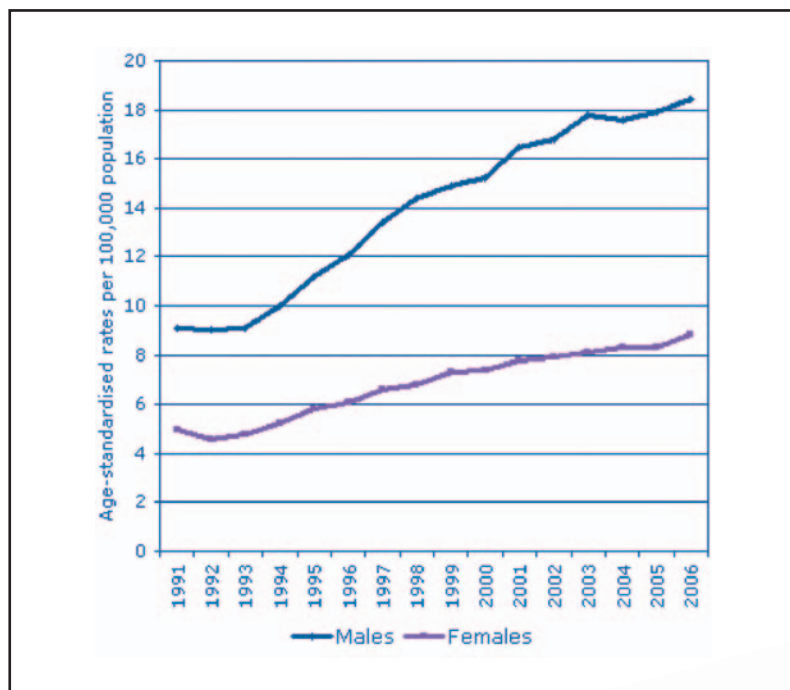
Regional number of assessments = 8

5 Boroughs Partnership NHS Trust	2
Bolton, Salford and Trafford Mental Health NHS Trust	2
Cheshire and Wirral Partnership NHS Foundation Trust	3
Cumbria Partnership NHS Foundation Trust	3
Lancashire Care NHS Trust	1
Manchester Mental Health and Social Care Trust	2
Mersey Care NHS Trust	2
Pennine Care NHS Trust	3

Additional Information

National overview of alcohol deaths – Rates in the UK continue to rise

Alcohol-related death rates by sex, United Kingdom, 1991-2006



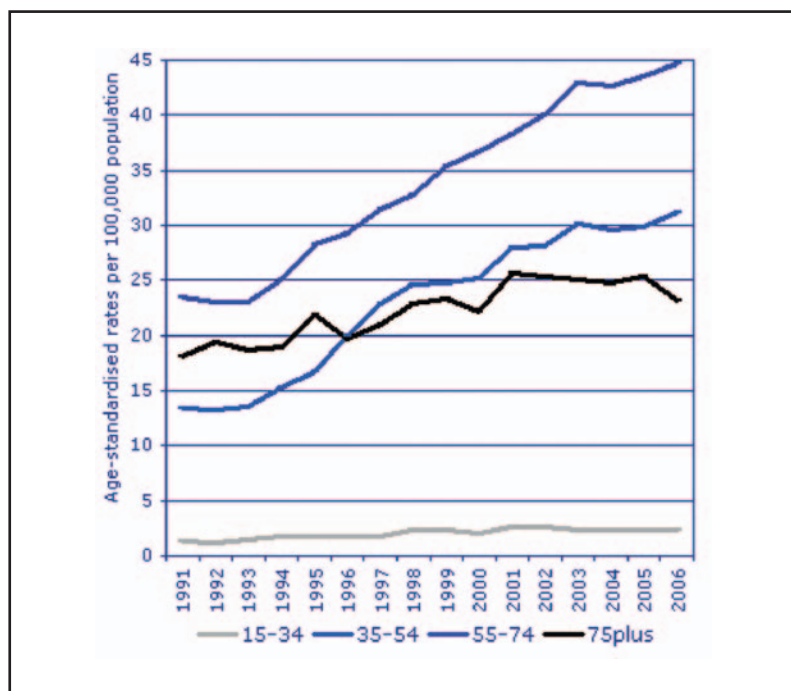
The alcohol-related death rate in the UK continued to increase in 2006, rising from 12.9 deaths per 100,000 population in 2005 to 13.4 in 2006. Rates almost doubled from 6.9 per 100,000 in 1991. The number of alcohol-related deaths more than doubled from 4,144 in 1991 to 8,758 in 2006.

In 2006 the male death rate (18.3 deaths per 100,000 population) was more than twice the rate for females (8.8 deaths per 100,000) and males accounted for two thirds of the total number of deaths.

For men, the death rates in all age groups increased between 1991 and 2006. The biggest increase was for men aged 35-54. Rates in this age group more than doubled, from 13.4 to 31.1 deaths per 100,000 over the period. However the highest rates in each year were for men aged 55-74.

Sources: Office for National Statistics, General Register Office for Scotland, Northern Ireland Statistics and Research Agency, 2008

Male alcohol-related death rates by age group, United Kingdom, 1991-2006

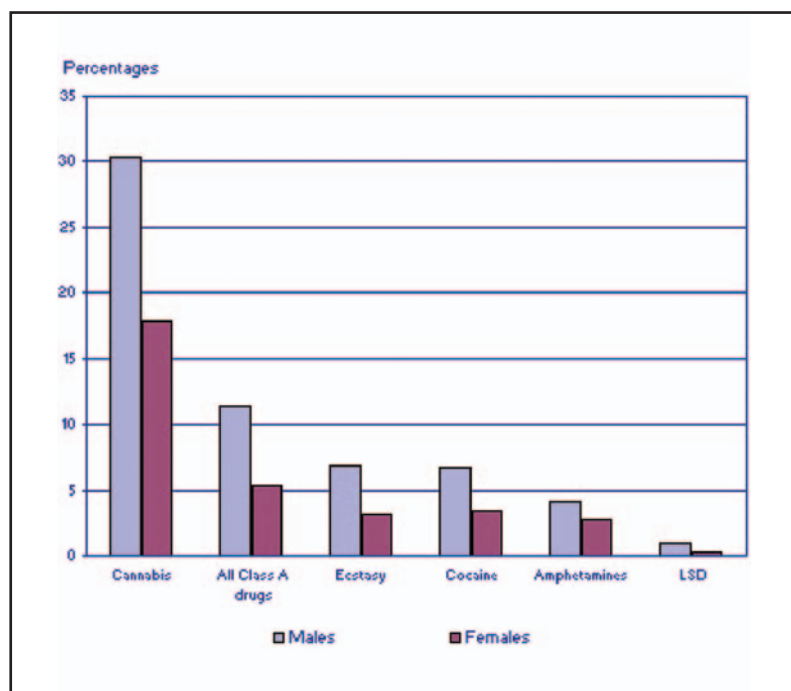


Death rates by age group for females were consistently lower than rates for males, however trends showed a broadly similar pattern by age. The death rate for women aged 35-54 doubled between 1991 and 2006, from 7.2 to 14.8 per 100,000 population, a larger increase than the rate for women in any other age group. As for men, the highest rates in each year were for the 55-74 age group.

Between 2005 and 2006, for both sexes, rates remained the same for those aged 15-34 and increased for those aged 35-54 and 55-74. There were small falls in the rates for those aged over 75, down 8 per cent for men and 6 per cent for women.

Sources: Office for National Statistics, General Register Office for Scotland, Northern Ireland Statistics and Research Agency, 2008

Drug misuse – 1 in 3 young men use cannabis



Prevalence of drug misuse by 16 to 24 year olds in the previous year, 2004/05, England and Wales

In 2004/05, 14 per cent of men and 8 per cent of women aged 16 to 59 in England and Wales said that they had taken an illicit drug in the previous year. Among young people (those aged 16 to 24), 33 per cent of men and 21 per cent of women said they had done so in the previous year.

The most commonly used drug by young people was cannabis, which had been used by 30 per cent of young men and 18 per cent of young women in the previous year.

Cocaine and ecstasy were the most commonly used Class A drugs. In 2004/05, 7 per cent of men and 3 per cent of women aged 16 to 24 had used cocaine in the previous year, and the same proportions reported use of ecstasy in the past year.

Since 1998 there has been an increase in the use of cocaine among young people. In contrast the use of cannabis, amphetamines and LSD has declined.

Drug offences accounted for 3 per cent of recorded crime in England and Wales in 2005/06. Drug offences can cover a range of activities, including unlawful production, supply, and most commonly, possession of illegal substances. Total recorded drug offences increased by 23 per cent in 2005/06 compared with 2004/05. The increase, for the most part, was due to a 36 per cent increase in the recording of possession of cannabis offences that coincided with an increase in the number of formal warnings for the possession of cannabis. This increase in formal warnings accounts for around two thirds of the increase in cannabis possession offences.

In 2004, the latest year for which data are available, the total number of drug seizures in England and Wales declined by 2 per cent to 107,360. Seizures were 19,000 lower than in the last peak in 1998. HM Customs and the National Crime Squad generally seized larger amounts while local police forces made a greater number of smaller seizures.

Compared with 2003, in 2004 there were fewer Class A seizures (down 2%). Cannabis was reclassified from being a Class B to a Class C drug on 29 January 2004, and accounted for 70 per cent of the total number of seizures in 2004. Data for Classes B and C in 2004 are therefore distorted and should not be directly compared to those of earlier years.

In terms of the quantity of drugs seized, 4.6 tonnes of cocaine and 4.6 million tablets of ecstasy were seized in 2004, decreases of 33 per cent and 31 per cent respectively on 2003.

Sources: Office for National Statistics, General Register Office for Scotland, Northern Ireland Statistics and Research Agency, 2008

Weighted population figures

Provisional Mid-2007 Population Estimates: Selected age groups for Primary Care Organisations in England; estimated

Resident population (experimental)

Strategic Health Authorities in England

	Thousands			
	All ages	Children	Working age	Older people
	Mid-2007	0-15	16-64M/59F	65M/60F and over
ENGLAND	51,092.0	9,655.8	31,791.7	9,644.5
North East	2,564.5	464.5	1,591.2	508.8
North West	6,864.3	1,308.8	4,240.1	1,315.4
Yorkshire and Humber	5,177.2	973.4	3,224.7	979.2
East Midlands	4,399.6	816.3	2,730.4	852.9
West Midlands	5,381.8	1,051.2	3,285.0	1,045.7
East of England	5,661.0	1,079.9	3,454.2	1,126.9
London	7,556.9	1,455.6	5,058.9	1,042.4
South East Coast	4,283.2	811.5	2,571.4	900.3
South Central	4,025.4	773.1	2,524.2	728.1
South West	5,178.0	921.4	3,111.6	1,144.9

These data are on boundaries that were in place on 29 September 2008

- Tameside and Glossop PCT reports to North West SHA but part of the PCT falls within East Midlands SHA.
- Lincolnshire Teaching PCT reports to East Midlands SHA but part of the PCT falls within Yorkshire and the Humber SHA.
- Berkshire East PCT reports to South Central SHA but part of the PCT falls within South East Coast SHA.
- Swindon PCT reports to South West SHA but part of the PCT falls within South Central SHA.

Note: As some PCO's are split between SHA's, PCO's in some areas will not sum to SHA areas.

Note: Figures may not add due to rounding

Source: Office for National Statistics.

Prevalence of neurotic disorders among older people: by sex and gross household income, 2000

As with many other illnesses, mental health problems are associated with socio-economic disadvantage. Results from the 2000 Psychiatric Morbidity Survey of people living in private households in Great Britain found that, among those aged 60 to 74, the likelihood of having a neurotic disorder increased in both sexes as household income fell. Among women in this age group, the prevalence of neurotic disorder, such as anxiety or depression, was around three times as common among those with a weekly household income of under £200 (16 to 18 per cent) as it was among those women with a weekly household income of £500 or more (6 per cent).

Additional information can be found by visiting:

<http://www.statistics.gov.uk/StatBase/ssdataset.asp?vlnk=7466&Pos=1&ColRank=2&Rank=272>

Drug related deaths: by selected drug type, 1994 to 1996

Until recently, the main published source for drug deaths was the annual Home Office Addicts Index statistical bulletin. This contained information not only on people registered on the Index who had died in the year, but also on all other deaths which had an underlying cause described as Drug Dependence or Non-Dependent Abuse of Drugs, suicide and accidental poisoning. These data were based on information supplied by the Office for National Statistics (ONS). With the closure of the Addicts Index, however, this data is no longer published in this format. Data on deaths due to drugs, classified by ICD code, are still included within the routine mortality statistics published annually by the ONS.

Additional information can be found by visiting:

<http://www.statistics.gov.uk/StatBase/xsdataset.asp?vlnk=883&Pos=&ColRank=2&Rank=272>

DH INFORMATION READER BOX

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