LEEDS DUAL DIAGNOSIS PROJECT

Care Pathway Evaluation

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RATIONALE

- DD Care co-ordination protocol agreed by network members in 2008
- Identified agreed assessment, care co-ordination and joint working criteria
  1) Since introduction no further monitoring has taken place
  2) Currently no mechanism to systematically monitor prevalence of DD across services
- Care Pathway Evaluation aims to address these 2 areas
- Learning used by DD Strategy Group + Senior Commissioners to inform future strategy + service development

QUICK GUIDE FOR CARE CO-ORDINATION & REFERRALS:

STEP 1: Screening

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

STEP 2: Using the Pathways Guide

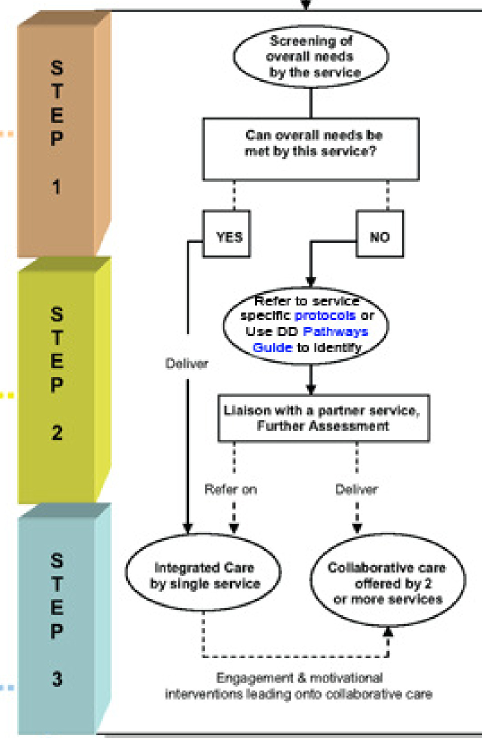
- The pathways guide is essentially a directory with brief descriptions of various services that often come into contact with people with Dual Diagnosis issues.
- Information gathered through initial screening should be used to **'match' specific client needs to specific services**. The pathways guide clusters services in different 'Sections' to facilitate the process of 'matching'. Some guiding questions to help in this process are:

  - Is the person in crisis? → See section A.
  - Presenting symptoms of common mental disorders? → See section B.
  - Presenting symptoms of severe mental disorders? → See section C.
  - Requiring drug / alcohol related interventions? → See sections D & E.
  - Homeless or requiring support with housing? → See sections F & G.

STEP 3: Care Models

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

A service comes into contact with a person with combined mental health & addiction problems



CARE CO-ORDINATION

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

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

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BACKGROUND

- Pilot service evaluation undertaken in 2012
- 2 questionnaires piloted on 6 network members services
- Aimed to identify if services/practitioners were able to provide the information required
- Would a larger scale evaluation be feasible
- Learning from the pilot used to improve and inform full evaluation

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METHODOLOGY

- No funding available and limited timescale
- Required a pragmatic approach
- Real world research methodology
- Active engagement of stakeholders via DD Working Group
- 2 standardised self completion questionnaires were developed in conjunction with members of the DD Strategy Group (included senior commissioners, LYPFT, St Anne's)
- Administered online via survey monkey

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QUESTIONNAIRE 1 - SUMMARY

- Focused on prevalence, demographics, screening + training
- Completed by service mangers of all network members
- Analysis not yet complete
- Not clinical threshold for DD
- Snap shot of potential numbers who may require support
- Practical significance = Inform capacity building + future DD strategy

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QUESTIONNAIRE 2 - SUMMARY

Standard of Care / Care Co-ordination Protocol

Participation and Response Rate

- 330 questionnaires sent (approx 33% of practitioners in network services)
- 90 response = 27% response rate

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

QUESTIONNAIRE 2 - SUMMARY

Step 1 – Screening + Assessment

Screening Tools

- Drug/alcohol and Statutory MH Services identified using agreed screening tools
- Vol. Sector MH + housing support services rarely use screening tools

Service ability to meet overall DD needs

- majority of participants believe their services can meet the overall mental health and substance use needs of people accessing their service
- Only 9 participants identified their service can rarely meet peoples DD needs
- Vol. Sector MH + housing support services had most difficulty meeting DD needs

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QUESTIONNAIRE 2 - SUMMARY

Step 2 – Joint Working

Common Reasons for Joint Working

1) Complexity + managing risk
2) Difficulties engaging with client + client not engaging with service
3) Time limit of service + not meeting service criteria

Top 3 agencies routinely engaged in joint working

1) LAU
2) CMHT
3) To varied to identify

QUESTIONNAIRE 2 - SUMMARY

Step 2 – Joint Working

How often referrals are accepted for joint working

- Majority identified always or often accepted
- Significant number suggested about half or rarely

Common reasons referrals not accepted

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

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QUESTIONNAIRE 2 - SUMMARY

Step 3 – Care Co-ordination

How joint working is monitored

- CPA and Joint Care Planning most commonly identified
- Significant number identified informal monitoring
- Only 3 participants did not know

How lead role is determined when joint working

- Named care co-coordinator and key worker primarily identified
- Only 6 people did not know

QUESTIONNAIRE 2 - SUMMARY

Discharging and Exiting Services

Moving on to meet ongoing DD needs

- Equal numbers identified fairly easy + fairly hard, majority neutral
- Response consistent across all sectors
- Contrasts with initial experience of joint working

Frequent barriers to planned discharge

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

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NEXT STEPS

- Full report and executive summary to be published and made available to all
- Stakeholder members of the DD Strategy Group will meet to discuss and interpret the findings
- Further investigation e.g. focus groups may be required to explore issues in greater depth
- Learning from the DD Care Pathway Evaluation will be used to inform the DD Strategy Group; alongside information from the current sector reviews being undertaken.
- This will influence the development of a future dual diagnosis strategy, and continue to improve access to treatment for people with coexisting mental health and substance use.

Thank you for listening

Questions ?