Leeds Dual Diagnosis Network

Care Pathway Evaluation – Summary

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A copy of the full evaluation report can be downloaded from -
http://www.dual-diagnosis.org.uk/DDCarePathwayEvaluation2013.pdf

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SECTION 1 – BACKGROUND

Introduction

The coexistence of mental health and substance use difficulties is commonly referred to as dual diagnosis in the United Kingdom (Guest & Holland 2011). The prevalence of dual diagnosis in mental health and substance use services is high and should be considered usual rather than exceptional (DoH 2002a). It is associated with poorer outcomes and consequently has a disproportionate impact on healthcare costs than mental health or substance use alone (Crawford and Crome 2001). Historically, health and social care services have not been designed to meet the needs of people with these dual difficulties and consequently they have fallen between the gaps of service delivery (Abou-Saleh 2004).

The Dual Diagnosis Good Practice Guide (DoH 2002) was the first policy document to directly address the need to improve service provision in this area. The good practice guide emphasised the need to develop care pathways, multi-agency working and care co-ordination protocols. It was in this context that the Leeds Dual Diagnosis Project was commissioned in 2007 with the aim of improving access to treatment and outcomes for people who experience co-existing mental health and substance use difficulties. It is a multi-agency network developed to ensure that services that come into contact with this client group are readily able to assess, engage and to co-ordinate care effectively.

Rationale

The Leeds Dual Diagnosis Project developed a care co-ordination protocol in 2008 in consultation with its network members which describes locally agreed assessment, co-ordination and joint-working criteria. Since the introduction of this protocol no monitoring has taken place to identify whether the guidance identified is embedded in practice. Furthermore, there is currently no mechanism in place to systematically monitor the prevalence of people with co-existing mental health and substance use difficulties accessing services which this protocol applies to. Consequently a gap in knowledge and learning persists regarding these two vital areas and the undertaking of this care pathway evaluation aims to address these issues.

The findings from the evaluation will be used to inform the DD Strategy Group; alongside information from the current sector reviews being undertaken. This will influence the development of future dual diagnosis strategy; and continue to improve access to treatment for people with coexisting mental health and substance use.

Context and Background

In 2012 a pilot service evaluation was undertaken by the Leeds Dual Diagnosis Project Manager in collaboration with stakeholder members of the Dual Diagnosis Strategy Group. The pilot study adopted a real world research method which is a pragmatic approach for small scale projects which evaluate professional practice in a natural setting (Gray 2004).

The purpose of this study was to pilot a service evaluation method which aimed to:

1 - Identify if services that form the Leeds Dual Diagnosis Network are able to provide data on the prevalence of people with co-existing mental health and substance use problems accessing their service.

2 - Identify what standard of care members of the Leeds Dual Diagnosis Network are currently providing for people with co-existing mental health and substance use problems in relation to the practice identified in the Leeds Care Co-ordination Protocol.

The evaluation piloted two questionnaires on a small sample of services from the Leeds Dual Diagnosis Network. Questionnaire 1 focused on identifying the prevalence of dual diagnosis in services and was completed by service managers. Questionnaire 2 focused on the current standard of care being provided by services and was completed by practitioners. Following completion of the pilot evaluation stakeholder members of the Dual Diagnosis Strategy Group met to interpret and discuss the findings. The learning from the pilot process was used to inform the improvement of the evaluation methodology and a full evaluation of all services that comprise the Leeds Dual Diagnosis Network was undertaken by the project manager

Limitations

Methodology

- The evaluation adopted a real world research approach therefore the Dual Diagnosis Manager designed and conducted the evaluation which could be perceived as problematic in terms of maintaining impartiality.

- This approach was a pragmatic choice due to the limited resources available and tight time frame for completion which needed to fit the priorities and work streams of the Dual Diagnosis Strategy Group
  .

Questionnaire 1 – Prevalence Data

- The numbers provided by services are approximate and represent a snap shot of the possible prevalence of people with coexisting mental health and substance use at the time of undertaking the evaluation

- The numbers represented do not reflect the number of people who meet clinical threshold for DD as valid screening tools were not used by all services. Alternatively the data reflects the potential number of people who may require support to meet their coexisting mental health and substance use difficulties

- The limitations of databases used by the majority of services means that they are unable to identify if people are accessing another service to receive support for their coexisting mental health and substance use needs. Consequently it is inevitable that double counting will be reflected in the data and potentially overestimate the number of people accessing services with these needs

Questionnaire 2 – Practitioner Questionnaire

- The data collected in this questionnaire reflects practitioners' personal views and does not provide a definitive answer to the standard of care members of the Leeds Dual Diagnosis Network are currently providing for people with co-existing mental health and substance use problems in relation to the practice identified in the Leeds Care Co-ordination Protocol.

- The data collected can help identify themes in relation to the questions asked and a further stage of evaluation e.g. focus groups may be beneficial to explore specific themes or areas further.

SECTION 2 – SUMMARY OF FINDINGS

QUESTIONNAIRE 1 - Prevalence, Screening + Training

This questionnaire was sent to all the services represented in the Leeds Dual Diagnosis Network in December 2012 for completion by the service manager.

Participation

Table 1 – Response Summary

Total No. of Questionnaires sent	59
Total No. of Responses	52

• 52 of the 59 services (88%) participated in the care pathway evaluation illustrating the value services place on improving services for people with coexisting mental health and substance use and the positive role the Leeds DD Network plays in facilitating this process.

• 5 of the 7 services who did not participate were from statutory sector mental health services (LYPFT). The current transformation process the organisation is going through and difficulties providing the information requested were key factors which contributed towards non-participation.

1 – Prevalence

• Despite the challenges and limitations in providing accurate data the majority of services who participated were able to provide the information requested.

• The prevalence rates of people with coexisting mental health and substance use problems identified in the evaluation is consistent with previous studies undertaken in the UK.

Table 2 – Prevalence of DD identified by sectors

Sector	Approx. No. currently accessing with coexisting MH + SU	Range of DD prevalence identified (low – high)
Alcohol + Drug	813	5 - 67 %
Criminal Justice	202	4 - 44 %
Homelessness	500	22 - 67 %
Statutory Sector Mental Health (LYPFT)	UTP	9 - 75 %
Voluntary Sector Mental Health + Mental Health Housing Support Services	591	3 -78 %

See appendices for methodology used to gain prevalence data

Drug + Alcohol Services

• The largest numbers were indicated in CDTS's and ADS with between 161-248 clients (37-67%) in the last quarter (July-Sept 2012)

• 813 people with coexisting mental health and substance use were identified in this sector. Leeds Addiction Unit (LAU) was not able to provide any data and ADS could only provide data on new presentations. Consequently this number is likely to be significantly underestimated.

Criminal Justice Services

• 202 of the people accessing these services were identified as having coexisting mental health and substance use difficulties.

• 143 of these were accessing DDR/RAPS. DIP/IOM and CRI don't currently use TOP and the lower numbers identified in these services may reflect the limitations of their services to measure or capture this information.

Homeless Services

•500 people accessing these services were identified as having coexisting mental health and substance use problems.

Statutory Mental Health Services (LYPFT)

• High numbers of people with coexisting mental health and substance problems were identified in the AOT. This supports the importance of the joint working protocol with City Wide Harm Reduction facilitated by Leeds DD Project.

• The data provided by AOT, inpatient and R+R services is consistent with prevalence rates identified in previous studies.

• The data provided by CMHT's and ICS was very limited and not sufficient to provide an accurate rate of prevalence in these services.

Voluntary Sector Mental Health + Mental Health Housing Support Services

• Aspire (early interventions in psychosis) clearly had the highest number (180) of people with coexisting mental health and substance use problems accessing their service in this sector.

• Due to the large number of services this sector covers generalising trends is difficult. However, there are clearly a significant number of people accessing all services with coexisting mental health and substance use problems.

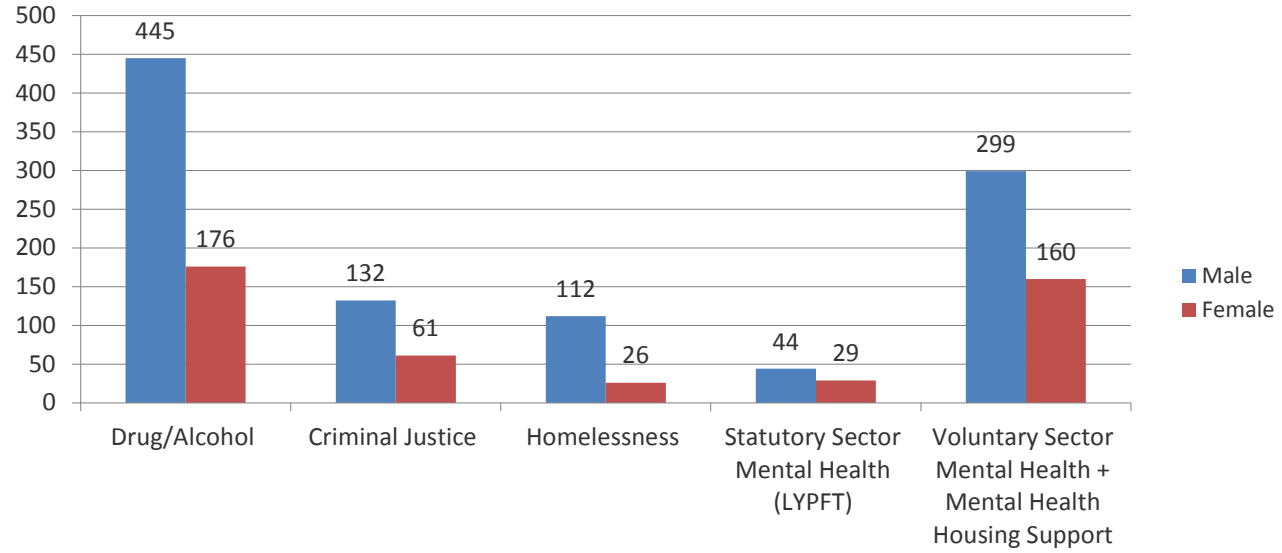
2 – Discharge Information

All services were requested to provide information on the number of people with coexisting mental health and substance use difficulties who had been discharged from their services in the last quarter for a variety of reasons e.g. completion of care plan, disengaged from service, transferred to another service etc.

• Although services record discharge information for service user almost all services that participated had difficulty in providing accurate discharge information as they are not able to cross reference this information with specific regard to people with coexisting mental health and substance use difficulties.

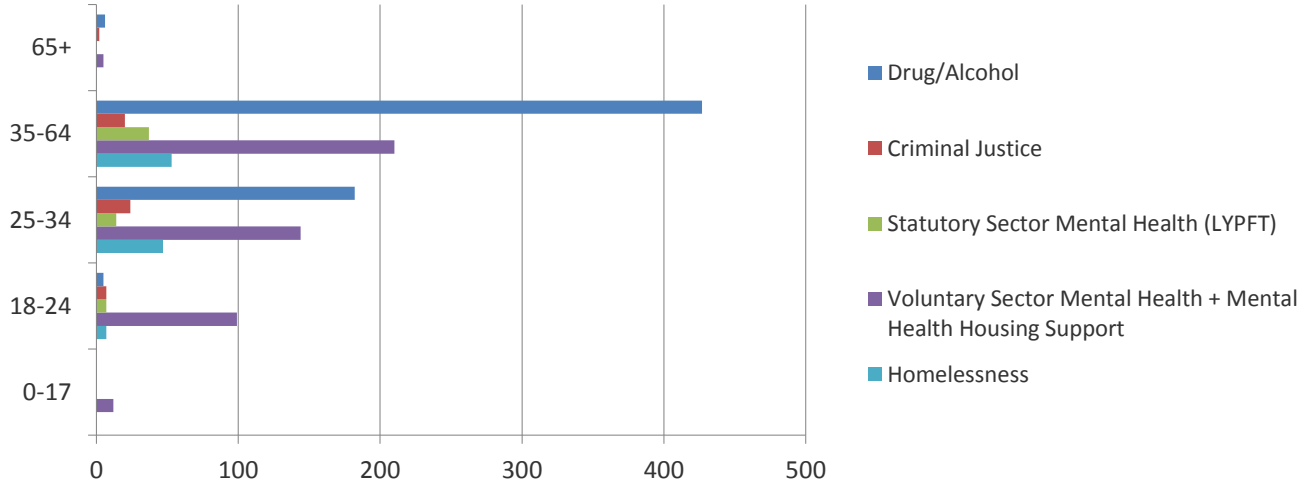
3 – Demographic Data

Chart 1 – Gender



• The gender ratio of people currently accessing service is consistent across all sectors approximately 70% male v 30% female.

Chart 2 - Age



• The largest number of people accessing services were in the 35-64 age group. The age categories used however are not proportional and difference trends were identified across sectors.

• Drug/alcohol services identified large numbers in the 35-64 age group potentially reflecting the aging population of drug users. Voluntary sector mental health and mental health housing services identified a large proportion of people in the 18-24 and 25-34 age groups, potentially reflecting high rates of prevalence in early intervention with psychosis service (Aspire).

Ethnicity

• Data provided regarding ethnicity was of a poorer quality than age and gender demographic categories i.e. data was not provided or fully completed. Consequently it was not possible to interpret or present meaningfully.

4 – Severity

Participants were requested to provide information on the percentage of people accessing their services in line with the 4 categories of severity identified in the Department of Health Dual Diagnosis quadrant – Visit http://www.dual-diagnosis.org.uk/?cat=46 for more information.

• The databases used by all services are able to provide very limited information with regard to the severity of people accessing their services with coexisting mental health and substance use problem.

• The information provided therefore reflected the perceptions of service managers and was consistent with the DD quadrant mapping undertaken by the Leeds DD network in April 2012. See http://www.dual-diagnosis.org.uk/?cat=46

• The percentages of people accessing services from each category identified in the Dual Diagnosis Quadrant (DoH 2002) primarily reflect the commissioning basis of services.

• Housing services indicated supporting the widest range of people with regard to categories of severity.

5 – Screening

The recommended screening tools to be used by Leeds Dual Diagnosis Network members are AUDIT, ASSIST, Brief Mental Health Screening Tool, GAD7 and PHQ9. These are identified in the Leeds Dual Diagnosis Care Co-ordination Protocol

• Drug and Alcohol Services - All routinely use the recommended screening tools to identify mental health and substance use problems. There is some inconsistency across the sector with some services not currently using PHQ9 + GAD7.

• Criminal Justice Services – All routinely screen for mental health problems although not all currently use PHQ9 + GAD7.

• Homeless Services – 2 of 3 services use screening tools to identify mental health problems and only 1 service to identify substance use problems. Furthermore, the screening tools identified are currently only used sometimes as opposed to routinely.

• Statutory Sector Mental Health Services – The standard of practice across services in this sector was extremely varied. 3 services indicated routinely using screening tools to identify substance use, 6 services sometimes used these screening tools and 3 services indicating never using screening tools.

• Voluntary Sector Mental Health and Mental Health Housing Support – Only 1 of the 24 services in this sector identified using screening tools to identify mental health and substance use problems.

6 – Training

Availability and approximate percentage of staff who have received training -

• Drug and Alcohol Services - All services have a wide range of training opportunities available and high levels of practitioners have completed basic training in all areas (75-100%). 9 of 10 services indicated having 25 % or more practitioners trained to level 3 DD standard. This figure may be overestimated however as 25% was the smallest category participants could choose.

• Criminal Justice Services – All services indicated the majority of practitioners had completed training in all basic areas. 2 services did not indicated level 3 DD training was available to practitioners and only 1of 3 services had practitioners trained at this level

• Homeless Services – Training opportunities for practitioners and levels of training varied widely across the 3 services in this sector.

• Statutory Sector Mental Health Services – Basic training in all areas is available to the majority practitioners however the availability of specific dual diagnosis training is variable across services. Similarly, the majority of staff have received basic DD training although only the minority have been trained to dual diagnosis level 2+3 standards.

• Voluntary Sector Mental Health and Mental Health Housing Support – The majority of services indicate the availability of basic training in all areas, and therefore high levels of basic training are evident across the sector. The availability of specific DD training is extremely varied and only 3 of 24 services have practitioners trained to level 3 standard.

Sources of training –

• All sectors indicated that basic awareness training is sourced in-house or by local providers.

• LAU is identified by all sectors as the access point and provider for specialist DD training i.e. Level 3

• The DD Project, DD Network and DD lead practitioners are identified by a large number of services as a source of basic DD awareness training and a link to access specialist training.

QUESTIONNAIRE 2 - Practitioner Questionnaire

This questionnaire was sent by email to frontline practitioners who work in services represented in Leeds Dual Diagnosis Network at the time the evaluation was undertaken (December 2012). The structure of the questionnaire follows the key steps identified in the Leeds Care Co-ordination Protocol. The protocol was agreed by all network partners in January 2012 and describes locally agreed assessment, co-ordination and joint-work criteria.

QUICK GUIDE FOR CARE CO-ORDINATION & REFERRALS:

STEP 1: Screening

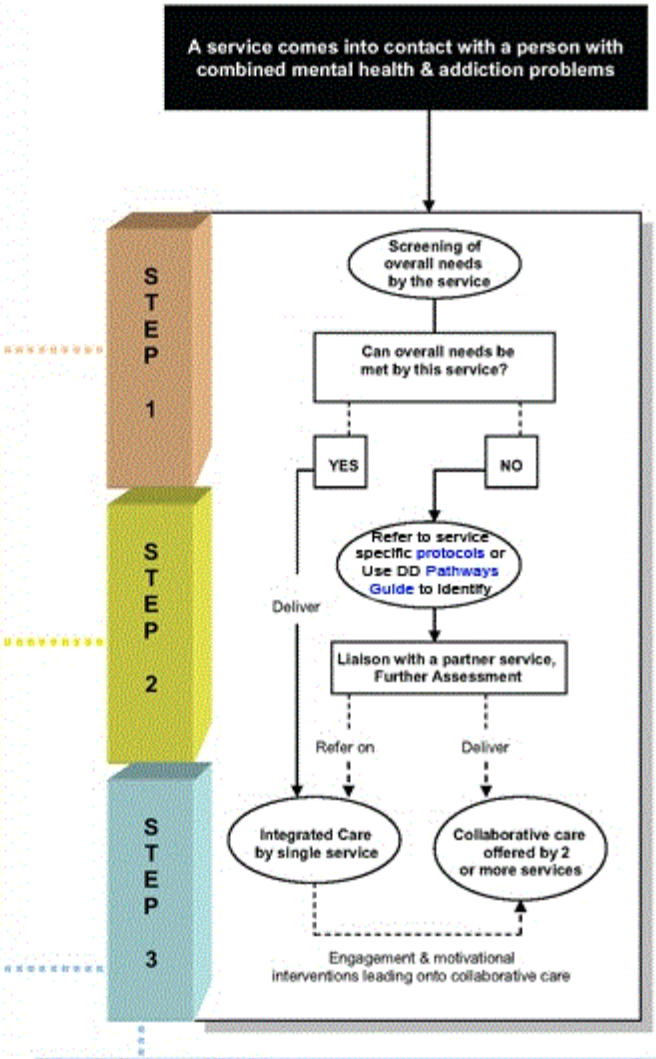
- Screening of overall needs –as a minimum– should consider: mental health history & current symptoms, substance use history & current patterns, housing status / housing needs, risk history & current risks, physical health needs.
- Services that are NOT mental health specialists can use brief questionnaires to gather information about mental health before considering referral options:
  Brief Mental Health Triage
  GAD7 + PHQ9
- Services that are NOT drugs treatment specialists can use a range of standardised assessment tools to establish patterns & severity of substance use:
  AUDIT, ASSIST.

STEP 2: Using the Pathways Guide

- The pathways guide is essentially a directory with brief descriptions of various services that often come into contact with people with Dual Diagnosis issues.
- Information gathered through initial screening should be used to **'match' specific client needs to specific services**. The pathways guide clusters services in different 'Sections' to facilitate the process of 'matching'. Some guiding questions to help in this process are:
  - Is the person in crisis? → See section A.
  - Presenting symptoms of common mental disorders? → See section B.
  - Presenting symptoms of severe mental disorders? → See section C.
  - Requiring drug / alcohol related interventions? → See sections D & E.
  - Homeless or requiring support with housing? → See sections F & G.

STEP 3: Care Models

- The Department of Health's Dual Diagnosis good practice guide (2002) describes *integrated care* as a best practice model: where treatment is offered concurrently for mental health, substance use and other related needs during the same period of care.
- In some cases, clients may access *integrated care* within a single specialist service, and this approach is often preferred by service users and maximises engagement and continuity of care.
- In other cases, care may be offered following a collaborative or shared care model: where two or more services are involved in offering different aspects of care & support. The defining feature of collaborative care is the delivery of services under a shared and explicit care plan describing the aims, expectations and roles of the different services/people involved. Care co-ordination under CPA can be taken as a model for this approach.
  N.B. – If a service does not formally care-ordinate e.g. via CPA the expectation remains that a named service will still take the lead role in liaising between the relevant services involved in a persons care.



CARE CO-ORDINATION

In accordance with local care co-ordination guidelines, where more than one organisation is involved, care should be co-ordinated by a named service. There are specific conditions based on which specific services would take on the role of care co-ordination:

CONDITION	CARE CO-ORDINATOR
Severe and Enduring Mental Health Problem (and combined addiction)	Secondary care mental health team (e.g. CMHT, AOT)
Common Mental Health Problem (and combined addiction)	Community Drugs Treatment Service
Involvement in criminal justice sector (and dual diagnosis)	Criminal Justice service (e.g. DIP, forensic services)
Homelessness (and dual diagnosis)	Homeless team (e.g. NFA, Street Outreach Team)

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Participation

Table 3 – Overall Response Summary

Total No. of Questionnaires sent	330
Total No. of Responses	90

Table 4 – Response Summary by Sector

Service Type	Response Count	Response %
Drug/Alcohol	19	21.1%
Criminal Justice	5	5.6%
Homelessness	1	1.1%
Statutory Sector Mental Health (LYPFT)	22	24.4%
Voluntary Sector Mental Health + Mental Health Housing Support	43	47.8%
	90	**100%**

• 90 practitioners participated in the evaluation giving a response rate of 27%. Although this may appear low it is consistent which the current literature identifying rates of response between 10-40% for external online surveys (Lefever et al 200, Nulty 2008).

• 48% of respondents were from voluntary sector mental health and mental health housing support services, 24% from statutory mental health services (LYPFT), 21% from drug/alcohol services, 6 % from criminal justice services and 1% from homelessness services. This response represents a good cross section of the Leeds DD Network. In addition, it is broadly representative of the total workforce across all sectors.

Step 1 – Screening + Assessment

• Drug/alcohol services and statutory sector mental health services (LYPFT) are currently using the agreed screening tools identified in the Leeds Dual Diagnosis Care Co-ordination protocol. There use in statutory mental health services (LYPFT) however is less consistent than drug/alcohol services

• Voluntary sector mental health and mental health housing support services indicated that they rarely use screening tools.

• Practitioners perceptions of the categories of severity of coexisting mental health and substance use problems their services could support was consistent with those identified by their managers in questionnaire 1. Furthermore this was also consistent with the Leeds Dual Diagnosis Quadrant which was mapped in April 2012 - http://www.dual-diagnosis.org.uk/?cat=46

• The majority of practitioners believe their services can meet the overall mental health and substance use needs of people accessing their service. However a significant number of practitioners from voluntary sector mental health and mental health housing support services indicated having difficulty meeting peoples overall needs.

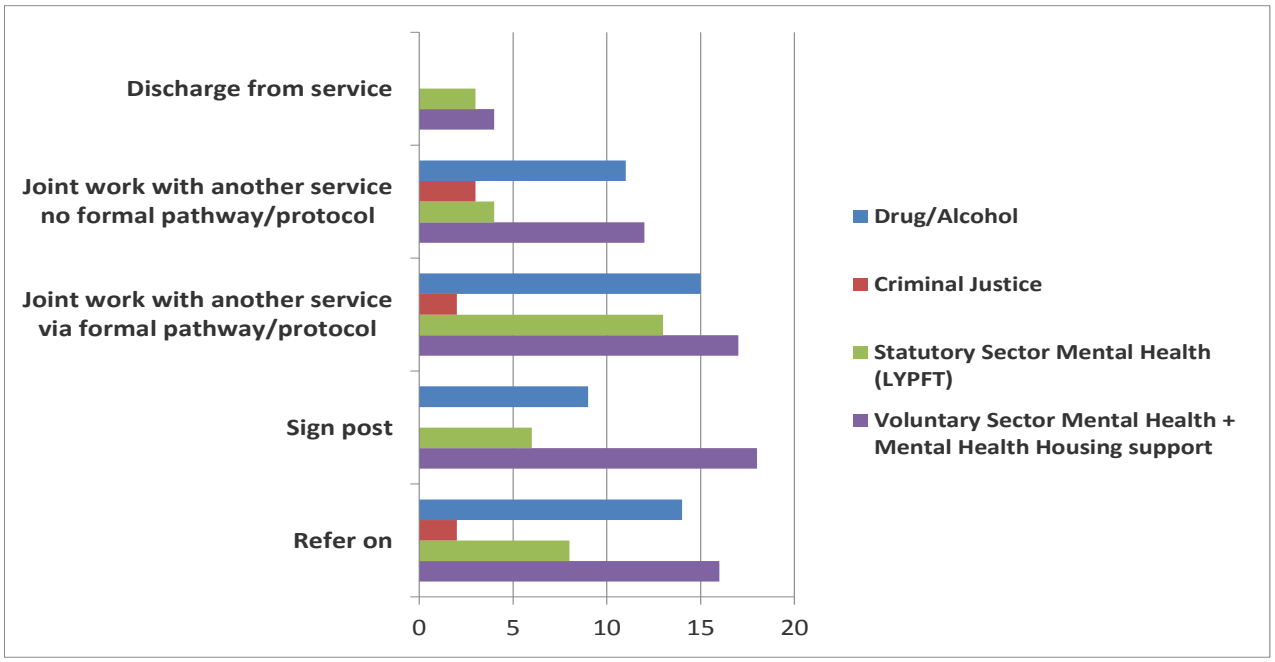
Step 2 – Joint Working

Common reasons for joint working with another service –

• Complexity and managing risk were the most common reasons for seeking to joint work with other services.

• A significant number of practitioners also indicated difficulties engaging with client or client not engaging with service as reasons for joint working with other services.

If you cannot meet the needs of a client with coexisting mental health and substance use problem what do you do?



• Joint working is most commonly undertaken via formal pathways or protocols although a significant number of participants identified using no formal pathway.

• LAU was the most common agency identified to routinely engage in joint working and CMHT's the second most popular. Practitioner's third choice of referral agency was extremely varied.

• Practitioners identified that referrals for joint working are always or often accepted. However, a significant number of practitioners from voluntary sector mental health and mental health housing support services indicated that only about half of their referrals were usually accepted

Most common reasons for referrals not being accepted -

Rank	Themes Identified
1st	Level of Substance use
2nd	Statutory sector MH services reluctance to work with substance use
3rd	Criteria of services
4th	Risk
5th	Engagement

• Drug/alcohol, criminal justice and voluntary sector mental health + mental health housing support services indicated difficulties referring to CMHT's when substance use was considered too high.

• Drug/alcohol and criminal justice identified that clients may fall between the criteria of primary and secondary care mental health services, or that there is a lack of clear criteria when referring to services e.g. LAU

• Statutory sector mental health services (LYPFT) identified difficulties when clients were considered high risk or mental health issues were perceived as needing to be addressed first.

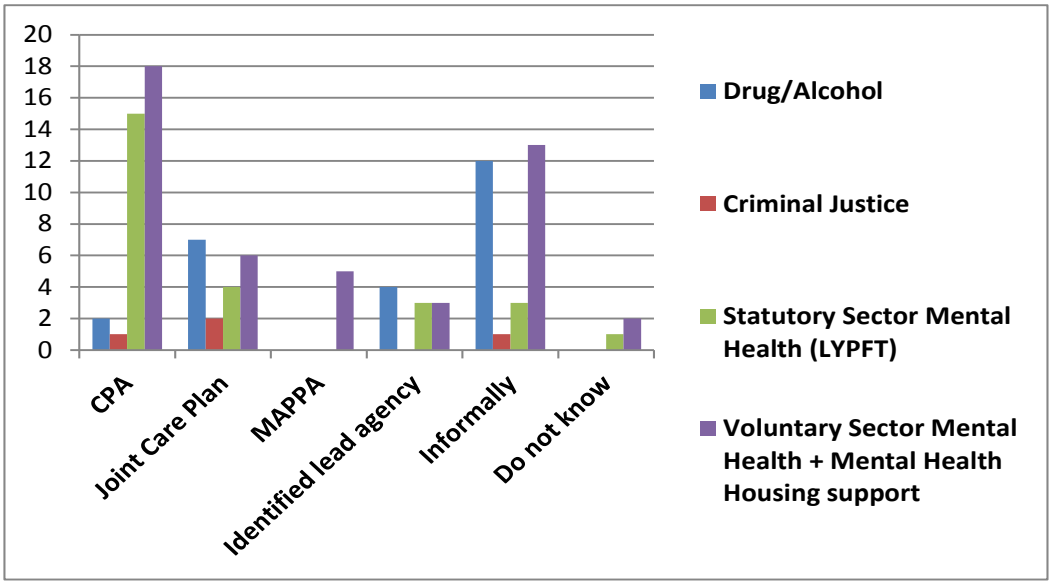
• Voluntary sector mental health and mental health housing support services indicated difficulties when clients were having problems engaging or their substance use was considered too high/low.

Step 3 – Care Co-ordination

• When joint working has been agreed with another agency the majority of practitioners indicated that engaging with this agency was fairly or very easy.

• The importance of relationships between practitioners and services was identified as being an important feature of this process. This supports the importance of the Leeds DD Network promoting positive working relationships between services and facilitating joint working.

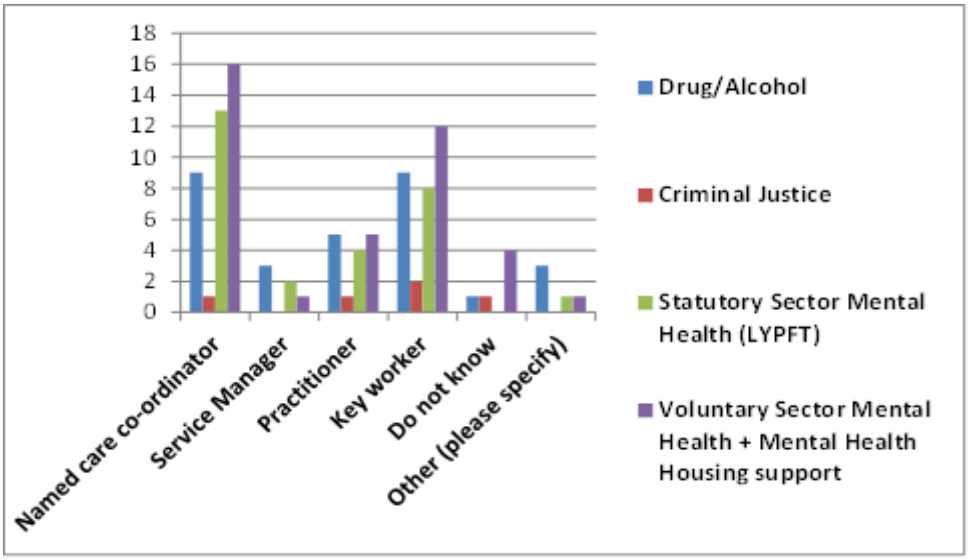
How joint working is monitored



• Care Programme Approach (CPA) was the most common method of monitoring joint working; although joint care planning is also commonly used.

• A significant number of practitioners primarily from drug/alcohol and voluntary sector mental health/mental health housing support services highlighted that joint working is monitored informally.

How is the lead role in managing collaborative working with another agency determined?



• Practitioners identified that the lead role in managing joint working with another agency is normally determined with a named care co-ordinator (39) or key worker (31)

Discharge and Exiting Services

• A wide range of outcome tools are used by practitioners across network member services to identify appropriate discharge. The tools used vary across sectors depending on their appropriateness.

• Moving people with on to other services to meet their on-going coexisting mental health and substance use needs was identified as challenging. See table below for the most common reasons identified by practitioners.

Most frequent barriers to a planned discharge

Rank	Themes Identified
1st	Engagement difficulties
2nd	Finding Services Appropriate to clients need
3rd	Client reluctance
4th	On-going substance use
5th	Service capacities/waiting lists

SECTION 3 – RECOMMENDATIONS + NEXT STEPS

Prevalence

The vast majority of service could provide information on the prevalence of people with coexisting mental health and substance use accessing there services. The quality of information provided was significantly impacted by the limitations of client management systems used by services.

- In the future DD information should easy to obtain from all client management systems.
- Databases and client management systems need to be more integrated across all sectors.
- Wherever possible services should be using the same client management systems for a more consistent approach.
- Consistency of the use of client management systems needs developing across 3rd sector agencies.
- To ensure consistency across services primarily working with substance use all services will use TOPS in the future. This will be identified in commissioning.
- Completion of TOPS needs to be consistent citywide. This will be included in service monitoring and NDTMS reporting requires a minimum of 80% completion.
- The introduction of the substance use pathway in LYPFT services will enable DD data to be readily available in the near future beyond care cluster 16 (dual diagnosis).
- LYPFT DD Implementation Group will be mapping a small sample of CMHT case loads to help identify DD prevalence. This will be used to help inform future service provision as part of the on-going transformation project.
- The high rate of prevalence identified by Aspire (Early Interventions in Psychosis) requires further exploration. The DD Project will liaise with Aspire and regional colleagues to gain information from York and another core city to enable a comparison with Leeds.

Screening

- The introduction of the LYPFT substance use pathway in the near future will promote routine screening for people accessing LYPFT services.
- In drug and alcohol services screening for mental health will be undertaken as identified in the Common Mental Health Problems Protocol currently being reviewed by the DD Project. The protocol emphasises the need for low level interventions to be delivered in house.
- The remodelling of drug and alcohol services will reflect the standards identified in the Common Mental Health Problems Protocol.
- The current delivery of level 2 training across the city will help improve the screening skills of practitioners from all sectors.

Discharge Information

This information is currently recorded but not cross referenced with specific regard to DD.

- Commissioners will look at what information they want from providers and this will inform future outcome based commissioning and payment by results (PBR).

Demographics

- The DD Project will liaise with LYPFT and Aspire to explore the potential for these services to provide an ethnicity breakdown of people accessing their services with coexisting mental health and substance use difficulties.

- The DD Project will liaise with young peoples and adult mental health and substance use services i.e. CAMHS, Platform, Aspire, LYPFT + LDCP to determine how these services are currently linked and facilitate any future development.

Training

- The DD Project will work with network partners to clarify the confusion around the 3 different levels of DD training available to network partners in line with 'Closing the Gap: A capability frame work for working effectively with people with combined mental health and substance use problems' (Hughes 2006).

- The current training approach adopted by the work DD Network requiring all network partners/DD lead practitioners to be trained at level 3 will be reviewed.

- Commissioners will look at the competency based skills required by different services and include these in service requirements.

Joint Working

- A significant amount of joint working was identified as taking place via informal pathways which rely on established relationships and trust between practitioners and services. This highlights the importance of the DD Network and its role in facilitating positive relationships. The DD Project will investigate how these relationships and pathways could be developed in the future.

- The service user experience of being sign posted to services will be examined in more detail by the DD Expert Reference Group. The aim will be to gain an insight into how service users navigate services e.g. how useful is sign posting to services? What information do services users need to act when sign posted? Do service users find out about services from professionals or peers? The learning from this consultation will be feedback to the DD Strategy Group to inform future DD strategy and care pathway development.

- DD lead practitioners in West Leeds from the CMHT, CDTS + LAU currently meet on a monthly basis to discuss referrals, joint working and good practice. The DD Project will support LYPFT + LDCP to formalise and replicate this model across Leeds in the other 2 localities i.e. East and South.

- The DD Project will ensure all network partners are kept up to date and aware of the criteria and referral process into services within the DD Network.

- The need for consistency when joint working will be reflected in DD training and in service level agreements

- The DD Project will continue to promote active relationships between services and challenge perceptions and attitudes that create barriers to effective joint working relationships i.e. LYPFT reluctance to work with substance use + difficulty referring to CMHT's. Practitioners and managers will be encouraged to contact the DD network if there is evidence of this occurring in practice.

Care Co-ordination

- When people are not under Care Programme approach (CPA) the monitoring of joint working is often informal. The DD Project will investigate informal joint working by arranging a focus group at a future DD Network Event. Learning from this focus group will be feed to the DD Strategy Group to inform future DD strategy and care pathway development.

- The DD Project will explore how the role of DD network and DD lead practitioners can be developed in the future to include a greater emphasis on care co-ordination.

SECTION 4 – FUTURE EVALUATION

- The completion of this evaluation demonstrates that it is feasible to undertake a project of this scope with active support from key stakeholders, a pragmatic approach and limited resources.

- This evaluation has created a template methodology on which future evaluations can be based, and provided a baseline of data with which to compare it.

- A evaluation of this nature should be conducted by the Leeds Dual Diagnosis Network on a regular basis e.g. bi-annually as part of a cyclical learning process which contributes towards an evidence based approach to development of local dual diagnosis strategy and service development. This is congruent with the primary function of Leeds Dual Diagnosis Project which aims to improve access to treatment and outcomes for people with dual diagnosis.

- The learning from this evaluation process should be used to further improve and refine future evaluation methodology e.g.

    1. Questionnaires could be simplified removing questions that did not provide meaningful or useful data.

    2. The sample size of questionnaire 2 was arguably too large and could be administered to Dual Diagnosis Lead Practitioners rather than a larger number of frontline staff.

    3. Involvement of service users to explore their experience of navigating services and care pathways would add qualitative depth to the findings.

    4. The support of commissioners, service managers, key organisational staff and practitioners is essential to maximise participation and engagement.