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# **DUAL DIAGNOSIS**

## **Good Practice Handbook**

Helping practitioners to plan, organise, and deliver services for people with co-existing mental health and substance use needs



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# Foreword

**The *Dual Diagnosis Good Practice Guide*, published by the Department of Health in 2002, provided a framework in which to consider the complex needs of people with mental health issues and problematic substance use. Turning Point is actively engaged at the frontline to understand the issues involved in developing and implementing services to meet those needs.**

This handbook brings together the practical lessons that Turning Point has gathered from its own experience and from talking candidly to a range of voluntary and statutory sector professionals about what has worked and, equally importantly, what has not.

There is now broad consensus about many of the underlying principles for a quality service. These include the importance of incorporating a values base to support constructive relationships and recovery; involving service users and carers; having locally agreed definitions of dual diagnosis; and working in partnership with a wide range of agencies to provide co-ordinated health and social care.

It is encouraging that services are genuinely listening to what is needed in their area rather than adopting a 'one size fits all' approach. However, the extent of this variety underlines the importance of drawing together learning and good practice. It is vital that both frontline staff and commissioners are able to draw on the evidence of what has worked and have a realistic understanding of the process and costs of implementation.

It is clear that there is a long way to go to genuinely meet the complex and changing needs of people with co-existing issues. But we commend this handbook as a valuable step on the road to achieving high quality services and real quality of life improvements for service users and their families.



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# Part A:

good practice  
components,  
key policies and  
commentary

# Section one: introduction

## What's in the handbook?

This handbook has been written to support the development of services for people with co-existing mental health and substance use problems.

At the heart of the handbook is a series of case studies showing how particular services have implemented good practice. Based on extensive discussions with both professionals and service users, we also discuss the key issues and learning points and propose components of good practice.

The key aims of the good practice guide are to:

- Build on current dual diagnosis guidance and demonstrate its application in a range of settings and services
- Promote dialogue between professionals so that experiences, knowledge, skills and resources are shared
- Provide case studies, demonstrating how good practice can be replicated elsewhere and including contact details and resources to share
- Through the sharing of learning, to enable services to improve care pathways and provide quality support.

The development of the handbook has been funded by the Department of Health (DH) and supported by a steering group, which brings together the expertise of service users, practitioners and providers. The Care Services Improvement Partnership (CSIP) and the National Treatment Agency (NTA) are key partners.

Although the handbook only covers services in England, much of the material will be applicable elsewhere.

The handbook can also be downloaded from the publications area of the Turning Point website ([www.turning-point.co.uk](http://www.turning-point.co.uk)).

This handbook can be read in conjunction with the *Dual Diagnosis Toolkit: Mental Health and Substance Misuse* (Turning Point and Rethink, 2004), which provides an introduction and overview of dual diagnosis and includes information about specific mental health and substance use problems. This toolkit is also available through the Turning Point website.

## Who is this handbook for?

The dual diagnosis handbook is a practical manual primarily for staff involved in the development and delivery of services for people who have co-existing mental health and substance use problems. It will be useful for those working in specialist dual diagnosis services and more generic teams. There are also some key messages for commissioners and those in other strategic roles.

## What the handbook offers

The handbook contains practical information designed to help you to learn from, and apply, good practice in your services. It is divided into five sections.

1. Introduction
2. The components of good practice
3. Key guidance and policy documents
4. Commentary
5. Case studies

After this **introduction**, there is a section describing the **components of good practice**. These were identified at the initial stages of the project and used as a framework to gather information from services. In developing the components, we consulted our steering group and reviewed literature and government policy relating to dual diagnosis.

The **key guidance and policy documents** section gives a very brief summary of the relevant policy framework.

We then include a **commentary** which examines some of the main themes from interviews with organisations featured in case studies, and feedback that we received from a whole range of services working in the field of dual diagnosis. 'Snapshots' of good practice help to illustrate some of these points.

The key part of the handbook contains the **case studies** from services working with people with a dual diagnosis in a range of settings and localities. These include advice that practitioners would like to share and offers practical help for anyone seeking to develop dual diagnosis work.

**A note on language**

We recognise that there is a range of terminology in this field and we have tried to keep jargon to a minimum. Acronyms have been spelt out in full when first used, and a list of abbreviations can be found on the inside back cover. We are aware of the different terms used around substance use and misuse. In this handbook we have generally used 'substance use' when referring to individuals, but retained 'substance misuse' when describing service provision. In the case studies, we have, as far as possible, retained the language used by the services themselves.

**How we gathered the information**

We gathered information from 40 services and held in-depth conversations with 15 of these to establish their areas of strength and the challenges faced in developing their work. We also received valuable feedback from four dual diagnosis workshops.

# Section two: the components of good practice

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These components represent the best available consensus on the elements of good practice. They are drawn from the practical experience of professionals and service users as well as from research and policy guidance.

## Working with service users, carers and families

People providing dual diagnosis services do best when they take time to listen and when service users are treated with respect. Working with people who have direct experience of using services, as well as their carers and families, is vitally important at all stages of good practice.

We have also mentioned working with service users and carers in the other components where it is especially relevant.

### Good practice standards

- Information about services should be accurate, in straight-forward language, in accessible formats and in a language that people can understand
- There should be openness, dialogue and good collaboration with service users, carers and families to ensure that everyone is well informed about the services on offer, and that they have clear expectations about the working relationships between service users and staff
- Services and staff should take account of different values and perspectives

- Services should be culturally sensitive and take gender, race and sexuality issues into account
- Service users, carers and families (as appropriate) should be consulted and actively involved at all stages of service development, from planning to service delivery and evaluation.

## Planning and commissioning of services

The main focus of this project is on practitioners and delivery of care. However, we recognise that good service delivery is improved with good commissioning.

### Good practice standards

- Commissioners and providers should be aware of the nature and scale of the issue (informed by local audits and service mapping). This enables appropriate planning and targeting of services and mitigates risks to the health and wellbeing of individuals.
- There should be a co-ordinated approach to commissioning mental health and substance use services to ensure that funding of treatment for people with co-existing conditions is adequate, secure and long-term, although funding may come from different streams.
- Planners and identified joint commissioners of services should be working with local implementation teams (LITs) and drug and alcohol action teams (DAATs) to ensure a co-ordinated approach.
- Contracts with providers and service specifications should explicitly address co-existing mental health

and substance use problems.

- The services that are commissioned should connect to both national and local policies on dual diagnosis.
- Commissioners should develop strong partnerships with providers and engage service users in understanding needs.

## Service delivery

The *Dual Diagnosis Good Practice Guide* (DH, 2002) recommends 'mainstreaming services' to ensure that, as far as possible, all service users with severe mental health issues and problematic substance misuse are treated within mainstream mental health services.

### Good practice standard

- Service delivery protocols should be agreed between mental health and substance use teams.

## Locally agreed definition of dual diagnosis

The *Dual Diagnosis Good Practice Guide* (DH, 2002) advises services to "generate focused definitions which reflect the target group for whom their service is intended."

### Good practice standards

- There should be a locally agreed definition of dual diagnosis shared within an agency and across agencies

- There should be adequate referral mechanisms for people who fall outside this definition so that they can access the support they need.

### Inter-agency working

Defining target client groups and agreements on provision, as described above, should be achieved through inter-agency collaboration across mental health and substance use services from all sectors. There may be different models of effective inter-agency working including dedicated dual diagnosis teams, assertive outreach teams specialising in dual diagnosis and networks of expert local clinicians. Agencies should have a shared and consistent approach to working with an individual with a dual diagnosis to ensure that their work is complementary.

#### Good practice standards

- There should be a local strategy for working with people with co-existing needs. This needs to be adopted by all relevant agencies.
- Explicit local protocols on multi-disciplinary and multi-agency working should be developed.
- There should be systems and protocols in place on confidentiality and sharing information between agencies. This includes clarifying what information can be shared, and in what circumstances.
- There should be mechanisms for liaison between different mental health and substance use services, regardless of what model of service exists locally.
- Practical ways to improve integration at service

delivery level should be promoted; eg through a local dual diagnosis network.

- When agencies work together, each agency should be clear about their individual roles and take responsibility for fulfilling them.
- Agencies should know when it is appropriate to seek help from other agencies.

### Assessment

Assessment is a crucial part of the process as it affects an individual and influences their subsequent treatment and care pathways. Substance use among people with mental health problems is common and affects treatment outcomes. Assessment of substance use should therefore form a routine part of mental health assessments and vice versa.

#### Good practice standards

- Assessment should be multi-disciplinary and multi-agency, given the complex needs of people with a dual diagnosis.
- Every service user should be asked basic screening information about their mental health and substance use.
- Any comprehensive assessment should include a detailed mental health history and a detailed substance use history, a physical health assessment and an assessment of a client's motivation to change.
- Assessment should include a risk assessment. This should include discussion about management of risks with service users who are partners in the process.

### Treatment and co-ordination of care

These components do not look at individual clinical interventions or make judgments about the relative effectiveness of different types of intervention. Our focus is on the process and organisation of care. We are interested in how guidance has been applied to improve care pathways and to support individuals with a dual diagnosis and the staff working with them.

Treatment needs to focus on the 'long haul'. Services should tolerate and continue to work with service users who have poor attendance records and who do not comply with their medication.

Effective treatment needs to be evidence-based and provide an integrated response with good brokerage arrangements to address multiple needs.

It is important that time is spent engaging with service users with a dual diagnosis before treatment plans are made. For a variety of reasons, service users often have difficulty in approaching mainstream services. It is therefore vital to engage with them in a meaningful and positive way to work towards long term recovery.

#### Good practice standards

Treatment should include:

- Engagement
- Enhancing motivation for change
- Active treatment
- Relapse prevention
- Access to a full range of substance use services and

- mental health services, as appropriate
- Availability of a range of pharmacological, psychological and social interventions.

### **Experience and skills**

There are different approaches to training (eg training individuals or training whole teams). Training does not need to be purchased from outside the organisation and training from local providers should be encouraged.

#### **Good practice standards**

- A training strategy should identify the needs of all staff and professional groups working in statutory and voluntary organisations, including both Trust staff and stakeholder groups.
- Training should take note of the service user's experience; ideally, service users should take part in delivering it.
- There should be adequate, supportive supervision structures and mechanisms which are consistently applied to ensure that training is influencing practice.
- There should be mechanisms for information exchange, sharing skills and inter-agency training.
- Education and training partnerships should be developed to ensure that service users, carers, families and professionals have access to up to date information and advice.
- Skill acquisition should be both formal and informal; creative approaches such as job shadowing should also be considered. It is also important to recognise transferable skills.

- Training should include ethical and legal issues, medication and interaction with other substances, relapse prevention, care co-ordination and an understanding of the impact of race, culture and religion.

### **Monitoring, evaluation and research**

It is important that systems are in place for monitoring and evaluation so that lessons learnt can improve service delivery. Service providers should aim to research and develop new treatment approaches and re-examine the needs of service users who have previously been considered difficult to engage and treat.

#### **Good practice standards**

- Explicit monitoring requirements should be agreed with providers. These should be included in service agreements and specifications.
- There should be agreement around key indicators, data collection, measurement of outcomes and how this information is used. Outcomes should reflect the needs of the service user.
- There should be specific measurable objectives and agreed timescales which are regularly reviewed.
- There should be a multi-agency approach to developing clinical audits. The audit should specifically address dual diagnosis work.
- There should be an audit cycle covering all aspects of the service where feedback from all stakeholders should be fed into service provision, staff awareness and practice.

# Section three: key guidance and policy documents for dual diagnosis

This section highlights the main policies and guidance influencing care provision for people with a dual diagnosis. Some of the policy documents from the mental health or substance misuse field that are relevant to dual diagnosis are listed below. Some of these documents are due for updates in the near future. For a comprehensive listing see:

[www.eastmidlands.csip.org.uk/dd/dd.zip](http://www.eastmidlands.csip.org.uk/dd/dd.zip)

## Dual Diagnosis Good Practice Guide (DH, 2002)

The *Dual Diagnosis Good Practice Guide* provides a framework to help strengthen services and advocates a move towards an integrated system of care delivery. It focuses on bringing the care of people with severe mental health problems and problematic substance use into the mainstream, through mental health services taking the primary responsibility for their treatment.

Substance misuse agencies (both alcohol and drugs) should provide specialist support, consultancy and training to mental health teams. Where service users have less severe mental health problems, mental health services should provide similar support to substance misuse agencies.

It stresses the importance of clear care pathways of joint working and treatment, with both LITs and DAATs taking the lead.

## Dual Diagnosis in Mental Health Inpatient and Day Hospital Settings (DH, 2006)

This guidance covers the assessment and clinical management of patients with mental illness who are being cared for in psychiatric inpatient or day care settings and who also use or misuse alcohol and/or illicit or other drugs. It also covers organisational and management issues to help mental health services manage these patients effectively.

## Closing the Gap (DH, 2006)

*Closing the Gap: A Capability Framework for Working Effectively with People with a Combined Mental Health and Substance Use Problems* draws on existing national occupational standards in mental health, substance misuse and other fields to bring together one set of competencies for working with people with a dual diagnosis. There are three levels: core, generalist and specialist.

## The Care Programme Approach (DH, 2001)

*The Care Programme Approach* (CPA) is the framework which all services, including drug and alcohol providers, are advised to use for people with severe mental health and substance misuse problems. CPA guidance is under review with the possibility of

one level of care replacing the two current categories of 'standard and enhanced'. However people with a dual diagnosis are highlighted as a key group for whom services should make provision<sup>1</sup>.

## Models of Care for the Treatment of Drug Misusers (NTA, 2002)

Parts of *Models of Care for the Adult Treatment of Drug Misusers* has been replaced by *Models of Care: Update 2006* (NTA, 2006) and *Models of Care for Alcohol Misusers* (DH, 2006).

Models of care are two national frameworks for the commissioning of adult drug misuse and alcohol misuse treatments that are expected to be available in every part of England to meet the needs of diverse local communities.

## The National Service Framework for Mental Health (DH, 1999)

The framework sets out how services should be planned, delivered and monitored. It states that "the needs of people with a dual diagnosis should be met within existing mental health and drugs and alcohol services".

<sup>1</sup> New guidance is due in 2007 for implementation from April 2008.

# Section four: commentary

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The components of good practice (see section two) represent the ideal benchmarks for developing dual diagnosis practice and provision. This commentary outlines what people working in this field have told us about their experiences of delivering services and highlights common themes identified over the course of the project. It also draws on the written material we have received from the workshops held at each of the four 'Reaching out, Changing Habits' dual diagnosis conferences<sup>2</sup> as well as comments from our steering group.

The aim is to summarise the main points raised; to indicate the changing horizon of service delivery and practice as identified by service users and providers themselves; and to suggest some key learning for future practice and service development. We have referred to the wider policy context briefly where relevant (see section three).

## Strategic issues: planning and commissioning of services

### Complex health and social needs requiring a range of inputs

The provision of high quality services to people with a dual diagnosis of mental illness, substance and/or alcohol use remains a major challenge for policy makers, commissioners and providers. The *Dual Diagnosis Good Practice Guide* (DH, 2002) advocates mainstreaming the care of people with "severe mental health problems and problematic substance misuse" so that

mental health services take the lead responsibility. This approach aims to avoid service users being shifted between services and falling through the net of care. However, despite the above definitions and efforts to provide a framework, individuals who do not meet these criteria can continue to fall through the gap between services.

In addition, when compared with a mental health diagnosis alone, both literature and our experience indicate that people with a dual diagnosis are likely to have:

- More severe mental health problems
- An increased risk of suicide, victimisation or being violent
- Less compliance with medication and other treatment
- More contact with the criminal justice system
- Family problems and/or a history of sexual/physical childhood abuse.

As highlighted by the Social Exclusion Unit's report *Mental Health and Social Exclusion* (2004), services need to reach beyond their own boundaries and recognise that people's difficulties are not purely health-related, but are compounded and influenced by a range of other factors, such as housing, employment or social isolation. In short, individuals with a dual diagnosis are an extremely heterogeneous population, requiring a range of interventions suited to their needs which no one treatment service or agency can meet.

### Lack of designated dual diagnosis funding

While it is widely recognised that co-ordination between agencies is key to meeting these complex needs, in practice this has often proved difficult. One reason for this is the way in which different policies and accountabilities drive separate sectors and services. Funding is also provided through a variety of routes that have, since 2002, focused primarily on substance use and criminal justice. Where dual diagnosis services are funded through Primary Care Trusts (PCTs), the levels of funding can vary depending on individual PCT priorities and budgets.

Although not unique to the dual diagnosis field, several services stated that the mismatch between available resources and individual service user preferences for particular types of treatment and care, forms another barrier to developing service provision. When finances are limited, dual diagnosis posts can be vulnerable to cuts as they do not directly contribute to current NTA treatment targets. Some services have pointed to the overload of central government initiatives and the subsequent impact on staff morale, turnover and training. Restructuring also affects service delivery as a high turnover of staff is unsettling for service users.

Services felt that there is sometimes another danger that people with more straightforward needs do not receive appropriate services. Substance misuse service users who have anxiety and depression may find that not all services can meet their mental health needs: eg because they lack the resources to provide psychological interventions for depression.

<sup>2</sup> These were run by the DH, CSIP and Home Office between October 2006 – January 2007.

**Key learning points**

- For a combined response to meet some of the health and social care needs of people with a dual diagnosis, commissioners might want to explore concurrent funding streams – (eg for mental health support services and substance misuse) – or look to share budgets to provide social care for vulnerable groups.
- Co-ordinating services and working in partnership is crucial to help achieve value for money and improve the effectiveness of outcomes, which are increasingly important to commissioners.
- While trying to cater for people with a range of needs, services should not neglect those whose needs are more straightforward.
- Service provision must be based on a local needs assessment of how frequently service users access both mental health and substance misuse services. The voluntary sector can play a key role in working with commissioners to understand the local market and to design and develop services.

**Getting Trust commitment and working with partners****Northumberland, Tyne and Wear NHS Trust**

The Trust has identified a directorate lead for dual diagnosis and a dual diagnosis strategy has been given priority status within the current Trust business plan. Service users are offered specialist assessment and treatment from a broad range of mental health and care services within the Trust in

line with their identified needs.

Working in partnership with the University of Northumbria at Newcastle, a regional dual diagnosis interest group has been established since 2001. Some of the aims of this forum are sharing good practice between agencies, building in service user and carer experiences, and developing a shared understanding of the most effective care packages.

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**Operational issues: delivering services and building partnerships****Defining the task is the first step**

In order to work together, local agencies need to define what they mean by 'dual diagnosis'. In practice, this can be a complex task not only in terms of language but also of underlying philosophy eg the extent to which health or social models are adopted.

There is no universally agreed definition of dual diagnosis but, when planning and delivering provision, it is important that services adopt a local definition, relevant to local needs. It should include major mental

health and mood disorders, personality disorders and substance use.

We are aware that dual diagnosis is a contested term partly because of the differing needs of people with multiple diagnoses and health problems. Dual diagnosis may not be the most appropriate language in all circumstances, and terms like 'enhanced care' and 'complex needs' are also commonly used.

Historically, services have not addressed the unique problems of those struggling with dual diagnosis; instead, they have treated the mental health problems and substance use as separate problems. However, more services are now being developed to treat both issues together. Among the services we contacted, multi-disciplinary approaches are widely seen as being more effective. The core of success in any setting is the availability of empathetic, hopeful relationships that provide integrated and co-ordinated service.

**Developing integrated models of care**

There are several issues that make integrated treatment difficult to implement. These include:

- Funding streams that are separate and can rarely be combined
- Agency turf issues that may not be able to be resolved
- Legitimate differences of professional philosophy regarding the best possible treatment
- Staff who lack the minimum degree of cross-training required for them to work together and

understand each other's vocabulary, treatment philosophies and care approaches

- Multiple, pressing needs for housing, medical care, vocational training that may need to be addressed before treatment for co-occurring disorders can be successful.

These themes are acknowledged in the substance misuse field in *Models of Care* (NTA, 2006) and on integrated care pathways in *Models of Care for Alcohol Misusers* (DH, 2006).

The CPA (see section three) is effective when it is reviewed regularly and when teams work well together. However, co-ordinating care between different agencies and professionals can still be difficult because of time and other pressures.

### Developing effective partnerships

Although we found that some services are developing effective partnerships, these are often the exception rather than the rule and many people felt that there needs to be 'more action and less talk'. However, services also need to recognise that partnerships take time to develop.

Common barriers to partnership working included perceived hierarchies within professions, different professional values (eg the medical model versus social interventions) and competing priorities between services. Effective teamwork also depends on individual personalities and a culture where staff can feel free to air their views and be innovative. Service

providers highlighted that many dual diagnosis workers often feel 'burned out' and disempowered to develop effective partnerships and others felt that frontline workers are not listened to.

### Key learning points

- Inter-agency working should include statutory and voluntary services along with agencies working within the criminal justice system.
- Developing partnerships needs support from senior management. This should be spelled out in business planning and in an organisation's strategic frameworks.
- Successful partnership working depends on good communication. This needs to be formalised with pathways agreed and responsibilities and roles identified for each team.
- Better co-ordination and collaboration of services for individuals with a dual diagnosis is needed within and between mental health and substance misuse services and others.
- Multi-agency approaches need to be developed with the extensive involvement of service users and carers.
- There should be a locally agreed definition of dual diagnosis but flexibility should be built in to reflect local variations.
- Confidentiality should not be used as a barrier to working together. Inter-agency arrangements should be made in ways which are consistent with the right to confidentiality. There should be a process to explore how confidentiality can best be managed for the service user, their family, and the workers involved.

### Strong partnerships across agencies and with services



#### Leicestershire Partnership NHS Trust

The Trust has established links with a wide variety of local partnership agencies including local DAATs, the strategic health authority (via the local implementation group), statutory and voluntary services and CSIP.

These partnerships will enable all teams within the Trust to access dual diagnosis services. Each service group will have a member of staff who has received in-house training in dual diagnosis. For complex needs, referrals are made to the nurse consultant for dual diagnosis.

Mental health and drug service staff work jointly with specific clients in meeting both their drug and mental health needs. Services currently provided within joint working include:

- Inpatient detoxification
- A daycare programme
- Individual counselling based on motivational interviewing techniques
- Community prescribing
- Group work
- Access to drug rehabilitation centres.

The Trust hosts a yearly conference to bring together clinicians, service users, carers, statutory

and non-statutory staff and commissioners to consider current issues for this client group.

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## Providing assessment and treatment

### Importance of early and shared assessment

Service providers emphasised that there should be awareness-raising programmes that encourage earlier detection of substance use and mental health issues for individuals with a dual diagnosis. A non-judgmental service user centred approach is needed to connect with service users who are often vulnerable, chaotic and too poorly motivated to receive help. Some service providers also argued that information gained from a joint assessment by all agencies involved in the care of people with a dual diagnosis, whether they are public, private or voluntary sector, should be used effectively.

### Assessment to consider a range of health and social factors

The services that we contacted considered that important areas for a comprehensive assessment include:

- Current, recent and past substance use
- Mental health
- Physical health (including sexual health)

- Social circumstances (including accommodation and family situation – especially children, employment or finances)
- Legal situation
- Personal and family history
- Service users' perception of their situation, their reasons for using and their motivation for change.

### Treatment that draws on a range of approaches

There is currently no standardised treatment for dual diagnosis, largely because it ranges across such a large number of problems and involves both substance misuse services and mental health services. Services are increasingly using motivational interviewing and CBT approaches, particularly in conjunction with pharmacology.

Although support, encouragement and the belief in the possibility of change is essential, treatment of people with a dual diagnosis can be challenging because their needs are typically complex and often long-term. There are also social factors to take into account, such as lack of housing or difficulty in accessing benefits which can also hinder successful treatment.

### Key learning points

- Assessment should ascertain how an individual's life is directly or indirectly influenced by mental illness and substance use. It should include the service user's perspective on how they would like to benefit from intervention and what areas they would like to prioritise.
- Services need to develop, and adhere to, clear policies

on joint assessments. They should also ensure that all agencies or services involved in providing care and treatment participate in the joint assessments and are fully aware of the outcomes. The result should be to integrate assessments so that they go beyond separate mental health and substance use assessments.

- Effective services recognise that recovery tends to occur over months, even years and they need to take a long-term perspective.
- Services need to be flexible enough to be able to respond to people's presenting needs and there should be realistic timeframes.

### An integrated approach addressing health and social needs



#### Walsingham House, part of St James Priory Project, Bristol

The St James Priory Project is a registered charity. It has operated in Bristol city centre for 10 years, offering comprehensive support to people with a history of homelessness and substance dependency. Walsingham House has grown out of this work and is an evidence-based dual diagnosis service to meet the needs of people who have historically bounced between services and received poor service outcomes.

The service is a residential treatment programme for people with co-existing mental health and substance misuse problems, including personality

disorders. It offers an integrated approach to treatment which is provided by one team with skills in both mental health and substance misuse. The team advocates a biopsychosocial model<sup>3</sup> underpinned by cognitive behavioural therapy (CBT).

Through partnership working with statutory and voluntary providers, the service addresses care pathways for service users once treatment is completed. Referrals are accepted from statutory and non-statutory agencies, as well as from self-funders.

Services include a mix of: group therapy, workshops, one-to-one counselling, mental state monitoring, psychiatric review (including medication), community skills, nutrition and dietary information, budgeting skills, progression to independent living skills, and exercise programmes. The service also provides specialist input for addictions, crisis and risk management planning, including access to Mental Health Act assessment. There is limited detoxification monitoring (for Bristol service referrers). Out of area clients must have already undergone detoxification.

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## Working with service users and carers

### Many agencies may be involved

Individuals with substance use and mental health problems are directed, or present themselves, to a wide variety of different agencies. These include health and social services, voluntary organisations, probation services, housing departments and the police. However, service users may still fail to receive appropriate help.

Service users have a vast range of experiences, skills, strengths and vulnerabilities and will therefore engage with services at different levels. Supporting people with a dual diagnosis and their families is a long and slow process and continued engagement is essential. Many people have lives that are too 'chaotic' to attend set appointments and may need an outreach approach to enable them to maintain contact with services.

### Offering continuity of care

When they are in contact with services, service users and carers often feel unsupported and under-valued. Service users value face-to-face contact and 'continuity of care' with key workers. Frequent changes of staff can work against this but, if service users meet other members of a team, engagement can continue if a worker is absent or leaves.

### Involving families and carers

Involving carers is a relatively recent phenomenon. Many carers feel that professionals do not trust them with information and that, consequently, they need to be very assertive to extract it. The extent of a carer's

involvement can be dependent on the personalities of the workers within a service and on the extent to which carers see themselves as carers. They are often anxious about identifying themselves as users of services, even though they may need to access some of the support offered by dual diagnosis services and other social and health services.

Carers have a wealth of knowledge and personal experiences through living with and/or caring for someone with a dual diagnosis. Families are the most common primary care-givers and consistently report difficulties in accessing the support they need, when they need it. In addition, many people with a dual diagnosis have no contact with their family and are very socially isolated. For these people, holistic support from a professional can be pivotal.

Individuals with a dual diagnosis may also be concerned that they are perceived to be poor parents. This can prevent them from engaging with services for fear of their child/children being taken into care.

### Key learning points

- Service users and carers often know what interventions work best for them, so should be involved with the development, delivery and monitoring of all dual diagnosis services and other general services.
- Services need to establish realistic expectations around service user and carer involvement. It is important that they are involved in an ongoing programme, and not just occasionally or in a tokenistic way.

<sup>3</sup> The 'bio' or biological – understanding the process of illness and the treatment required, such as medication; the 'psycho' or psychological – offering appropriate talking therapies; and the 'social' – offering accommodation, income and meaningful daytime activity.

- Services should be careful not to use jargon and acronyms that exclude service users and carers.
- Services should develop a trusting, supportive and consistent working relationship with service users. This will make it easier for their needs to be more regularly reviewed and therefore will help services to be more responsive.
- Workers supporting carers should be included on care plans where appropriate.
- Service users who do not have an identified carer should be provided with community support to prevent isolation. Families should be offered support and education.
- Services should recognise the needs of younger carers.
- Carers should be fully involved and informed about care plans by services. but at the same time recognising that some users can have tensions about carer/family involvement.

### Working with service users: facilitating self-help



#### Dual Recovery Anonymous (DRA)

Dual Recovery Anonymous (DRA) is a London-based, non-profit making, self-help programme for people recovering from drug and/or alcohol use and co-existing mental, emotional, personality and mood disorders. DRA members meet regularly to share experiences and provide mutual support. There are two meetings each week and membership is open to anyone with a dual

diagnosis who has a desire to achieve and maintain abstinence from alcohol and non-prescribed drugs. It is based on the 12 step programme of Alcoholics Anonymous.

The programme aims to help people with a dual diagnosis to achieve recovery from chemical dependence and emotional or psychiatric illness by focusing on relapse prevention and actively improving the quality of its members' lives.

The programme is funded by the voluntary contributions of the members although outside assistance (eg a venue for meetings) may be accepted. All members are, or have been, users of substance use and/or mental health services. Meetings are closed to professionals so that they provide a truly safe space to discuss any matter concerning dual diagnosis and recovery.

DRA does not require a diagnosis or referral from a professional or service provider. However, professionals can have a key role in promoting DRA to their clients.

Some DRA members undertake outreach work aimed at increasing awareness of the programme and its principles. Members of the group have given talks to patients on psychiatric wards (including forensic units), therapy groups (in both the mental health and substance use sectors), and at conferences, seminars and training events.

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#### For meetings information

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### A service with strong user input



#### Hartlepool Dual Diagnosis Service

As part of the Tees, Esk and Wear Valleys NHS Trust's development of the dual diagnosis service, a steering group was formed in October 2004. This included representatives from service user groups, mental health professionals, community support workers, commissioners and other key stakeholders. The steering group was instrumental in designing the way the service would be delivered and developing relevant policies and procedures.

The steering group agreed that the service would operate as a virtual team and would be inclusive in its approach by supporting individuals whether they were receiving care in the mainstream mental health service or the substance misuse service.

Service users have been actively involved throughout the development and implementation

of this service by participating in the steering group, as well as in the development, consultation and piloting of intervention booklets and information leaflets, and by evaluating the service.

Team members attend service user-led forums on a regular basis and links have been established with the Hartlepool user forum (substance misuse service user forum) and mental health service user and carer involvement groups.

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### Providing services for black and minority ethnic (BME) communities

The main policy relating to developing services with BME communities is *Delivering Race Equality in Mental Health Care* (DH, 2005). This is a comprehensive action plan for eliminating discrimination and achieving equality in mental health care for all individuals from BME groups.

The Department of Health's black and minority ethnic community drug misuse needs assessment project, carried out by the University of Central Lancashire<sup>4</sup>, has amassed a great deal of information about the

pattern of substance use by different ethnic groups. Improvements in assessment and management of substance use for BME groups should be delivered in the context of *Delivering Race Equality in Mental Health Care*.

#### Recognising the needs of different populations

Black and minority ethnic groups are extremely heterogeneous. Among those with co-existing mental health and substance use needs, some minorities are over represented (eg African-Caribbean groups) while others are under-represented (eg Asian groups). Services frequently mentioned this as an area of concern, although few of them were actively engaged in 'reaching out' proactively to these communities. Several services reported an increase in the number of service users from Eastern Europe.

Increasingly, it is also the case that many BME service users are born in the UK and have English as their mother tongue and so come from the same or a similar culture to white British users, but still have very different experiences of dual diagnosis services. This is because service providers may still hold unintentional subconscious stereotypes about BME communities that can affect the range and delivery of the treatment offered to these service users.

#### The reality on the ground

Most service providers involved with this project did not offer BME specific services. The service providers we contacted felt that there were recurring barriers to working with BME groups, including misunderstanding

rather than stigma and language issues. Some service users felt that hiring staff from the same cultural group helped to address these issues: others felt that having staff who are racially and culturally competent (but who may be from a different ethnic background) was more important than a cultural match. Other service users believed that getting a service at all or a good service was more important.

#### Key learning points

- Healthcare professionals need to be aware of the make up of BME groups within the community they serve
- Incorporate racial and cultural awareness into the assessment and treatment of each service user
- Reach out to religious and community organisations to encourage referrals into services or as another network of support
- Offer cultural and racial awareness training to staff to increase their awareness of their own racial and cultural attitudes and their subconscious beliefs regarding race and culture
- Understand that some behaviour that one culture considers to be signs of mental illness may be acceptable in a different culture
- Be aware that a service user from another culture or a BME background may hold different beliefs about causes and treatment of their dual diagnosis.

<sup>4</sup> Bashford J., Buffin J., Patel K. Department of Health's Black and Minority Ethnic Drug Misuse Needs Assessment Project., University of Central Lancashire Centre for Ethnicity and Health. Preston, Lancashire: University of Central Lancashire Centre for Ethnicity and Health, 2003.

## Developing the dual diagnosis workforce

### Training and development challenges

As in other areas, staff development in the dual diagnosis sector is vital and many providers are addressing this issue. The most frequently cited challenges include: gaps in formal training; lack of ongoing professional development programmes; and in some organisations, low salary levels. Services felt that, generally, dual diagnosis is poorly understood and that there has been a lack of adequate and ongoing training. Services also felt that training can be variable in quality and not necessarily reflect their training needs.

Accessing training can also be difficult as most dual diagnosis training is not mandatory. Services recommended that training on dual diagnosis should be built into staff inductions and also identified a need for rolling programmes to enable staff to opt in and out of training as appropriate. Service providers felt that staff should not have to wait more than six months to access training.

### Applying skills in practice

Services stressed the importance of ensuring that practice development and supervision was embedded into practice and highlighted the need for change in organisational cultures. Services also recognised that it is important to capitalise on existing skills, which need to be differentiated between core and specialist skills. Some service providers felt that dual diagnosis has too much of a mystique about it and staff do not realise that some

of their existing skills are transferable and very relevant. *Closing the Gap* (see section three) draws on existing occupational standards to bring the competencies needed to work with people with mental health and substance use needs into one framework and is helpful in addressing many of the issues outlined above.

In addition to formal training, some service providers felt that the reality of time and resource constraints meant that staff themselves should take a pro-active role in their own learning and development.

### Key learning points

- Mental health staff require drug and alcohol awareness training and vice versa. Awareness training should also reach out to relevant professionals in related services.
- Multi-disciplinary and multi-agency training (ie cross training) needs to be in place to ensure a shared philosophy and knowledge base.
- Dual diagnosis training needs to be part of core training and made part of the process of mapping care pathways.
- Any training programme should explicitly state which staff need training and ensure that the content meets their specific needs.
- Skills development needs to take account of changing situations, including new policy frameworks and changing patterns of drug use.
- Training and development can also be offered in innovative ways that make the most of new technologies, such as the internet and interactive DVDs, as well as on the job training.

### Partnership working: multi-agency training and peer supervision



#### Intensive Support Team, Cambridgeshire and Peterborough Mental Health and Social Care Partnership NHS Trust

The Intensive Support Team is an assertive outreach team based in Huntingdon and is a part of Cambridgeshire and Peterborough Mental Health and Social Care Partnership Trust.

The team has a high proportion of service users with a dual diagnosis and recognised the need for local, inter-agency training. The team accessed an eight-day training course entitled 'working with clients with substance use and mental health problems'. This was run by a senior counsellor from a non statutory agency, Dialdruglink, and a clinical psychologist specialising in substance misuse. The course was attended by a range of professionals across different services.

Following the training, the team set up a peer supervision group which is facilitated by the same specialist clinical psychologist. The team use this group as a flexible forum to discuss challenges and opportunities around particular clients, have further training, bring in other substance use workers and develop a comprehensive resource file.

Team members feel that the group has made them more confident and better equipped to do their job.

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and Social Care Partnership NHS Trust  
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### Delivering dual diagnosis training to mental health staff across London



#### **Pan-London dual diagnosis training**

The pan-London dual diagnosis training is a five day course primarily designed to meet the needs of mental health staff who lack competence in working with substance use issues. However, it can be adapted to meet the needs of a variety of groups. Issues addressed include the nature of dual diagnosis, prevalence, policy guidance, drug and alcohol awareness, assessment and treatment options.

Training is usually delivered one day a week over five weeks and participants are expected to practice the skills they have learned between training days. The course can be adapted to incorporate locally focused content, such as the use of assessment tools, information about local services and care pathways.

A variety of strategies are put in place to support the application of learning in practice and to promote further learning. These include recall days, joint work with a specialist dual diagnosis worker, individual and group supervision, and facilitating time in other services; eg mental health staff working in substance misuse services.

The trainers are usually staff working in dual diagnosis roles that have training as a core part of their job description. Pan-London trainers' networks are held three times a year and are supported by the London Development Centre.

Evaluation of the training indicated that participants thought the content was relevant to their clinical work: 99% reported gaining a better understanding of dual diagnosis issues and 93% thought they would be able to incorporate the training into practice.

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## Monitoring and evaluating services

### Variety of approaches in practice

The way in which health and social care is commissioned and provided has changed over recent years with a stronger focus on evidence and delivery of quantifiable outcomes. Evaluation may be imposed for particular organisational reasons rather than growing organically as a service develops. We found that the application of evidence-based practice varied and the quality of monitoring and evaluation was not consistent between services.

Services recognised the importance of evaluation to improve service provision, but argued that it should be qualitative and service user-focused, rather than commissioner-driven and quantitative. Some service providers felt that evaluation focused on numbers of people seen, as opposed to exploring whether the needs of service users are being met.

Services were very much aware that there is a difference between performance management and evaluation, and also highlighted the fact that there are no national performance management targets for people with a dual diagnosis.

There are many variables to take into consideration when planning an evaluation and some services felt that sometimes it was just not possible to carry out more than a process evaluation. Outcomes for service users (eg satisfaction, quality of life and recovery) are multi-faceted and were felt to be difficult to measure objectively.

### Skills and time constraints

Service providers felt that there was a presumption that staff had the skills to carry out evaluation but that most people had not been trained to do this. Evaluation is also often omitted because of the time it requires; time that is not accounted for in job descriptions or in business plans for new services. As an evaluation and monitoring system develops, it needs to be built into day-to-day routines and to provide tangible evidence of the use and value of services and therefore become a basis for decision-making and supervision.

### Key learning points

- Dual diagnosis services should be evaluated to create a stronger evidence base. It is particularly important to identify innovative and emerging good practice.
- Outcomes against which services are evaluated should be clear and agreed.
- It is helpful to agree milestones against which progress can be monitored.
- Good evaluation should involve service users and carers and all service contracts should specify monitoring and evaluation arrangements.
- Services need time to embed their work before results can be properly analysed.
- If there are lots of demands on practitioners it may be best to start with a simple system of monitoring and evaluation and make the system practical, easy to maintain and immediately useful.
- Ensure that feedback from evaluation is communicated to a range of stakeholders including service users, practitioners and commissioners.



# Part B:

## case studies

- 1: County Durham and Darlington Multi-Agency Dual Diagnosis Project
- 2: Nottinghamshire Dual Diagnosis Service
- 3: Humber Mental Health Teaching Trust Dual Diagnosis Liaison Service (DDL5)
- 4: Dual diagnosis course, York University, Department of Health Sciences
- 5: The COMPASS Programme
- 6: The Friday Group
- 7: Turning Point Support Link
- 8: The Amber Project
- 9: St Jude's Hostel, part of The African Caribbean Community Initiative (ACCI) and Omari Housing Consortium
- 10: Grafton Ward, Manchester Mental Health and Social Care Trust
- 11: The Rampton Hospital Substance Misuse Treatment Programme
- 12: Lewisham Dual Diagnosis Service
- 13: The Westminster Dual Diagnosis Project
- 14: Intensive Management of Personality Disorder: Assessment and Recovery Team (IMPART)
- 15: Croydon Dual Diagnosis Service

# Part B: case studies

These case studies provide examples of good practice from service providers across the country. They were selected by assessing how their services met the criteria outlined in our 'components of good practice' (see section two). This information was supplemented using information from questionnaires, site visits and/or in-depth interviews, after which the case studies were subject to approval by the steering group.

They are intended to be broadly representative of the range of approaches taken by the services from which we gathered information. We recognise that there are other services that are providing good practice that we have not been able to include.

The terminology used in each case study is that of the service providers themselves and the views expressed are those of the services. However, these studies describe a range of service provision, including both direct work with individuals who have a dual diagnosis, whom we have called 'service users', and also work with other professionals, whom we have called 'clients'.

In each case study, 'insights from the service' outline learning points that are specific to the individual service providers and give details of the challenges and lessons learned by the service in developing their work. 'Key good practice points' are more generally applicable in any setting and are the service provider's views on what constitutes good practice in developing dual diagnosis services.

A key feature of the previous snapshots, and the following case studies, is the inclusion of contact details to enable practitioners to share best practice and resources, as well as information and experiences. Although every effort was made to guarantee the accuracy of the contact details at the time of going to press, as time passes, it is likely that these details will change over time.

# 1: County Durham and Darlington Multi-Agency Dual Diagnosis Project

**This case study describes the development and implementation of a strategy for managing dual diagnosis across a range of agencies. It demonstrates partnership working across services and commissioning structures and use of team leaders to cascade skills and information.**

## Overall purpose

To develop a strategic plan for dual diagnosis services across County Durham and Darlington.

The strategy is to support staff working with service users with concurrent needs including mental health, substance use and learning disabilities.

A key element of the strategy is to provide specialist dual diagnosis team leaders in mental health and substance misuse services. These people provide support, information, training and supervision to their own services.

The County Durham and Darlington dual diagnosis strategy is now being developed Trust-wide.

## Service summary

The County Durham and Darlington Multi-Agency Dual Diagnosis Project was established following publication of the *Dual Diagnosis Good Practice Guide* (DH, 2002). The work of the project has culminated in development of a multi-agency dual diagnosis strategy. This focuses in meeting service users' dual needs through a collaborative model of working.

The aim is to respond to the full range of mental health, substance use and learning disability issues by having a needs-led definition of dual diagnosis. A key element of the strategy is to encourage greater collaboration between services to deliver a single care plan with clear care co-ordination arrangements and to minimise multiple assessments. This is seen as a transitional stage towards an integrated model in which all aspects of an individual's care are managed from within mental health services (mainstreaming).

A range of training, development and support opportunities is provided, including:

- A practitioner network accessible to all staff. This provides an important forum for sharing experience and good practice.
- Clinical supervision for dual diagnosis leads and staff working in priority areas. This is delivered on an individual or peer group basis as required by practitioners.
- Dual diagnosis leads within mental health and substance misuse teams that provide ongoing support, information, training and supervision to their own services.

Dual diagnosis leads are identified by team managers taking account of local prevalence and the severity of the local dual diagnosis need. The lead is required to have a relevant professional qualification with experience working with dual diagnosis and possess relevant attributes and capabilities. The role of the lead is not to deliver clinical work but to provide

support and guidance to staff within their own teams, enabling them to develop dual diagnosis capabilities. Review of the role is underway to determine whether formal arrangements are needed to ensure protected time. A tiered training programme is in place which includes awareness and enhanced level training.

## Staffing

One dual diagnosis project manager for dual diagnosis was appointed for one year commencing March 2004; this was extended and now the post is funded with ring-fenced money until January 2008.

## Funding

Joint funding by Durham County Council Adult and Community Services, Durham DAAT, Darlington DAAT, six local PCTs and Co Durham and Darlington Priority Services NHS Trust (now Tees, Esk and Wear Valleys NHS Trust). The annual budget is in the region of £60,000 and the funding for this project has now been agreed on a recurring basis.

## Service user and carer involvement

Service users, carers and families have been involved in the development of the strategy from needs analysis (during which service user groups were consulted on the gaps and barriers experienced in accessing effective services) to involvement in devising and contributing to the strategy implementation plan.

## Partnership working

The dual diagnosis work is jointly funded by 11 agencies. The steering group for this project includes

representatives from providers and commissioners working with dual diagnosis; service users, DAATs, social care agencies, the mental health trust, the strategic health authority and PCTs, with clear links to LITs.

The practitioner network has over 200 members, several meetings have taken place and there are over 60 nominated leads. Networks have included dual diagnosis project updates, case presentations, speakers and workshops addressing the current evidence base on the use of cannabis and the onset of psychosis, alcohol use and dual diagnosis, medicines management and dual diagnosis.

#### Key outcomes

- The needs led, collaborative approach for service users means that exclusion or passing between services is minimised.
- Since the project was established in 2004, over 600 staff in mental health and substance misuse services have been trained to awareness level and the enhanced level training module for dual diagnosis leads has run three times. The 44 participants evaluated it positively.
- The practitioner network and dual diagnosis leads provide accessible support for staff to embed their learning into practice.
- To date 57 mental health and statutory substance misuse services have nominated dual diagnosis leads.

#### Key good practice points

- A local definition of dual diagnosis must be agreed and signed up to by all partners.
- Value the contribution of the local dual diagnosis network members by involving them in planning and presenting at events. Circulate members' queries to promote sharing of experience and practice.
- A tiered training and support structure from the dual diagnosis leads ensures that staff from all professional backgrounds in statutory and non-statutory mental health and substance misuse services have the core knowledge and skills they require, and can access information and development opportunities.
- Equip staff to work with dual diagnosis through ongoing, rolling training programmes, professional development and support.
- Promote the service widely both internally and externally.
- A collaborative approach is the most effective in bringing about cultural change, as staff and services accept that they all have a role working with people who have dual needs.

#### Insights from the service

- Make consultation on your strategy as broad as possible to promote wide ownership and make sure that strategic and frontline staff are involved.
- Get the strategic health authority on board through involvement in strategy development and listening events. Engage a wide range of stakeholders and 'sell' the positives of joint commissioning.

- Build a dual diagnosis intranet and internet site to promote the work of the service.
- Get as many organisations as possible to contribute to the funding of dual diagnosis work: there can be big gains from small funds.
- Needs assessment can provide evidence regarding gaps in current service provision which can help commissioners.
- A specialist team is not necessarily needed, as one identified post taking a lead can build sustainability.
- Employ a full time project lead and ensure that the post holder has the right skills match for the job; that they are enthusiastic, knowledgeable and a good networker and also that they have clinical credibility.
- Make sure that you have good communication with your partners: this should be open, regular and frequent.
- Reinforce existing services. Adopt the philosophy that 'dual diagnosis is all of our business'.
- Training and staff support is vital and must be structured around training needs assessment, based upon achieving dual diagnosis capabilities, objectively evaluated, and revised as policy and the evidence base changes.

#### Evaluation and monitoring

- Steering group consisting of commissioners and stakeholders
- Clinical governance structures, through planning and dissemination of audit and data collection
- Clinical audits; eg dual diagnosis leads activity and support needs
- Service user surveys

- Training evaluation
- The impact of the lead dual diagnosis role is being evaluated in spring 2007 by measuring outcomes of the role.

### Contact

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### Resources to share

- Dual diagnosis strategy <http://cddps.tevv.nhs.uk/dualdiagnosis/MultiAgencyStrategy.pdf>
- Further information about the dual diagnosis project [www.cddps.nhs.uk](http://www.cddps.nhs.uk)
- Further information is available from Mandy Barrett, including dual diagnosis project planning, dual diagnosis needs assessment, strategy development, strategy implementation, establishing a local dual diagnosis network, developing tiered training packages and evaluation reports and clinical audit of dual diagnosis lead activity and support needs.

# 2: Nottinghamshire Dual Diagnosis Service

2

**This case study illustrates how a central dual diagnosis service provides consultancy, liaison and training at a county level to support local frontline teams. This helps to drive more integrated working and reach into a wide range of settings across sectors.**

## Overall purpose

The service offers a consultancy role to mental health services to promote liaison between substance misuse and mental health services. The aim is to develop more effective relationships and promote more seamless patient care.

## Service summary

The Nottinghamshire Dual Diagnosis Service is county-wide and offers support to services (both statutory and non-statutory) throughout Nottinghamshire. The team existed in the city from 2001 and became operational across the county from June 2006.

The team acts in a consultancy and liaison role, taking referrals from agencies across the county. It undertakes:

- Face-to-face work with service users to help them tackle their complex needs
- Liaison and support to services (mental health and substance misuse) to facilitate development of appropriate care pathways for this service user group
- Staff supervision – individually or in groups
- Training and teaching of students and other healthcare and related professionals.

The service works across all Trust mental health teams and other non-statutory sector agencies in a wide range of settings including GP practices, forensic wards, drug and mental health services, and statutory substance misuse services. Criminal justice services and prisons are becoming an increasing priority. Work is prioritised depending on the level of service users' needs and the prevalence of dual diagnosis in the caseloads of service providers.

## Staffing

- One nurse consultant and eight clinicians. Currently all psychiatric nurses although posts are open to other qualified professionals and individuals with significant experience in dual diagnosis.
- One session of an addiction consultant psychiatrist and occasional input from specialist psychiatric registrars.
- Administrative support.

## Funding

The service is funded entirely through the city and county DAATs. Funded until March 2008, when the pooled treatment budgets will probably be mainstreamed. The budget is £450,000 (this excludes prescribing costs which are largely met by the PCT).

## Service user and carer involvement

Service users are involved in service development through participation in steering group meetings. Service users have been involved in interviews for team appointments. Two service users and a carer have been involved in delivering a dual diagnosis

course at Nottingham University. They are also regular attendees at a regional dual diagnosis forum.

There is some concern that the service users who regularly involve themselves are not necessarily representative of other users who may have chaotic lifestyles and be more vulnerable.

## Partnership working

A wide range of partners includes:

- Partners internally within the Trust such as Community Mental Health Teams (CMHT) staff and inpatient staff
- General practitioners
- Forensic psychiatric services and criminal justice partners, such as criminal justice integrated teams (CJITs), the police and magistrates
- Social services
- Non-statutory mental health and substance misuse agencies.

## Key outcomes

- An increase in confidence of mental health staff when working with this service user group.
- Positive changes in attitudes of staff, carers and service users towards others with drug/alcohol problems.
- Assessment of service users for the possibility of the complicating effects of substance use.
- Increased understanding amongst non-statutory agencies of the issues posed by combined mental health and substance use problems. Staff have a better understanding of the part they can play in working with this client group.

### Key good practice points

- Staff who work in the team need to have a high level of expert knowledge and skills in relation to mental health, substance misuse and dual diagnosis.
- The direct clinical work of the dual diagnosis clinicians enhances their ability to adapt mental health and substance misuse interventions to meet the needs of service users. This also gives them credibility with partner agencies, especially when training.
- Service users are involved in training and group work and this reaps enormous benefits for other service users in terms of peer support and modelling.

### Insights from the service

- Take a long term view based on therapeutic optimism when working with service users.
- Dual diagnosis teams should be proactive rather than reactive and engage service providers and service users assertively; eg through liaison clinics, home visits (or seeing people in a place of their choice), spending time on inpatient units and with community teams.
- Develop a specialist team which has clearly defined responsibilities, otherwise highly skilled staff end up getting pulled into doing routine tasks.
- All partners need to feel ownership of the project – match funding is a good way to achieve this.

### Evaluation and monitoring

- Internal audits and a review by the Healthcare Commission.
- Two service improvement reviews.
- Reports to the local DAATs (City and County).
- NIMHE Positive Practice Award (2004) highly commended.

### Contact

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### Resources to share

- Annual report
- Service audit
- Intervention tools and brief assessment forms (Substance Misuse and Mental Health Brief Assessment Tool).

# 3: Humber Mental Health Teaching Trust Dual Diagnosis Liaison Service (DDLs)

3

**This case study shows how a central team of specialist dual diagnosis workers is providing support to frontline staff. This promotes mainstreaming of dual diagnosis within mental health services.**

## Overall purpose

The aim is to support mainstream mental health staff in assessing and delivering interventions to service users who have a dual diagnosis. This is achieved through a 'practice development model' of informal and formal training sessions and also by providing an information resource, modelling interventions, providing guidance on good clinical practice, advice, supervision and co-working and liaising between substance misuse and mental health services.

## Service summary

The DDLs evolved from a Trust-wide strategy produced in response to the *Dual Diagnosis Good Practice Guide* (DH, 2002) and was led by a multi-disciplinary project management team. Current developments are directed and supported by a Trust dual diagnosis steering group, comprising representatives from the addictions service and a broad range of mental health services. The initial pilot has recently been substantially enhanced to deliver services across all four PCT areas within the Hull and East Riding area.

The DDLs 'clients' are other professionals rather than service users themselves. Workers offer advice and support to a wide range of practitioners including inpatient units, CMHTs and specialist services such as

assertive outreach, forensic services and the young person's psychosis service. The DDLs nurses do not offer advice to service users except in the context of joint assessments or modelling interventions with a CMHT worker.

The DDLs workers help to establish appropriate screening and assessment, undertake short pieces of work jointly with the patient's key worker, and supervise direct work with the key worker. None of the team has key worker or care co-ordinator responsibility.

Change is assessed through audit, monitoring staff attitudes pre- and post-placement, case note audits and by interviewing senior clinical and operational staff at the end of each placement.

The DDLs is involved in postgraduate teaching and plans to participate in pre-registration nurse training.

## Staffing

The current DDLs team comprises four whole time equivalent staff (three addiction nurses and a nursing team leader). A member of the team is allocated to each PCT area.

One DDLs worker is sited within each PCT area for a period of six months on placement. At the end of the six month placement the DDLs nurses rotate to another CMHT whilst maintaining links with previous placements.

## Funding

The service is funded partly by mental health income from two PCTs (Hull and the East Riding of Yorkshire). The devolved budget is £50,000 and the shortfall in income to support the team is provided through reconfiguration of existing mental health posts.

## Service user and carer involvement

The Trust has a strategic approach to service user involvement and service users are invited to contribute to service development plans. The original impetus to develop the service arose from service user feedback regarding gaps in service delivery for patients with a dual diagnosis

Feedback from service users and other professionals is used to shape service developments. Individual patients are directly involved in the care planning process.

## Partnership working

Partnership working takes place with mental health services, social services, and mainstream substance misuse services. The DDLs nurses develop close links with the integrated CMHTs and their associated inpatient units. The nurses sit within the Trust's substance misuse service governance structure and work closely with the senior management team. A weekly multi-disciplinary meeting (including the clinical director and clinical nurse specialist from substance misuse services) provides an opportunity for DDLs nurses and community and inpatient staff to discuss complex cases.

Partnership agreements cover arrangements with other services.

#### Key outcomes

- Increased confidence and skills of front line mental health staff
- Improved screening, detection and assessment of substance misuse by community and inpatient mental health staff
- Improved patient outcomes as a result of the implementation of appropriate care planning and evidence based interventions
- Dual diagnosis is becoming part of the 'core business' of adult mental health services.

#### Key good practice points

- Provide tools and skills (eg assessment tools, modelling motivational and brief interventions) that are consistent and backed up by good quality, evidenced-based research
- Address existing practice and emphasise the need for change where appropriate
- Value and encourage the efforts and good practice of mental health staff
- Do not elevate people's expectations too early and then not be able to meet them
- Encourage ownership and stimulate others to problem solve, develop their own structures and tackle obstacles to implementation
- Target resources where they will have the biggest impact
- Educate mental health staff on the importance of the 'mainstreaming' agenda

- Provide greater understanding of the complex needs and relationships between substance misuse and mental health; eg by joint working, peer supervision or educational events
- Check that service developments and positive changes in practice are sustained.

#### Insights from the service

- The strategy must be approved by the Trust's Board and have the support of senior clinical and managerial staff
- Develop informal as well as formal networks early on
- A service such as this needs qualified and experienced staff working within a formal governance structure
- The service advocates the adoption of a practice development model.

#### Evaluation and monitoring

The impact of the DDLs is audited at the beginning and end of each placement. Mental health staff complete questionnaires evaluating attitudes and competencies in dual diagnosis and case notes are audited to assess changes in assessment and screening for substance misuse problems. The Trust addiction service is responsible for continued monitoring.

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#### Resources to share

- DDLs service delivery plan
- Policy and guidance on the clinical management of drug and alcohol users (inpatient setting)
- *Management of Alcohol Problems On Psychiatric Wards* (Trust Policy, January 2007)
- Staff attitudes questionnaire.

# 4: Dual diagnosis course, York University, Department of Health Sciences

4

**This case study shows how training courses offered by an academic institution can be tailored to meet the specific work-related needs of dual diagnosis professionals. It also describes how training can be best embedded in practice.**

## Overall purpose

This training aims to look at the complex relationship between substance use and mental health, examining the implications for service users, carers, workers and services. It is open to anyone working with people who have a mental health problem, regardless of the severity.

The training draws on the emerging evidence base for working with this service user group to examine how participants can work more effectively with these individuals. The course encourages inter-professional learning and collaboration.

## Service summary

Each course attracts a variety of practitioners including drugs workers, probation officers, accident and emergency staff, general practitioners, walk in centre staff, practice nurses, health visitors, midwives, prison health care staff and those working in mental health. The training provides a blend of skills training and theoretical evidence.

The training covers the following areas:

- Risks and effects of substances
- Prevalence of dual diagnosis

- Assessment and engagement
- Formulation
- Pharmacology
- Interventions; motivational techniques, cognitive behavioural techniques and cognitive behavioural integrated treatment
- The evidence base
- Advocacy
- Pan-European research.

The course length is one day a week for six weeks, or is run over 12 weeks at a half-day a week.

## Staffing

There are five contributors to the training:

- A service user who facilitates a session and is a member of the course management group
- A nurse specialist who facilitates a session on the physical needs of this client group
- A professor who has expertise in this field
- Clinicians with credibility and up to date experience with the client group
- A senior researcher who has expertise in the evidence base for dual diagnosis.

## Funding

The service is jointly funded by the Workforce Development Confederation and the NTA. Funding is ongoing with no defined time limit set on current levels.

## Service user and carer involvement

A service user facilitates a session, giving their own experience of the services they encountered. Video

material provided by service users is also used in the training sessions.

## Partnership working

Partners include the local DAAT, the voluntary sector (such as Compass), the Yorkshire and Humber Regional NTA, local authorities, PCTs and acute Trusts.

## Key outcomes

By the end of the training participants should be able to:

- Discuss the concept of addiction and how this relates to mental health
- Demonstrate an understanding of the commonly used illicit drugs and misused prescription drugs
- Describe the relationship between mental illness and substance use
- Understand the skills and tools used with this client group
- Describe different models of treatment and service delivery.

This is measured in two ways: essay, and group and individual supervision provided by the course facilitators.

## Key good practice points

- It is important to make dual diagnosis training relevant to people in whatever context they are working, ie not just those working with severe mental illness.
- Try to tailor each course to the needs of the people attending.

- Involve service users in the planning, delivery and evaluation.
- Involve facilitators who have either clinical or research credibility; this is important if the most up to date and objective information is provided.
- Running a course over several weeks gives people opportunities to practice what has been taught between sessions.
- It is more effective to have supervision and modelling of practical issues during, or soon after, a course so that learning is not lost.
- Funding for training should include both the statutory and independent sector. This ensures a good mix of professionals attend the training.

#### Insights from the service

- A mixture of delivery methods is used including information giving (lectures), journal clubs and homework, which includes practising the skills taught in the work place and feeding back the following week (good and bad!)
- Shorter courses do not work as well as there is insufficient time to challenge entrenched attitudes
- Extra effort has been made to ensure open access to staff from the independent sector as they provide the majority of substance misuse services within our region.

#### Evaluation and monitoring

- Course evaluations.
- External bodies – Quality Assurance Agency.
- Peer observation; a lecturer from the university observes facilitation of part of the course to ensure the teaching methods and delivery are of a good quality.
- Summaries of evaluation are sent to the Workforce Development Confederation and the NTA.
- Students and training managers evaluate how attending the course has made a difference to their work practices. The main differences reported are improved confidence and knowledge when dealing with the client group. Staff have also suggested ways their service could be improved to meet the needs of the client group. This ranges from changing assessment methods to reorganising team structures and roles.
- We are able to evaluate the effectiveness of training in part by offering ongoing supervision to teams who predominantly work with a dual diagnosis clients. We are not able to offer this service to all teams.
- Comments and evaluations help shape the future content and delivery of training. We do this mainly by discussing specific changes within the course management team.

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#### Resources to share

- Teaching materials, including powerpoint presentations, academic work
- Contact lists
- Literature and booklists
- Evaluation data and tools.

# 5: The COMPASS Programme

5

**This case study profiles a team that offers both clinical work and training/practice development support. It illustrates how a team based within substance misuse services is helping mental health services to provide integrated care.**

## Overall purpose

The COMPASS Programme in Birmingham provides a service to people who experience severe mental health problems and use drugs and/or alcohol problematically. The team also provides training and clinical input to mental health teams to promote a model of integrated treatment.

The service aims to:

- Ensure that service users with a dual diagnosis receive support and interventions to meet their needs
- Support staff to work with service users who may be difficult to engage and who present with complex needs.

## Service summary

The service works directly with service users and is part of the substance misuse directorate. The service also provides support, training and clinical input to mental health and substance use services to promote a high quality of care.

The service takes a harm reduction approach to minimise the risks of problematic substance use for individuals with a dual diagnosis. It operates in an

urban environment, with a very diverse multicultural population and high levels of social deprivation.

Key elements of the service include:

- Ensuring that Cognitive Behavioural Integrated Treatment (C-BIT) interventions<sup>5</sup>, based on the C-BIT manual, are delivered within mainstream mental health services
- A variety of training for staff of different disciplines, including:
  - A two session group programme for inpatient units: this supports clients to discuss substance use, its impact on their mental health and strategies for change
  - Training in assessment, formulation, treatment planning and engagement for ward staff, primary care, rehabilitation and recovery and home treatment teams
  - Drug and alcohol awareness sessions across the Trust.

## Staffing

A team manager, one clinical nurse specialist, one community psychiatric nurse, one occupational therapist, one clinical psychologist, one session per week from a psychiatrist and a team secretary.

## Funding

Funding was initially from the Mental Health Challenge Fund. It is now from the three PCTs covering North Birmingham. Plans to expand the COMPASS Programme to a city-wide service are being discussed

as part of a city-wide dual diagnosis strategy. The annual budget is currently £233,000 per annum.

## Service user and carer involvement

Service users were consulted during the development of the C-BIT training and accompanying manual. This was also an opportunity for service users and the teams working with them to build engagement in a different context.

Ethical approval is being sought to formally assess the views of service users, carers and staff on current treatment approaches and the ongoing development of our services.

## Partnership working

In addition to users and practitioners in mental health and substance misuse services, the service works with housing, employment and training providers and local universities.

## Key outcomes

- The achievement of an integrated treatment approach within assertive outreach, early intervention services and the homeless mental health team
- Ongoing improvement in confidence and skills of staff to work with service users with combined problems
- Enhanced assessment skills have resulted in clinicians being more able to develop formulations and individualised treatment plans with service users
- Successful engagement and retention of service users in treatment

<sup>5</sup> The COMPASS Programme takes a shared care integrated approach and has developed a model of Cognitive Behavioural Integrated Treatment (C-BIT), which was evaluated through a treatment trial in five of the Trust's assertive outreach teams.

- Comprehensive training package in place for staff based on a researched and evaluated model of intervention (C-BIT)
- Ongoing development of evidence based interventions through the COMPASS Programme research committee.

### Key good practice points

- Ensure that the Trust supports the development of the service and has a clear dual diagnosis strategy.
- Identify a local definition of dual diagnosis in conjunction with partner agencies.
- Identify clear and realistic goals with service users regarding what they want to achieve and take a long term optimistic approach.
- Form good relationships with the teams that the service works with, and make sure that they understand the service's philosophy and rationale.
- Identify care pathways and joint working protocols between mental health and substance misuse services, including alcohol services.
- Develop a comprehensive training package based on local need, and ensure there is a process in place to follow up training and monitor the impact on service users and staff.
- Identify a process for the development of evidence-based interventions within the service.

### Insights from the service

- Maintain a clear focus on the development of the service and appreciate that initially you may not be able to meet the demands of all those involved but that your service can develop over time.

- It is important to discuss with service users the possible positives about using drugs or alcohol and once rapport has been established to discuss the negative impact of drugs and alcohol.
- Partnership working is vital to developing a clear common understanding of issues and opportunities and getting services to work closely with each other.
- Undertaking direct clinical work enhances credibility when providing training as trainers can refer to case examples and demonstrate the links between theory and practice.
- Enhance team skills and build confidence not just through training but with individual support and development of individuals.
- If possible, train whole teams and also provide training for new staff joining the team so that there is consistency in approach.
- Ensure that there is a process in place to follow up and assess whether training is leading to integrated treatment.

### Evaluation and monitoring

The service was founded on the results of a prevalence and training and support needs survey. This examined where there was greatest need within the region for a service for individuals with co-existing severe mental health and substance use difficulties. The survey also looked at the staffing requirements to fulfil identified needs.

The COMPASS Programme continues to be a research led service. Academic and medical professionals sit on the COMPASS Programme research board, which

meets monthly to discuss ongoing development of the service from a research perspective.

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### Resources to share

- Prevalence survey questionnaire
- Training and support needs questionnaire
- Published papers related to COMPASS Programme work with some other useful references
- Information regarding the development of an integrated model within mental health services (C-BIT)
- Information on running groups
- Visitors sessions offered on a regular basis for clinicians, service managers, commissioners to attend regarding setting up a service and service delivery
- Information regarding the COMPASS Programmes ongoing research and development.

# 6: The Friday Group

6

**This is a facilitated self-help group offering social/recreational activities, a shared meal and a discussion group. It illustrates how service users play an active role in delivering the service and the positive impact of providing social support.**

## Overall purpose

The Friday Group was established in May 2003 to address the unmet needs of service users with a dual diagnosis in Redbridge, part of the North East London Mental Health Trust (NELMHT). It was identified that this client group was difficult to engage and did not utilise traditional CMHT services. Hence their multiple health and social care needs were not being adequately addressed.

## Service summary

The philosophy of the project team is that service users are the experts in their own care and hold the key to appropriate service responses. We therefore went out and talked to disengaged service users in their own environments to identify the kind of services they wanted.

The Friday Group was developed as a result and set out to meet the needs identified. It has three main components: social/recreational activities, a shared hot meal and a discussion group. Cultural outings, guest speakers and creative workshops are also held. There is a weekly planning meeting where members decide meal choices, discussion topics, future events and changes to the group structure. All members receive a weekly letter to inform them of the next week's

activities and update them on events. Members are not required to stop using substances or work towards abstinence, however they commit to not using prior to, or during, the group.

As well as the group activities we have had a wide range of external speakers at the request of group members. These have included benefits advisors, debt counsellors and vocational projects. We have regular ear acupuncture taster sessions that have led to many group members accessing the drop-in acupuncture sessions at the drug and alcohol service.

The Friday Group operates an open access system. Group members are never discharged (unless they explicitly request it) and continue to receive weekly update letters even if they do not attend for long periods. Many members who have 'moved on' subsequently return for brief periods in times of crisis to get back on track.

Although the Friday Group is a small service only operating for two hours per week, members have shown significant improvements in terms of service engagement, mental state, level of substance misuse, housing stability and social/vocational activities. Although the service has no formal systems in place to measure outcomes, it closely follows the progress of both our current and graduate members.

## Staffing

The Friday Group is a joint project between CMHTs and substance misuse services. As such, group facilitators are able to provide information on a variety of services in both areas and facilitate referrals. Group members are also an information source for their peers. The Friday Group often acts as a gateway to other services, particularly for peer and self-referrals of people who may be unfamiliar with local services and how to access them.

## Funding

The service was initially funded by a Queens Nursing Institute 'Innovations and Creative Practice' award of £6,000. Redbridge DAAT have provided the £4,000 yearly running costs for 2006/2007. Staffing costs are borne by the CMHTs and drug and alcohol service.

Funding bids currently have to be submitted to the DAAT/NELMHT on a yearly basis. Funding has been agreed by Redbridge DAAT for 2007/2008.

## Service user and carer involvement

Group members' opinions continue to shape local service developments for service users with a dual diagnosis. This not only includes the ongoing evolution of the group but also local policy development. For example, group members reviewed and provided a written response to the 'Substance Misuse in Acute Inpatient Settings' Policy Consultation and NELMHT's dual diagnosis strategy. A focus group of Friday Group members contributed to the development of Redbridge DAAT's dual diagnosis strategy.

Although at present the service does not actively address the needs of families/carers in all of its activities, members are continually involved in the development and future of the group.

There is a formal member evaluation every three months where feedback is sought via focus groups and anonymous questionnaires.

### Partnership working

The Friday Group started as a small pilot in one CMHT. Following initial success, interest was shown by other local providers to develop services following the same model. Instead of replicating work, the group suggested that if all agencies worked together, cross-team collaboration would enable the expansion of the Friday Group to a borough-wide service.

The Friday Group is now facilitated by the clinical specialist in dual diagnosis, a community mental health nurse from one of the CMHTs and a nurse drug worker from Redbridge Drug and Alcohol Service. This has broadened our referral base, improved accessibility and opened up channels of communication and referral pathways between services. It has also proved to be cost and time efficient, as there is no undue pressure on any one service. Collaborative working has also meant that the group has never been cancelled in its four years of existence as facilitators are always available from at least one of the teams.

### Key outcomes

Over the year April 2005/2006, 39 people attended. Twenty one were referred by mental health services, three by drugs services and 15 were self/peer referrals. As the group is drop-in style, some members attend regularly and others utilise it on an ad hoc basis, often in times of need. A further 10 members receive regular update letters because they have been past attendees or have recently been referred.

- Group members are better engaged with other local services and consequently have made improvements in their mental health and level of substance use. Where people's chaotic lifestyles have impacted on their ability to access local services, we have brought services to them by having sessions at the project (eg housing, substance misuse services, psychological services, physical health monitoring).
- There has been a significant fall in re-admission rates for regular group members, with some sustaining a year or more out of hospital for the first time.
- Several group members who had been denied housing due to past anti-social behaviour have demonstrated such sustained change that they have been accepted for independent housing. Others have been able to move from supported housing to independent accommodation.
- Three group members are currently hoping to return to work and have accessed supported employment opportunities. Another has been employed in a voluntary capacity at the resettlement project.
- Involvement in the DAATs 'treatment planning day' has also grown, with three attending in 2004, nine

in 2005 and 10 in 2006. Users' views have helped identify treatment/service priorities for substance misuse services.

### Key good practice points

- The service was developed through outreach to, and consultation with, users to ensure that it was appropriate to their needs
- By engaging with the group, members build up a trust in the 'system' and are more likely to access help elsewhere, particularly if other services are advocated by their peers
- Group members are always given feedback on service development initiatives they are involved in so that they can see the value of their participation
- Treatment needs to be long-term and focused, and services should be able to tolerate and continue to work with poor attendance and clients who do not comply with their medication
- Providing a service around service users' explicitly stated needs gives them a reason to want to engage with services.

### Insights from the service

- It is important that time is spent on engaging with service users with a dual diagnosis before treatment plans are made
- As the service evolves around their changing needs it gives service users a reason to remain engaged
- People are far more likely to respond to a personal rather than professional recommendation
- Peer support from group members who are in the later stages of recovery and who can give real life

- examples of their own experiences is very useful
- A high level of peer referrals suggests that the project meets the needs of the local dual diagnosis population.

### Evaluation and monitoring

Group members were involved in a piece of qualitative research about engagement issues for people with a dual diagnosis, with separate focus groups held for service users, inpatient staff and community staff. The results are being used to inform service development and staff training initiatives.

Their involvement in a qualitative research project has also helped shape the scope of the clinical specialist in dual diagnosis.

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### Resources to share

- Qualitative research report
- Yearly service report 2004/2005.

# 7: Turning Point Support Link

**This is an outreach project providing support for people with a dual diagnosis living in the community. It illustrates how close partnership working enables the service to take a holistic approach to address a wide range of needs and also the value of building trust before addressing mental health and substance use issues.**

## Overall purpose

Turning Point Support Link provides intensive community support to people who are experiencing mental health and substance use difficulties and who may also have a history of offending behaviour.

A key part of the philosophy is to build trust and respect by focusing on issues which service users feel are important to them before going on to address some of the deeper issues associated with their mental health and substance use. The aim is for service users to gain confidence, increase their independence, improve their quality of life and reduce hospital re-admissions.

## Service summary

Based in West Hertfordshire, the service offers community outreach to some 55 people at any one time. In addition to mental health and substance use problems, some service users may have additional issues such as personality disorders, eating disorders, self-harming behaviour and a forensic history. Staff work closely with service users and other agencies to develop individually tailored support plans. The work is underpinned by solution focused therapy which concentrates on a person's strengths.

## Services offered include:

- Practical support, such as securing and keeping tenancies, assistance with benefits and budgeting, and accessing health care.
- Long-term emotional support.
- An out of hours telephone service which provides a safety net when other services are closed.
- Advocacy – supporting service users to express their needs and views. This can cover a wide range of activities including support in CPA meetings, court hearings, contacting utility companies, acting as 'appropriate adults' if service users are arrested and help in obtaining specialist legal advice.
- Supporting service users to link into community services; eg education, volunteering, sport and leisure, and signposting to other services.
- Supporting development of social and life skills.
- Computer skills training and work experience, through an IT suite and an online shop selling cards and gifts made by service users.
- Various groups including: a women's group, men's group, art group and housing support group.

All referrals come from the local CMHTs. The caseload varies between 6 and 12 depending on the support needed. The service can provide one to three hours of support per service user each week for as long they continue to have identified needs.

## Staffing

The service comprises a service manager, team leader and six project workers. Each service user has one main worker, but all service users meet other staff

members to ensure continuity during periods of leave or absence.

Staff may come from a variety of professional backgrounds and have experience of working with people who have a dual diagnosis. They also have a good understanding of services in the community.

There is regular supervision and training for all staff in mental health, solution-focused approaches, dual diagnosis, personality disorder, self-harm and preventing suicide.

## Funding

The service is funded through Hertfordshire's Joint Commissioning Team.

## Service user and carer involvement

Ongoing service user feedback is gained through reviewing and evaluating their support plans. For the service as a whole, regular service user events and feedback questionnaires are used. Service users have also been involved in fundraising for trips and activities as these are not core funded.

The service aims to work in a holistic way, involving family and friends as appropriate. Project workers have contact with family members and friends during home visits or by telephone calls. Whilst staff do not provide direct support or break confidentiality, they will give advice and signposting to other relevant services.

### Partnership working

Close inter-agency working and referral routes with a whole variety of other services and professionals is vital to the project's success.

### Key outcomes

- Sustained changes in behaviour such as fewer incidences of self-harm
- Reduced hospital admissions
- Increased confidence and self-esteem amongst service users
- Greater willingness to engage with other relevant services
- Interest in self-development through interaction with mainstream community activities.

### Key good practice points

- Ability to provide a holistic service that works with a wide range of complex needs.
- Engagement comes first by building a positive, trusting relationship with the service user before meaningful work can be done around their mental health or substance use.
- Adopting a long-term perspective, recognising that individuals may need to work on many areas of their life before they are stable enough to reduce/stop their substance use.
- Maintain clear and consistent boundaries, especially when working with service users with a personality disorder.
- Staff should have a good knowledge of local services and agencies and build links with them.
- Transparent risk assessment and risk management.

- Focus on supporting service users to engage with existing services ie mainstreaming dual diagnosis.
- Recruitment and retention of good quality staff. As well as training, this involves developing interpersonal skills which promote engagement; eg being non-judgmental, flexible, calm in crises, consistent and positive.

### Insights from the service

- Service users' mental health difficulties and their drug/alcohol use is just part of a much bigger picture and may not be their most pressing priority.
- People with a dual diagnosis are often very chaotic and simple things like arriving at an appointment on time can be difficult to achieve. Offering a trusted person to accompany them can make it much easier for them to engage with a new service.
- Honesty, consistency and good communication with the service user about what you can, and can't, offer is important, as is honesty about sharing information with other services.

### Evaluation and monitoring

The service conducts an annual service review. Support plans are reviewed every three months by service users and staff. There is outcome monitoring of: engagement rates, hospital admissions, number of contacts, number of phone calls to professionals and number of appointments that we support service users to attend. Service user and referrer questionnaires are completed annually.

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### Resources to share

- The service's annual report
- Anglia Polytechnic University (now Anglia Ruskin University) evaluation by Prof. Shulamit Ramon 2003.

# 8: The Amber Project

**This project provides support for lesbian, gay, bisexual and transgender (LGBT) people who are concerned about their drug/alcohol use and mental health. It illustrates how a specialist LGBT service can help people to engage with mainstream services. Satellite services in CMHTs have also improved access and engagement and promoted greater awareness of the needs of LGBT service users.**

## Overall purpose

The Amber Project provides information, assessment and individual and group therapy to LGBT people with multiple needs or a dual diagnosis.

## Service summary

The Amber Project is a partnership project run by CASA (a charity that provides support for people with drug and alcohol problems and multiple needs) and PACE (which provides mental health and well-being services to LGBT communities).

The service is an extension of a multiple needs/dual diagnosis service run by CASA. The joint project was developed from a six month pilot of a support group for gay men with a dual diagnosis. This work uncovered high levels of demand from service users across London.

The project offers a counselling service for LGBT people who fall outside the remit of many statutory and voluntary services in the area because of their multiple needs, or who are reluctant to engage with

mainstream services because of perceived homophobia or heterosexism. The majority of service users (87% in the first year of the service) have been sexually or physically abused as children.

The aim is to support users to become more aware of their psychological, emotional and interpersonal difficulties and reduce, control or stabilise their substance use. Users are offered a choice of short, medium or long-term therapy so that there is a realistic time frame to explore complex issues.

Therapists take a holistic approach, focusing on the person and their relationships rather than their diagnosis or their substance misuse issues. Service users are encouraged to define their own needs and goals. This non-directive approach enables workers to remain open to the full range of issues in an individual's life and empowers service users to make decisions for themselves. Substance use is not seen as an obstacle to therapeutic engagement but as part of the way in which the service user relates to the world, self and others. In addition to personal therapy, group work is used to explore difficulties in interpersonal relationships and to enable users to gain support from other people with similar life experiences.

The service supports access to a range of LGBT-friendly support services and, where appropriate and with consent, workers are able to share information. Service users are also supported to access other mainstream health and social services including housing, advocacy support and relapse prevention groups.

A feature of the service is that it helps the 'significant others' of service users to access services both for themselves and to enable them to support the care of the primary service user. Carers may also attend a 'family, partners and friends' service.

Service users self-refer or are referred by third parties. The service is promoted through liaison with mental health, drug and alcohol and LGBT services, and BME forums. Leaflets have also been distributed in lesbian and gay bars in central London to enable access to those who may have had no previous access to services.

## Staffing

Two part-time staff. Both are qualified psychotherapists with experience of working with people with long term mental health difficulties. Both positively identify as lesbians.

Higher staffing levels could provide a wider range of service options eg drop-ins or relapse prevention groups.

## Funding

Section 64 DH grant (£39,395 per annum for three years).

## Service user and carer involvement

The service was set up in response to the identified needs of gay men with a dual diagnosis. Feedback is obtained from user evaluations of the service. Efforts are made to enable significant others, carers and family to obtain their own support and to support the needs of the primary service user.

### Partnership working

The primary partnership is between PACE and CASA. In addition, CMHTs have set up satellite clinics which provide easier access to service users who find it difficult to travel. This has promoted more integrated working and better understanding between professionals. It has also raised the profile of the Amber Project and highlighted the needs of LGBT service users and difficulties they face in settings such as residential detoxification units and psychiatric wards.

### Key outcomes

- Service user evaluations from the first year of the service indicate that two thirds of service users had reduced their substance use. Two thirds strongly agreed that the service had helped with their mental health issues.
- Useful working relationships have been established with a range of services. Service users from across London are being referred, or are referring themselves, and engaging with the service.
- Service demand has been high with waiting times of up to two months. However this has not resulted in drop-outs, service users seem prepared to wait.
- This supposedly difficult-to-engage group have attended sessions regularly and the majority continue to attend for the full length of their contract.
- Service users move on to use other services from which they continue accessing support; eg rehabilitation, self-help, life-coaching or private therapy.
- Awareness of LGBT issues in mental health and drug and alcohol services has been raised.

### Key good practice points

- A LGBT-specific service enables service users to be open about their sexuality and life experiences.
- Substance use and mental health symptoms are viewed as matters to be understood not simply managed.
- Allowing service users to define their own goals for therapy enables them to access services without first having to commit to cutting down or giving up their drug use.
- Giving service users the chance to work with lesbian or gay therapists removes a barrier to working, especially when sexual identity or lifestyle is an issue. However, it is important not to assume that the service users' sexuality is an issue or that they will be more comfortable with a therapist who identifies as LGBT.
- Offering the service at different locations facilitates access and promotes continuing engagement.
- Where service users are already engaged with other agencies but additionally choose to engage with a specialised LGBT or multiple needs service, we negotiate confidentiality limits, clinical responsibility and key working so that complementary and safe integrated working can take place.
- Outreach and educational visits to other service providers enhances understanding of the service and the advantages of targeted services. It may also raise awareness of the difficulties faced by LGBT people with complex needs when seeking support.

### Insights from the service

- Service users have highlighted their reluctance to approach generic services or to talk openly in those services. In order to deal with a drug problem, clients need to speak openly about life experiences and personal issues. This might be difficult for an LGBT person in a generic setting.
- Service users emphasised the perceived safety of working within a project that specifically targets LGBT people. They reported that they were able to talk to counsellors at The Amber Project about things they had not been able to talk about elsewhere.
- Service users are not just helped to manage their substance use or mental health difficulties but are invited to explore the context and meaning of the substance use in their lives and the relationship between substance misuse and emotional/mental health.
- Service users have been relieved to access a service where they are not required to 'sort out' their substance use issues before receiving psychotherapy that addresses their mental health issues and emotional distress.
- Work with family, partners and friends.

### Evaluation and monitoring

Alcohol Concern's 'alcohol outcomes spider', already in use by the CASA team, was adopted as the evaluation tool. It is completed near the start of work, after every 12 sessions and at the end of a piece of work. Because the spider is designed for use by alcohol agencies, there are several areas of dissatisfaction with it as measure of change for

complex cases. It does not satisfactorily describe severe mental health issues or allow for sexuality issues to be considered. It does however provide some way of measuring change over time. It is most suitable to measuring changes in substance use.

User evaluation questionnaires are used to gather qualitative feedback and service users are asked to complete an evaluation at the end of their engagement. The combination of the spider and user survey creates a quantitative and qualitative assessment of how effectively the service is addressing service users' needs and gives users an anonymous voice for feedback.

The only negative feedback received by the service has concerned waiting times and quality of premises.

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### Resources to share

- Alcohol Concern's outcomes spider:  
[www.alcoholconcern.org.uk](http://www.alcoholconcern.org.uk)  
[www.pacehealth.org.uk](http://www.pacehealth.org.uk)

# 9: St Jude's Hostel, part of The African Caribbean Community Initiative (ACCI) and Omari Housing Consortium

**This case study focuses on the development and implementation of a residential dual diagnosis service for African Caribbean men who have a forensic history, mental health problems and substance use issues.**

## Overall purpose

The African Caribbean Community Initiative (ACCI) is a community-based mental health charity providing a range of services for African Caribbean men and women in Wolverhampton who have severe and enduring mental health problems.

The Omari Housing Consortium provides housing services for African-Caribbean men who have severe and enduring mental health problems and who have been detained under the Mental Health Act in prison or in a long-stay secure or special hospital.

## Service summary

The consortium has a hostel, St Jude's, for African-Caribbean men between the ages of 25 and 55 who have complex needs, a forensic history, substance use issues and mental health problems. It is a six-bed unit including a shared kitchen, lounge and an activity room. The staffing, structured and unstructured activities and the day-to-day running of the hostel are all provided by ACCI.

In addition to substance use and mental health needs, 'complex needs' are defined as:

- Erratic or irrational behaviour which can draw attention, cause a nuisance or be deemed antisocial
- A range of low level, persistent offending typically associated with trying to obtain money for illicit substances
- An inability to effectively manage money and continuous problems of serious debt
- A poor basic level of education with associated lack of motivation or unrealistic expectations about work
- A propensity to form unhelpful or inappropriate relationships which can lead to additional problems and readmissions
- Poor self-esteem and confidence and lack of social contact and peer support.

The primary aims of Omari are to provide:

- Secure, safe and independent accommodation
- A service that supports the needs of the individual and that responds flexibly to changing needs
- An environment that meets the cultural, spiritual and emotional needs of tenants.

All tenants at St Jude's have a structured rehabilitation programme to assist with harm reduction or abstinence from illicit substances. This consists of:

- Day-to-day living skills, such as personal hygiene, basic room cleaning, communal cleaning rota, preparation and cooking of a meal

- Advice on harm reduction
- Safe sex advice, including literature and free condoms
- Daily observation of medication
- Alternative therapies, such as auricular acupuncture
- Talking therapy and group work
- Recreation activities that are available 24 hours a day, seven days a week such as: a film night, use of activity room with pool table, table tennis, books, computer games and board games
- An 'appointeeship scheme' where, as part of the rehabilitation process and accommodation package, service users are helped to manage their finances
- Life skills, such as debt management, shopping, and support with saving schemes
- Input from a range of services (see below).

## Staffing

St Jude's is staffed 24 hours a day, seven days a week by a mixture of male and female staff (14 in total). The team are specifically trained in black mental health issues and generic drug use and are aware of the importance of providing a service that is culturally appropriate.

## Funding

St Jude's is funded through the PCT and Wolverhampton City Council under its Supporting People initiative.

## Service user and carer involvement

Service users are elected as members of management committee.

### Partnership working

Services were developed in partnership with Wolverhampton City Council, local housing associations and Wolverhampton PCT. Work with other professionals includes the local psychiatric hospital, addictions services, community and forensic psychiatric nurses, probation, the police and vulnerable adults team.

### Key outcomes

- Individuals are kept out of the criminal justice system
- Greater rehabilitation into the community
- Greater engagement with statutory services and agencies
- Individuals are enabled to move to supported independent living
- Increased skill levels
- Enhanced employment opportunities
- Improved engagement with family/carer(s).

### Key good practice points

- The model works towards a phased progression to shared, semi-independent and then independent living
- There is an 'open office' ethos in which service users can easily talk to staff (each tenant is allocated a member of staff throughout their time as a tenant)
- The staff team speak a number of languages and dialects which enables service users to communicate using their mother tongue.

### Insights from the service

- Statutory services often do not recognise the importance of having a service that is specifically tailored for African-Caribbean people with a dual diagnosis
- Service users can be seen as 'trouble makers' and their real issues are not recognised
- There is a tendency to medicalise the problems of this client group and to fail to offer talking therapies.

### Evaluation and monitoring

- Support plans are reviewed every two months in conjunction with service users
- Annual service user survey
- Monthly tenants meeting

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### Resources to share

- Annual report.

# 10: Grafton Ward, Manchester Mental Health and Social Care Trust

**This case study illustrates how an inner-city acute mental health ward addressed the problem of illicit substance use. It shows how it is possible to combine controlling measures with collaborative engagement and to bring about significant culture change for both staff and service users.**

## Overall purpose

A policy was developed to promote safer management of substance use (drugs and alcohol) within inpatient mental health settings.

## Service summary

Grafton Ward is an acute mental health ward serving Central Manchester. Substance use on the ward was identified as a major factor contributing to high levels of tension, mental distress and an increased number of incidents. A robust solution to tackle the problem was required.

Initially, staff had concerns that the proposed strategy of zero tolerance for illicit drugs could not be combined with the prevailing culture of empathy, collaboration and 'rolling with resistance'. However, in practice, staff found that it was possible to deliver a two-pronged message. On the one hand zero tolerance was a legal matter to which they could not turn a blind eye. On the other hand, staff could continue to engage patients in therapeutic discussions about cutting down or stopping substance use.

The project was delivered in two stages.

- The development and implementation of a substance misuse policy to facilitate best practice within acute care settings. This was designed to help staff prevent substance use on wards and implement approaches to promote the wellbeing of patients, staff and carers when substance use does occur.
- A detailed action plan was devised.

## Staffing

Multi-disciplinary team of nursing, medical and occupational therapy staff. Use of agency or bank staff was kept to a minimum.

## Funding

NHS statutory service.

## Service user and carer involvement

The patient liaison service was involved in developing the substance misuse policy.

## Partnership working

Ward staff worked with the Greater Manchester Police and Central Manchester Acute Trust security team.

## Key outcomes

Success was achieved in:

- Reducing use of non-prescribed substances
- Reducing incidents related to drug use
- Reducing bullying and harassment between service users
- Reducing acuity and promoting a calmer ward

atmosphere

- Preventing self-harm in vulnerable service users
- Improved safety for patients and staff
- Increased patient involvement in ward activities
- Increased referrals to, and liaison with, alcohol and drugs services
- Changing the culture to become more open and encouraging sharing of opinions about non-prescribed drugs between staff and patients.

## Key good practice points

- Be honest about reasons for searches and restrictions. This results in criticisms of staff by patients being less personal.
- Offer drug treatment options; eg detoxification, craving management or replacement activities.
- Explain your drugs policy to service users and talk to them about their use of non-prescribed substances. Be consistent in giving your messages.
- Develop a multi-agency approach to tackle the issues of non-prescribed substance use. This should involve nurses, management, specialist practitioners, medical staff, drugs services, hospital security and police.
- Assertively engage patients in ward-based activities.
- Arrange group support and supervision for frontline staff to review progress, to troubleshoot and to coach staff in new approaches and joint working with drug and alcohol services.
- Identify all service users involved in using non-prescribed substance use on the ward.
- Provide every service user with a copy of the drugs policy information leaflet.

### Insights from the service

- Clear boundaries were established and service users not detained under the Mental Health Act were refused entry onto the ward if not agreeable to searches. Detained service users were refused time out if they would not agree to being searched on return.
- Bedrooms were searched in line with the substance misuse policy if the presence of non-prescribed substances was suspected.
- Police and sniffer dogs searched the main ward areas for non-prescribed substances.
- Having substance misuse staff to consult with, or gain advice from, was useful. It boosted staff confidence and sense of control.
- Develop the ward dual diagnosis link worker role to support staff in using psychological approaches regarding non-prescribed substance use<sup>6</sup>.

### Evaluation and monitoring

Staff and service user questionnaires indicated that staff morale had improved and service users became more involved in social activities and conversations. Overall there was a more positive atmosphere on the ward with reduced tension.

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### Resources to share

- Dual diagnosis toolbox (A draft manual of assessments and treatment approaches validated in substance misuse/mental health/dual diagnosis)
- The Trust's substance misuse in inpatient psychiatric settings policy.

<sup>6</sup> The dual diagnosis link worker programme allows staff with an interest in dual diagnosis to undertake additional training to resource their ward or unit. They link in with other link workers across the full range of substance misuse and mental health providers, thus promoting greater internal capability whilst improving joint working and appropriate referral practice.

# 11: Rampton Hospital Substance Misuse Treatment Programme

**This case study looks at how dual diagnosis is being tackled in a high security setting, focusing particularly on the substance misuse treatment programme. It highlights the importance of looking at the relationships between people's substance use, mental health issues and offending behaviour in an integrated way.**

## Overall purpose

The team provides a variety of substance misuse interventions to several different forensic populations based within the high secure services of Nottinghamshire Healthcare NHS Trust. While some of these directorates have catchment areas covering a large part of the east of England, two are national services and take patients from all over England. The aims of the programme are:

- To encourage patients to explore and understand the relationships between their mental disorder, substance use and offending behaviours
- To enable patients to develop the knowledge, motivation and personal skills to manage their mental disorder and substance use problems in a more positive and appropriate manner
- To reduce the overall level of risk patients may present to themselves or others by managing their mental health and substance misuse problems more effectively when in the community.

## Service summary

The Rampton Hospital Substance Misuse Treatment programme is a six-module treatment intervention comprising 63 individual sessions which has been

running for seven years.

In contrast to many other substance use interventions (which specifically focus on substance use as a stand-alone problem), this programme aims to relate substance use, mental health issues and offending behaviour as a set of integrated difficulties. The material has been developed with mentally disordered offenders as the prime treatment population, although the components could be used with non-offender populations. The programme has also been used within the personality disorder directorates at the hospital and a shortened version is used within two medium secure services in the Trust. A separate programme for women and patients with a learning disability is in development.

## Staffing

At Rampton the programme is delivered on a weekly basis over a 15-month period. Each session lasts about two hours and is delivered to a group of approximately eight patients. Three staff usually facilitate each group. This minimises disruption to the programme due to annual leave or staff sickness.

## Funding

The Home Office and Nottingham PCT commission the service for other PCTs nationally. All treatment is provided from the existing budgets for each directorate.

## Service user and carer involvement

Because of the nature of the service and the type of programme, the opportunity for service users and carer involvement is limited. However, patients participate in

end-of-programme evaluations and the local patient advocacy group has facilitated an anonymised evaluation of the therapists' facilitation skills and abilities.

## Partnership working

There are close working links in substance misuse treatment between the high secure and the medium secure services within the Trust. The nurse consultant and nurse practitioners within the team act as a point of contact for other regional medium secure services. This is useful in ensuring continuity of care for individuals moving from the high secure services to these units.

## Key outcomes

- About 170 patients have completed the programme since it started in 1999.
- Patients develop a more comprehensive understanding of the complex relationships that exist between their mental health, substance use and offending behaviour. Psychometric tools and a case formulation approach are used to evaluate this process.
- Patients feel empowered to work on their problems in a positive way.
- Individuals feel they can make an informed choice regarding any future use of substances.
- Each individual develops a comprehensive relapse strategy to help them maintain their chosen treatment goals.

## Key good practice points

- The substance misuse treatment programme was developed following an extensive literature review and integrates the epidemiological evidence with evidence-

based treatment approaches relating to substance use, offending behaviour, and mental disorders.

- Facilitators focus on the three areas of mental health, substance use and offending as an inter-related and complex set of problems.
- Facilitators are aware that the treatment needs of each group and the individuals working within it differ. They are also conscious of the underlying pathology that differing mentally disordered individuals bring to the group and how this is managed.
- Facilitators have a good understanding of mental disorder and substance misuse, which gives them credibility with their audience. This is especially important when working with individuals with a personality disorder.
- Facilitators are given protected time to enable them to take on a defined therapist role when delivering treatment. This is essential, especially for ward-based nurses who frequently encounter role-conflict issues between security and treatment.
- Facilitators come from a range of professional backgrounds.
- The appointment of a dedicated lead practitioner meant that there was sufficient time, resources, and funding to establish the service. Maintaining the service requires long term commitment and investment.

#### Insights from the service

- While links with community drug and alcohol services are useful, they often fail to understand the complex treatment requirements of forensic patients.
- Staff should receive specific training to deliver the

programme. This includes being sensitive to the needs of patients, issues related to the patient's gender, the various patterns and choice of substance used, and their life experiences, such as violence, trauma and abuse issues.

- Many senior nurses need to be convinced of the necessity for treatment. They have cost concerns and are often overloaded with more day-to-day issues. It is imperative to get them signed up to the value of delivering substance misuse treatment at an early stage.
- Substance misuse can be seen as a peripheral area and is vulnerable to cost cutting.
- Clinical services need to own the problem (ie view substance use as a treatment priority).
- Motivational approaches within a group context are very powerful.
- Keep any presentation simple but not patronising.
- Substance use is a major indicator of risk in forensic populations. It is also the best predictor of relapse. Being abstinent while in care does not mean that the problem has been addressed.
- Short term interventions do not work with forensic populations.
- Be aware of your own individual limitations.

#### Evaluation and monitoring

Completion rates are high at over 90%. Patients evaluate the programme very positively. They report that it empowers them to make informed choices about their future drug and alcohol use.

Since 2002, a project group of clinicians and

academics from sites across England has been trying to develop a multi-site evaluation of the programme. The aim is to evaluate the programme across several forensic services from high security to community outreach teams. To date, funding bids have been unsuccessful. However, we remain optimistic for the future and hope to make further bids.

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#### Resources to share

The programme is presently being revised but it will be available for other forensic services to purchase in the near future. The programme will only be available as part of a wider package which includes a training and supervision element. We feel this is essential as it is important that the integrity of the programme is maintained.

# 12: Lewisham Dual Diagnosis Service

**The Lewisham Dual Diagnosis Service provides a 'virtual team' of trained specialist dual diagnosis practitioners. These are based in mental health and substance misuse teams in a variety of settings including community, inpatient and assertive outreach services. The aim is to provide an integrated service to clients and to develop skills within the services.**

**The case study also illustrates some of the challenges of working with service users. Where there are separate user forums in substance misuse and mental health, it may be necessary to build links to enable engagement with people with a dual diagnosis.**

## Overall purpose

To promote an integrated model of care in which people with mental health and substance use problems have both issues addressed concurrently, in one setting, by one team.

## Service summary

Dual diagnosis practitioners are based within the South London and Maudsley NHS Foundation Trust's services (community drug and alcohol, psychiatric inpatient, community mental health and assertive outreach) and form a 'virtual team'.

The team's main focus is training, practice development and supervision. Practitioners also undertake some direct clinical work, support dual diagnosis work in partner agencies and facilitate care pathways between services.

Core training is the five day pan-London dual diagnosis course. Follow-up learning events are provided every three months. Learners are also encouraged to spend time in other services to enhance their skills and understanding of wider care provision.

Other training includes:

- Mental health for substance misuse services
- Substance use and risk
- Input to local GP learning sets
- Additional one-off training as required and as resources permit.

Clinical inputs include:

- Supporting staff to put training into practice; eg joint assessments and follow up work
- Short term management of service users who have traditionally fallen between services and 'hand holding' their referral to other services
- Providing formal and informal supervision to staff members and groups
- Helping service users to access a range of services in the borough.

## Staffing

There are eight posts: a team leader and six dual diagnosis practitioners. All have capabilities at level three in the 'dual diagnosis capability framework' identified in *Closing the Gap* (DH, 2006). The addictions consultant psychiatrist provides one session of consultation per month to the team. The consultant

nurse for dual diagnosis provides a weekly consultation session and monthly supervision for the team manager.

## Funding

Funding is primarily from the Drug and Alcohol Strategy Team (DAAST) and PCT pooled treatment budget (five posts). The assertive outreach posts (three) are funded 50:50 by the DAAST/PCT and the assertive outreach mental health budget. The mental health budget funds 20% of the consultant nurse post.

## Service user and carer involvement

Dual diagnosis service user initiatives have existed for over two years. Initially a dual diagnosis specific service user group was set up. Members were involved in: development of the dual diagnosis strategy; providing a consultation forum for proposed service developments and policy initiatives, staff interviews and induction; running stalls at local stakeholder events and delivering presentations.

For a variety of reasons, this group then broke down. A key factor was that there are separate user forums within substance use and mental health. Efforts are now being made to co-ordinate user input into dual diagnosis.

A local carers group is consulted about the dual diagnosis strategy and policy development. A workshop for the mental health carers' forum is planned for 2007. This will provide information about the service, explore agencies that can support carers and discuss what future input the service can provide.

### Partnership working

The team have developed good working relationships with a wide range of local services and groups.

Collaborative projects include:

- Running sessions in two of the voluntary sector substance use services to support their staff in working with people who have mental health problems
- Regular input to the drug intervention programme (DIP) team, such as delivering training on mental health issues and developing the team's risk assessment tool
- Regular meetings with primary care mental health and substance misuse leads to promote awareness of dual diagnosis issues
- Plans to run a group for cannabis users: participants include representatives from the dual diagnosis team, early intervention service and the community drug project (voluntary sector substance misuse service).

### Key outcomes

- Since April 2004, 124 people have received the five day pan-London training.
- 36 substance misuse staff have received mental health training.
- In the period between April 2006 – April 2007, the total number of referrals was 264.
- All clients taken on by the team are assessed on the clinician's drug use scale and/or the clinicians' alcohol use scale at the initial point of contact and when referred on. Data suggests that improvements are made over this period. The service is currently reviewing the use of assessment tools.

### Key good practice points

- A model for developing local dual diagnosis practice is in place and is reviewed regularly by the team
- Dual diagnosis practitioners are supported to maintain their substance misuse capabilities as they are only of value to mental health services if these are up to date
- In order to enhance skills and promote retention, practitioners have the opportunity to exchange roles within the team; eg from assertive outreach to inpatient
- The team attended a bespoke consultancy skills course to enhance their consultancy and change management skills
- It is important to have dual diagnosis practitioners in both inpatient and community services to promote continuity of care across sectors.

### Insights from the service

- Consult widely to promote engagement and ownership among a range of stakeholders.
- While joint work with colleagues is an ideal it can be difficult to achieve. It is important to negotiate at the outset about what is realistic and sufficient to achieve learning and good care.
- It is a challenge to balance responding to need with being realistic about what you can achieve with the available resources. Spreading resources too thinly can result in limited gains and in staff becoming burnt out.
- It is important that dual diagnosis practitioners' direct clinical work is time limited so that case loads don't become 'clogged up'. Service users can be referred back to dual diagnosis practitioners for

further input at a later time.

- Although having practitioners embedded within local services is essential to promote integrated care, these people can feel isolated. Good support and supervision is essential.
- It is important to have practice development and supervision as well as training.
- Nurse consultants played an important leadership and consultancy role in developing strategy and practice.
- Measuring outcomes in a robust manner is a significant challenge.
- Engaging team managers/leaders and consultant psychiatrists is crucial. Devoting time and energy to this is important.
- Keep positive, be resilient – changes do happen!
- Regularly review what you are doing and change it when necessary.

### Evaluation and monitoring

- Data from a survey of staff perceptions of the service suggested that staff have a good understanding of the role of the dual diagnosis practitioners, found them accessible and approachable, found the five day training helpful and rated joint work as very helpful.
- Evaluations of the five day training consistently rate it as well delivered, the content is perceived as extremely relevant and staff feel able to incorporate the dual diagnosis interventions into their practice.
- Monthly reports on service user work are submitted through the National Drug Treatment Monitoring System data entry tool (NDTMS).

- Activity other than client contact is also monitored. This includes: number of training days/sessions delivered, individual and group supervision sessions provided, joint sessions conducted and input provided to clinical meetings.
- Data summaries are fed back to commissioners in a quarterly monitoring meeting.
- Audit and evaluation of dual diagnosis developments on one inpatient ward took place in 2006 as part of the London Development Centre Acute Care Collaborative.
- A retrospective audit of alcohol detoxification is being carried out on the acute psychiatric admissions ward.

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### Resources to share

- Lewisham dual diagnosis strategy.
- Data collection tool.
- Staff questionnaire.
- Requests for consultancy skills training can be made to SLAM partners [www.unlockingideas.co.uk](http://www.unlockingideas.co.uk).

# 13: The Westminster Dual Diagnosis Project

**As in case study 12, the Westminster Dual Diagnosis Project showcases a 'virtual team' in which dual diagnosis workers are placed within mental health teams. The project is specifically designed to facilitate 'mainstreaming'.**

**The project highlights the contribution that dedicated dual diagnosis workers can make to improving understanding and shared processes between mental health and substance misuse services. It also looks at some of the difficulties around achieving cultural change and engaging service users.**

## Overall purpose

This service aims to promote the management of people with a dual diagnosis within adult mental health services in Westminster, in line with the mainstreaming message of the *Dual Diagnosis Good Practice Guide* (DH, 2002).

The dual diagnosis service operates as a 'virtual team', in which dual diagnosis workers are placed in different CMHTs but meet together, and are managed, as a team. This is to ensure consistency in care delivery, strategic planning and borough wide training, audit and research.

## Service summary

The role of team members is to: deliver direct clinical input, work towards implementation of the Trust and Westminster dual diagnosis strategy, audit the service, teach and conduct research.

Direct clinical work with service users includes undertaking joint assessments (using a modelling approach) and time-limited treatment with individuals whose care is co-ordinated by other members of the CMHT. This work may address:

- Drug/alcohol use
- Harm minimisation/health promotion
- Motivational interviewing/assessment of readiness to change
- Detoxification and rehabilitation
- Relapse prevention.

In line with the mainstreaming approach, all direct clinical work is undertaken jointly with the care co-ordinator. Input is available to any service user whose care is managed by the CMHT and who wants to address any aspect of their drug and/or alcohol use. Advice is provided on onward referral for patients with a substance use problem who are not appropriate for CMHTs.

Consultation and one-off assessments are offered to other parts of the adult mental health services (inpatient units, crisis resolution teams, early intervention service and the joint homelessness team).

The City of Westminster is a central London borough. Of the adult population, 73% is of white ethnic origin, 9% Asian and 7% black. The under-19 population is particularly diverse with white British residents comprising only 37% of this group.

## Staffing

The team consists of three specialist worker/nurse posts and one clinical lead. All have mental health and substance misuse experience. Each team member covers two CMHTs ensuring equity of service provision to both.

Strategic service development and consistency of approach is managed by the clinical lead.

## Funding

Two posts are funded from the DAAT and two from the LIT. The LIT posts are permanent. The DAAT posts are secured for the next two years when they will be reviewed in line with all DAAT expenditure.

## Service user and carer involvement

In early 2006 a user forum involving service users, advocacy groups, carers, members of the public and professionals was set up. This had a far-reaching remit including: developing links with other user forums; developing partnerships with the Patient Liaison service; auditing, evaluating and disseminating good practice; providing training; and supporting user involvement.

However, due to poor uptake, this model is being revisited and a two-tier approach to user involvement is being piloted with the following components:

A dual diagnosis service user community group is being set up with the aim of engaging people through acupuncture, drug and alcohol awareness activities, and drop in facilities.

Representation from the established mental health service user groups is being sought on the dual diagnosis operational group.

We are also approaching the carers of service users for a representative at the operational group. In the future we plan to run a relapse prevention programme in the inpatient units which will be available to staff, service users and carers alike.

### Partnership working

The service works with a number of agencies including:

- Substance misuse services. Drug and alcohol, both statutory and voluntary
- Substance misuse social services care management team
- Inpatient mental health units
- CMHTs
- Police. We have established formal links to local police services through police liaison meetings.
- The DAAT and LIT who jointly chair the local steering group. A constructive partnership with the DAAT and LIT has also resulted in the joint funding of the dual diagnosis posts.

### Key outcomes

- Dual diagnosis leads have been identified in all inpatient wards and community teams and have all attended the five day pan-London training. They assist in ensuring consistent screening of drug and alcohol use.

- A screening tool has been adopted and care pathway agreed so that all service users assessed by adult mental health services (inpatient or community) are asked about their drug and alcohol use and directed to appropriate treatment.
- 52% of drug and alcohol use screens were completed on inpatient units between September 2005 and February 2006 (where service users were asked about their drug and/or alcohol use and whether they wanted help).

### Key good practice points

- Allow plenty of time as adopting a mainstreaming approach can take longer than anticipated. Attempting to change culture within both mental health and substance misuse services is a complicated task.
- Devise multi-agency care pathways detailing the dual diagnosis service user's possible treatment journey.
- Strengthen CPA care planning to ensure drug and/or alcohol issues are included.
- Use a modular approach for training where staff can choose the days they want to attend which is relevant to their area of work and for which their service can release them.

### Project insights

- It has been helpful that substance misuse team leaders have attended the dual diagnosis operational group. Similarly, members of the dual diagnosis team have attended substance misuse clinical governance and clinical meetings. This has helped to bridge the gap between mental health

and substance misuse services.

- It can be difficult to ensure that skills learnt by staff as a result of training are maintained.
- There has been a lack of understanding within adult mental health teams about the nature of 'mainstreaming', its purpose and the policy behind it.
- Service user involvement has been difficult to establish. A start is being made to provide a forum that reflects the unique challenges of dual diagnosis service users.
- Modelling has limited effect, possibly due to mental health staff time constraints. This appears to be borne out by the lack of staff attending for supervision and limited number of clients attending clinics even though they are seen as useful and important.

### Evaluation and monitoring

Students on the five-day dual diagnosis training complete an evaluation form at the end of the course. Attitudes are assessed at the start of the course, at the end, and six months after completion.

A comprehensive service user questionnaire to evaluate the effectiveness of interventions has been developed with service user input. This is sent to all service users annually. The questionnaire focuses on access to the service, understanding of the dual diagnosis worker's role, plans and goals set with the dual diagnosis worker, and the extent to which interventions have been successful. Yearly audits of screening for drug and alcohol use and compliance with following the dual diagnosis care pathways are also conducted.

Other monitoring and evaluation indicators used include:

- The extent of links with other services
- Inpatient bed occupancy and contacts with crisis services.

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### Resources to share

- Rough guide to adult mental health services for substance misuse staff, and rough guide to substance misuse for adult mental health staff (these are a guide to services, giving brief information on services offered and for whom, as well as contact information and referral details)
- Information on care pathways
- *Strategy for Dual Diagnosis Service Provision: Joint CNWL Adult Mental Health Services and CNWL Substance Misuse Services 2003-2006* (Central and North West London Mental Health NHS Trust, 2003)
- Westminster dual diagnosis service annual report 2005-2006

- Westminster dual diagnosis service operational policy
- Service user questionnaire
- Drug and alcohol screening audit tools.

# 14: Intensive Management of Personality Disorder: Assessment and Recovery Team (IMPART)

**IMPART (formerly DDART and IMPACT) provides a highly targeted service for people with personality disorders and substance misuse problems. There is strong emphasis on bringing users together to share ideas about recovery and to receive ongoing support after leaving the service. Carers also receive support and advice.**

**The case study looks at how the service has been able to create a better understanding of personality disorder in other services and to encourage more appropriate referrals. It also provides useful lessons about working in teams and the qualities that are important for staff.**

## Overall purpose

The IMPART service offers a range of evidence-based psychological therapies to people who have a non-forensic personality disorder and co-morbid substance misuse. The service provides assessment, treatment and advocacy for service users and their carers, and consultation to referrers. The overarching aim of the service is to assist service users in their recovery and to help rebuild their lives.

## Service summary

IMPART is a dialectical behavioural therapy (DBT) service, with its policies and procedures developed from DBT principles<sup>7</sup>.

Referrals are accepted from mental health services, probation, housing, social services, physical health services, drug and alcohol services and GPs. IMPART

does not accept self-referrals.

Individuals are initially screened for the presence or absence of a personality disorder before full assessment is undertaken. There are strict criteria for admission to the service and this includes types of personality disorder where DBT therapy has not been proved to be effective. People who do not meet the criteria are returned to their referrer or referred to a more appropriate service.

Assessment: after a comprehensive assessment, a complex formulation (essentially a narrative of the individual's life tracing the origins of current difficulties, highlighting the range of current difficulties and possible diagnoses) is used to identify a treatment plan. The assessment takes 12 to 16 hours and includes tools to assess diagnosis, substance use, risk and social functioning.

Treatment options: service users receive treatment from several members of the team. This increases their attachment to the team as a whole and reduces difficulties when staff are on leave or leave the service. This is important when working with people with personality disorder who have fundamental difficulties with forming and maintaining healthy attachments to others.

All service users receive three to six weeks of motivational enhancement to help them explore the change process.

IMPART offers three main psychological therapies (DBT, CBT and schema focused therapy), according to the service user's needs. The DBT programme involves individual sessions, group skills training sessions and telephone coaching. Its main aim is risk reduction (reducing deliberate self-harm, suicide attempts, violence, substance abuse and self-neglect). The CBT programme focuses more on Axis I disorders, which include depression, anxiety disorders, eating disorders and psychotic disorders. The schema focused programme is for individuals assessed as being low risk, who wish to address the psychological factors which contribute to their difficulties.

Therapy groups such as communication skills, anger management, anxiety management, pain management and skills strengthening are also run.

IMPART offers an evening group to supporters of service users (carers or friends) providing information on personality disorder, ways to assist service users with use of skills and improving relationships in the social and family network.

A recovery forum is held each month. This forum helps individuals to understand the concept of recovery, in general and for themselves. It also allows individuals to raise issues about how to achieve recovery and, to consider with the group as a whole, what the obstacles to recovery might be. Finally, the forum asks individuals for ideas and feedback on developments in the service which would aid their recovery or the recovery of others.

<sup>7</sup> Dialectical behavioural therapy is a form of CBT, adapted specifically for people with borderline personality disorder.

Other services are also provided by IMPART:

- An 'alumni' group is for people who have completed treatment and moved on (eg returned to education or employment) but want to receive continuing support or share their successes and frustrations.
- A five module training package on working with personality disorder and substance misuse for any services in the local authority area (statutory and voluntary, health, mental health and social services). Supervision can also be provided to teams who have received training.
- External consultation, eg to practitioners enhance their capacity and skills to work with people with personality disorder and substance misuse, and with other service providers to increase their understanding about the needs of service users and to consider with them possible referral pathways.

### Staffing

The team is multi-disciplinary but all clinical staff provide psychological treatment. The team currently employs two nurses, one clinical psychologist, one CBT psychotherapist, two assistant psychologists, one occupational therapist (team leader), one consultant clinical psychologist (head of service) and two administrative staff. In addition the team has one specialist registrar undertaking special interest sessions to learn DBT and one clinical psychology trainee.

### Funding

The IMPART service was originally funded by the DH as a pilot project. On April 1 2007, IMPART was devolved to the PCT and funding is through existing commissioning

structures, with some additional funding from the DAAT.

### Service user and carer involvement

Service users have been involved in development of the service, participating on the steering committee, reviewing policies and providing feedback during the evaluation phase. In addition to the recovery forum (see above), service users participate in all appointments panels and reviews of documentation and procedures. They also deliver conference presentations and training. Service users are sent questionnaires and invited for face-to-face meetings at regular intervals (at least twice yearly) to identify concerns and achievements of the service. A robust complaints procedure is in place.

The service is developing a website in consultation with service users and carers ([www.nelpd.org](http://www.nelpd.org)). Future plans include a bulletin board for questions and answers, including responses to issues of concern raised.

### Partnership working

IMPART works in partnership with local mental health services, the local DAAT, social services, housing, probation and voluntary sector.

For people not offered psychological treatment with IMPART, staff provide advocacy support and referrals to other services (eg housing or social services). IMPART also provides consultation to referring or other services.

### Key outcomes

Outcomes are measured with the repeated use of the assessment measures and with a range other scales. These vary according to the needs of the service user, referrer and carers. For most service users the main outcomes are:

- A reduction in suicide attempts
- A reduction in deliberate self-harm
- A reduction in substance abuse
- A reduction in violence
- An increase in social functioning (eg friendships, relationships or neighbours)
- An increase in positive mood
- An increase in ability to cope with distress
- An increase in meaningful occupied time.

### Key good practice points

- Good and regular communication with all staff (both within the team and with other teams) is essential when working with personality disorder and substance use both for effective risk assessment and management and to encourage staff co-operation.
- It is important to recognise that if a person has a number of unmet social and personal needs, they will have less capacity to engage in intensive psychological therapy and change.
- Service users need to feel heard when voicing concerns/complaints and visible change should occur in response.
- It is helpful to separate the role of a psychological therapist from the role of care co-ordinator, though this is politically and practically difficult at times.

- Training needs to be supported through ongoing supervision or the learning is lost.

### Insights from the service

- Staff retention is difficult when working with personality disorder and substance use service users
- Key attributes in staff are creativity, flexibility and a non-judgmental attitude
- Staff must be robust in the face of slow progress in therapy with, at times, high risk individuals, so they need to feel secure and valued
- Relationships with other teams can be difficult – many services dislike personality disorder service users and attempt to ‘dump’ service users onto personality disorder services
- Recovery is different for every individual.

### Contact

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### Resources to share

- The service offers a number of open days. Contact Kellie Green (kellie.green@nelmht.nhs.uk) to enquire about the dates.
- Our website ([www.nelpd.org](http://www.nelpd.org)) will offer further information about IMPART.
- Staff from the IMPART team are available to deliver the training modules on personality disorder and substance abuse (contact Kellie Green for more information).
- Leaflets and some policies/procedures are available from Janet Feigenbaum. Teaching on the recovery model as applied to personality disorder and substance use is available from Marilyn Wilson (marilyn.wilson@nelmht.nhs.uk).
- Advice on developing a business case is available from Janet Feigenbaum.

# 15: Croydon Dual Diagnosis Service

**This case study highlights some particular initiatives to meet local needs, including a project around khat use in the Somali community and innovative working with local prisons to ensure that people with a dual diagnosis are not released as homeless.**

## Overall purpose

The overall purpose of the service is two-fold:

- To enable people with a dual diagnosis to receive mainstreamed treatment and support for their mental health and substance misuse needs from the primary service provider.
- To provide training, professional advice, support and consultation to all service providers in the borough who work with people who have a dual diagnosis. The goal is to enhance the quality of services and to assist providers in directing users to appropriate services.

In common with several other case studies, Croydon has moved to mainstreaming by providing dual diagnosis specialists who support mental health and substance misuse teams.

## Service summary

The Croydon Dual Diagnosis Service was set up with the active involvement of local service user groups and started in October 2003. It consists of the dual diagnosis lead for the borough and two dual diagnosis practitioners. Team members may be employed by either the Trust (South London and Maudsley NHS Foundation Trust) or the local authority

(London Borough of Croydon).

The initial focus has been providing training, support and consultancy to all staff in the borough who work with people who have a dual diagnosis, and to help to clarify care pathways.

The team delivers the five day pan-London dual diagnosis course, which is free to all teams who work with people with a dual diagnosis in Croydon. This training has been delivered to a wide range of staff including substance use, mental health practitioners, housing and rehabilitation providers. The mix of participants promotes development of working relationships and scope for initiating joint developments between services.

Other training with which the team is involved includes:

- Drug and alcohol training
- Mental Health Act training to the police
- Trust's clinical risk assessment training (risks associated with substance use)
- One-off training as required
- Delivering the pan-London course to other boroughs and voluntary agencies.

The team's extensive knowledge of services in the borough enables it to play an important role in resolving care pathway issues.

The service has also assisted the local Somali community with research into khat use. This groundbreaking initiative resulted in individual sessions being developed for young people, men and women. A poster competition, open to young people, led to the development of a leaflet in comic strip form. The published research is now being reprinted in Somali. All members of the Croydon Somali group have attended the five day pan-London dual diagnosis course. The dual diagnosis team have been invited to help the Somali community explore the specific mental health problems experienced by some users of their service.

## Staffing

Croydon dual diagnosis lead and two dual diagnosis practitioners.

## Funding

The funding streams are twofold; the DH pooled treatment budget via the DAAT and the London Borough of Croydon Adult Social Services.

## Service user and carer involvement

A representative of one of the local mental health service user groups has been a member of the dual diagnosis steering group since its inception. Several people from local service user groups have attended the five day dual diagnosis course.

## Partnership working

The team places a strong emphasis on working with the full range of services in contact with people with a dual diagnosis.

The dual diagnosis lead has contributed to a variety of projects in the borough. These include:

- Establishment of the local substance use service user group and assisting in providing training and support to its members
- A pilot project to improve communications between local prisons and agencies in Croydon to ensure that individuals with a dual diagnosis are not released from prison as street homeless
- A project group for *Models of Care* (see section three) and the development of a common shared assessment tool for use in all drug and alcohol agencies
- Being a member of the DIP operations group
- Being a member of Croydon's integrated adult mental health serious untoward incident panel.

### Key outcomes

Devising an effective method for measuring the outcome of the work remains a challenge.

- Since April 2004 more than 350 people across all agencies have received the five day pan-London training.
- There is a better understanding of mainstreaming and of the role of the dual diagnosis team. Agencies understand that the dual diagnosis team does not provide case management.
- Improved service experience for users which is evidenced by the number of requests for advice and assistance that the team receives from services.
- Improved understanding by all teams of the value of a holistic approach.

- Training for all staff and teams has facilitated 'mainstreaming' and reduced the 'pillar to post' effect.

### Key good practice points

- An inclusive definition of dual diagnosis is in place.
- The team have built strong working partnerships with a wide range of providers.
- A joint steering group for dual diagnosis, integrated mental health and substance misuse is in place. This incorporates a wide range of perspectives from statutory, non-statutory, mental health and addictions services.
- As part of the training, participants are encouraged to reflect on cultural differences, and the impact these have when working with service users.
- All members of the team attended a consultancy skills course for dual diagnosis workers in the Trust. This enables them to improve their change management and consultancy skills.

### Insights from the service

- Acknowledge and encourage the important work being carried out by voluntary and independent sector providers and include them in planning from the outset.
- Mainstreaming treatment for people with a dual diagnosis means 'culture change' and we were not surprised at the resistance we encountered in some areas.
- Take time to identify clear priorities and a realistic workload for your dual diagnosis team.
- Bringing together learners from different agencies

promotes inter-agency relationship building and breaks down barriers.

- Review where your support lies and push hard in those areas where most can be achieved as other areas that are less keen will follow at their own pace.
- It can be a challenge to get the right balance between 'joint working' with colleagues and 'doing it for them'.
- Maintaining a clear vision about what 'mainstreaming' means locally helps to clarify who should carry out the interventions needed.
- Embedding staff into teams was not practicable as there are just too many services.
- Through training, team members need to enhance their skills so that they can provide consultancy, effect change and educate across a broad spectrum of services. They need to be trainers, facilitators and diplomats with a good knowledge of drug, alcohol and mental health treatments.
- Where possible, whole team training is preferred as it promotes shared learning and culture change across the team.
- Involving team leaders and practitioner managers in establishing a system for practice development and supervision is essential.

### Evaluation and monitoring

The five day training is monitored using two instruments; one devised by the course developers and a more detailed questionnaire developed in Croydon which is more closely aligned to the individual sessions presented. Analysis of the data demonstrates consistently high ratings for the course

and individual comments are also very positive. The dual diagnosis service has been monitored by the Croydon dual diagnosis steering group. This group looks at activity, progress on the action plan and considers proposals for future initiatives.

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### Resources to share

- Croydon dual diagnosis strategy
- Terms of reference for the practitioner manager forum
- Training material for the pan-London five day dual diagnosis course
- Copies of the research report carried out by the Croydon Somali Community into khat use
- Report on the training delivered by the Croydon dual diagnosis team (April 2005 to March 2007)
- Croydon models of care policy – substance misuse services for adults, guidance for staff on integrated 'single' tools, policies, systems and processes.

# Conclusion

**Although it is hard to summarise such a wealth of experience, several key messages stand out from this project.**

First, it is clear that dual diagnosis remains a challenging field. While many teams are making progress in developing mainstream services, there are still key areas of unmet need where it proved difficult to find good practice and where there is much to be done. These include: services for women, services for young people, services for BME communities; support provided through primary care; and services for people involved in the criminal justice system.

Second, dual diagnosis is an all encompassing cross-sector and cross-agency concern. The sheer breadth and complexity of issues makes it essential that people using, commissioning, providing and working in services all work together. Dual diagnosis needs to become a bigger priority at a national, regional and local level.

Finally, it is encouraging that new ways of working and examples of good practice are emerging all the time. The wide range of service users and staff who have informed this handbook, is testament to the interest in, and commitment to, learning, improving practice, and developing provision. We hope this handbook honours their experiences and serves to inspire and inform others dedicated to improving services and quality of life for service users.

# List of abbreviations

<b>BME</b>	Black and minority ethnic
<b>C-BIT</b>	Cognitive Behavioural Integrated Treatment
<b>CBT</b>	Cognitive Behavioural Therapy
<b>CJIT</b>	Criminal Justice Integrated Team
<b>CMHT</b>	Community Mental Health Team
<b>CPA</b>	Care Programme Approach
<b>CSIP</b>	Care Services Improvement Partnership
<b>DAAT</b>	Drug and Alcohol Action Team
<b>DBT</b>	Dialectical Behavioural Therapy
<b>DAAST</b>	Drug and Alcohol Strategy Team
<b>DH</b>	Department of Health
<b>LGBT</b>	Lesbian, gay, bisexual and transgender
<b>LIT</b>	Local Implementation Team
<b>NDTMS</b>	National Drug Treatment Monitoring System
<b>NIMHE</b>	National Institute for Mental Health in England
<b>NTA</b>	National Treatment Agency
<b>PCT</b>	Primary Care Trust

## **About Turning Point**

We turn lives around every day, by putting the individual at the heart of what we do. Inspired by those we work with, together we help people build a better life.

Turning Point is the UK's leading social care organisation. We provide services for people with complex needs, including those affected by drug and alcohol misuse, mental health problems and those with a learning disability.

We have particular expertise in working with people who face multiple challenges. Many of our service users have co-existing substance misuse, mental health and other needs and so we have a strong commitment to improving provision and delivery of dual diagnosis services.

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