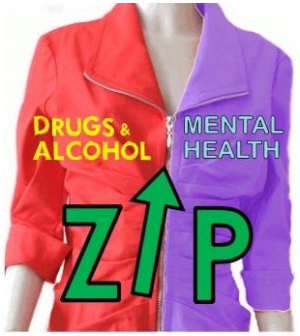

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The Leeds Co-occurring Mental Health and Substance use (Dual Diagnosis) Capability Framework

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Authors:

Professor Liz Hughes[1], Justine Trippier[2], Dr Cheryl Kipping[3], Richard Bell[4], and the ZIP Group[5]

[1]Professor of Applied Mental Health Research, University of Huddersfield and South West Yorkshire Partnership NHS Foundation Trust
[2] Consultant Nurse in Dual Diagnosis, Oxleas Mental Health NHS Trust
[3] Consultant Nurse in Dual Diagnosis, South London and Maudsley NHS Trust
[4] Leeds Dual Diagnosis Project Manager (January 2014 – January 2015), St Annes Community Services
[5] Service user group, Leeds

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Introduction

People who experience substance use and co-occurring mental health problems have long struggled to access the comprehensive care that they require. There are high levels of mental health problems amongst people using substance use services (especially depression, anxiety and personality difficulties) and significant levels of alcohol and substance use amongst people using mental health services. There is a need to ensure that staff working in a variety of settings have the capabilities to work comprehensively with this group. To address this need, and inform development of roles and training curricula, the Department of Health National Dual Diagnosis Programme commissioned a specific capability framework for "dual diagnosis". The result was "Closing the Gap" (Hughes, 2006). This was published in 2006, and has been used in Leeds to inform the Dual Diagnosis Strategy. However, it was agreed that this framework needed refreshing in light of the changed health landscape since the mid- 2000s and the role of the third sector in delivering services alongside the statutory ones. Therefore Leeds Commissioning Group commissioned Professor Liz Hughes to undertake some work to revise the original capability framework.

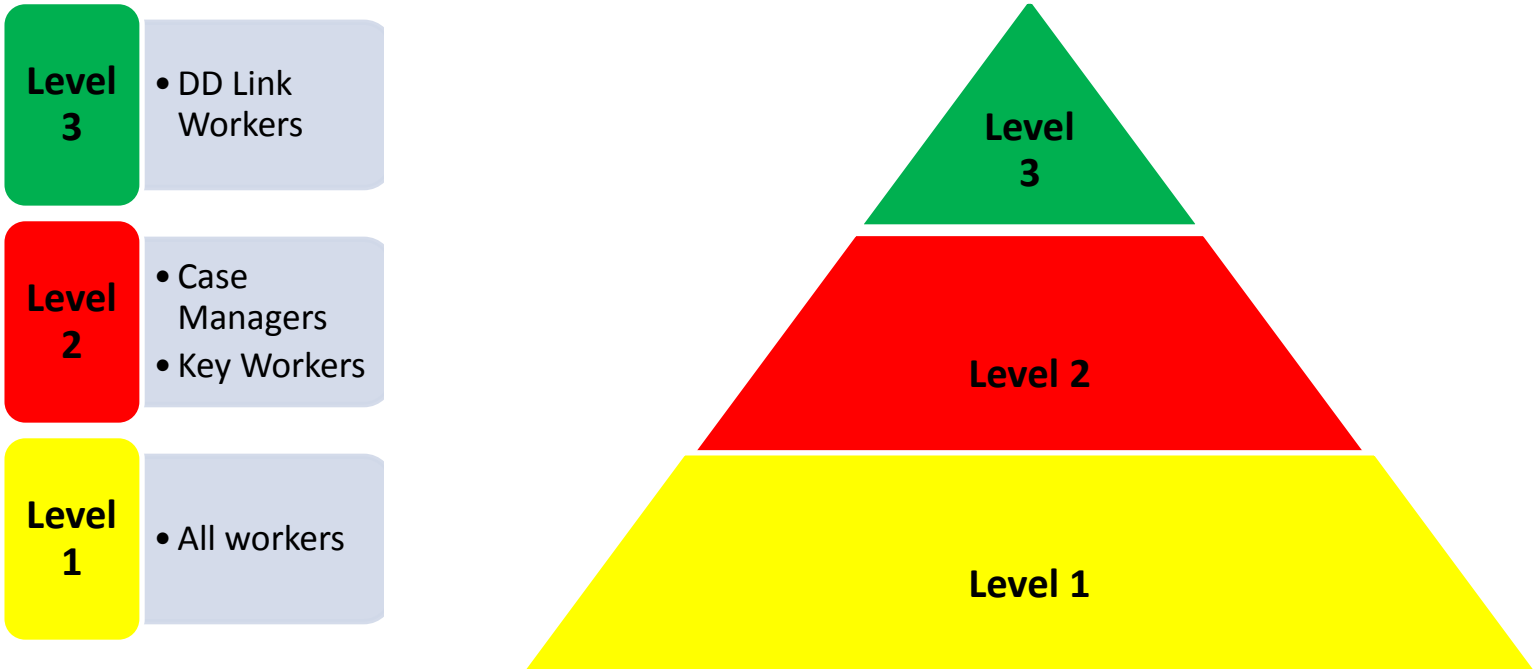
The aim of a capability framework is to define the knowledge, values and skills that people should possess when working with a specific client group. This is particularly important when working with someone who has multiple needs, who may need help and support from a variety of services, and therefore consistency across services is really important.

The Leeds COMHSU Capability Framework has been developed through consultation with a range of stakeholders including front line clinicians and (importantly) people with lived experience of co-occurring mental health and substance use (also known as "dual diagnosis"). The first stage was a stakeholder event to review the existing framework, consider the content and its relevance to the way that services were delivered in Leeds, and to make suggestions for adaptation. The second stage involved taking this feedback to a meeting with two external experts in Dual diagnosis (Justine Trippier and Cheryl Kipping). In addition, there was a session at the ZIP group meeting to discuss capabilities from the perspective of those who used services. All this input was collated into a new framework. This has been represented at a further stakeholder event and at the ZIP group for approval and any further feedback. This version represents the end result of this comprehensive consultation and listening exercise.

Dual Diagnosis Capability Levels

The capability framework is divided into three levels- each level to be described for each capability. There is a change from the original 'Closing the Gap' framework to recognise the growth in the role of the link worker (which wasn't in existence in 2006). Therefore level 1 remains as before; the basic capabilities that all staff should possess if they have direct contact with people with co-occurring mental health and substance use. Level 2 now refers to more specific capabilities that case managers, care coordinators and key workers would need. Level 3 is aimed at capabilities required to implement the link worker role taking into account the requirement to attend the network, and disseminate information to colleagues within their local service setting.

In addition to these levels, there will be the people who have a strategic role in Leeds related to the development of the dual diagnosis strategy. It was felt that as this is a small, professionally diverse, and specific set of people that defining their capabilities would be difficult. This role was originally "level 3" in the 2006 "Closing the Gap" framework.



Definitions and descriptions of levels

Level 1: Capabilities for all the capabilities that all workers (whatever their role and location) should be able to demonstrate. This focuses on identifying and accepting role responsibilities, basic drug and alcohol awareness and basic knowledge of why drugs and alcohol effect mental health. This also includes people who offer supportive roles to people with dual diagnosis but who may not be their main key worker (e.g. peer support, housing support, health care assistants, associate practitioners, staff in general medical settings such as primary care, emergency department, ambulance staff, police)

Training requirements: basic awareness level training, bespoke e-learning for support staff; National Department of Health E-learning

Level 2: Case Workers/Key workers

In addition to level 1, this is the capability aimed at workers specifically in mental health, social care, substance use and housing services that provide case management, key working, mental health support and treatment, substance use support and treatment. This defines the approach that they should be able to provide to people who present to them either as a referral or as a part of case load. This level is also appropriate to all services that come into contact with DD and have a role in delivering support i.e. housing, homelessness, criminal justice – not just mental health + substance use services. Note that depending on the role, the worker and their line manager should decide which of the level 2 capabilities are relevant to their role (it is not implied that every person at level 2 should have ALL level 2 capabilities).

Training requirements Access to a skills- based course which develops the practitioner further in identification, screening, assessment and basic treatment interventions

Level 3: Lead workers/Link workers

In addition to 1 AND 2, this level defines the advanced skills knowledge and attitudes that a person in a **named "dual diagnosis" role (such as a link worker)** should possess in order to perform effectively in this role. This level is specifically written for those who have a special interest in dual diagnosis, those who are link workers, senior clinicians. In such roles there is an expectation that as well as providing an advanced level care for people with DD, that they will also have some responsibility for supporting colleagues in the team in terms of sharing resources, clinical advice, role modelling, teaching sessions etc.

Training requirements: further consolidation of clinical skills learned in level 2 and introduction to advance practice skills, as well as mentoring, coaching, role modelling and supporting colleagues in developing their capabilities in dual diagnosis. Active involvement in the local dual diagnosis network.

Strategic leadership

Levels 1+2+3 plus capability to operate strategically across all services in defined geographical area

This is the senior person with strategic leadership for DD – This would include the named person who has been designated to lead the development and implementation of dual diagnosis strategy at a senior level. These roles typically commissioned to work across services in a geographical area. Examples would be nurse consultants, City or location wide leads. This role requires significant leadership skills and the ability and remit to operate with senior managers and commissioners. This would include members of the DD strategy group representatives from relevant stakeholder services

Training requirements: This level has no expected base line educational course and instead relies on the practitioners demonstrating capabilities purely by other means. Practitioners at this level might want to consider Masters or Doctoral level training with practical application in the field of drugs, alcohol and mental health

The Leeds Dual Diagnosis Capability Framework

Values/spirit of approach

People who have experienced dual diagnosis feel very strongly that there is a requirement of all the services to offer care and treatment within a philosophy of partnership, acceptance, compassion and evocation (Miller and Rollnick, 2012). This next section describes the values base on which the capability framework should be delivered by ALL services.

All services as well as individual workers need to consider and reflect on their values and attitudes to people with dual diagnosis and consider an action plan to ensure that the service reflects these values in the way they respond to people with dual diagnosis.

What users of service want: "a zero tolerance to bad attitudes"

1. See the person not just the diagnosis (acceptance)
2. Therapeutic optimism: "hope not heart sink". Believe **WE CAN DO IT**. Believe recovery is possible: **EVOCATION - believe that the person has the ability and answers within, and our job is to evoke this**
3. Role legitimacy: its everyone's business, its part of my role to do something, I will embrace working with people with co-existing mental health and substance misuse **(acceptance)**
4. Transparency and honesty…genuineness **(partnership)**
5. A workforce that is willing to "go the extra mile"

Knowledge

Like values, knowledge is not a "capability" in itself, but like values it is a requirement that workers have the requisite knowledge to support their ability to deliver effective care. In addition, knowledge and understanding of dual diagnosis will support more positive values towards this group, as well as increasing confidence to work with multiple needs. It is essential that all workers have the requisite knowledge to enable them to work confidently at the

level appropriate to their role. Each capability will require a set of knowledge e.g. multi-agency working requires knowledge of the Leeds dual diagnosis care pathway and referral processes.

However, all workers should be able to demonstrate knowledge on signs and symptoms of mental illness across a range of diagnoses; signs and symptoms of substance use; the interactions between mental illness and substance use, and an understanding of the causes (aetiology) of "dual diagnosis".

Therefore training will need to consider meeting the needs of workers whose predominant knowledge base relates only to mental health or substance use, and be able to address these gaps. It may be that mental health and substance use workers require some elements of separate training to incorporate this and avoid repetition.

Risk

It is well recognised that people with multiple needs of substance use and mental health are more at risk of exploitation, physical violence, sexual assault and of self-neglect. This is in addition to the increased risks to self and/or others. Risk is woven throughout all the capabilities to avoid seeing it as an isolated aspect of a persons care. All the capabilities address good practice in managing risk including:

- Effective engagement in services (Cap 1)
- Working well with other professionals and agencies (cap 2)
- Accurate and collaborative assessment of a persons needs (Cap 3)
- Safe management of clinical issues related to substance use and mental health (Cap 4)
- Care planning (includes risk management) (Cap 5)
- Access to timely interventions. (cap 6)

The Capabilities Framework Content

The capabilities framework attempts to replicate the care pathway through services from initial engagement, assessment, planning of care, clinical and psychosocial interventions (including social support) as well as effective multi-agency and multi-professional working relationships. Each of these should be delivered within the values-base identified previously.

Capability 1 - Effective engagement

"Nothing about me, without me"

Level 1	Level 2	Level 3	Evidence
• Be able to form a safe, trusting relationship. • Be friendly, helpful, welcoming and interested. • To spare the time to listen.	• + use therapeutic skills to form a safe trusting collaborative relationship	• + offer a range of creative strategies to engage people with the service you provide; taking into account the lack of trust and previous difficult experiences people may have had • Be able to offer support and advice to promote therapeutic engagement strategies in your colleagues	• Retention of people in services • Rates of DNAs • Service user's testimonials

Capability 2 - Working effectively with other services and organisations

"NO CLOSED DOOR"

Level 1	Level 2	Level 3	Evidence
• Be aware of a range of service providers and be able to offer simple advice and signposting	• + understand the local DD care pathway and joint working protocols developed organisationally and by the Leeds DD Project. • Know the referral process and remit of services within your area. • Undertake effective and coordinated joint working with other agencies and professionals.	• + support colleagues in their joint working. • Ensure that your colleagues have access to local service referrals and pathways. • Offer advice on referrals • Regular liaison with other link workers	• % rejected or accepted referrals • Successful transfer of clients between services • Testimonies • Use of Leeds DD Project website (pathways guide) + promotion to team

Capability 3 - Understanding the nature of the problem (screening/ formulation/assessment)

Level 1	Level 2	Level 3	Evidence
• Be able to ask questions that help identify areas of need	• + being able to use screening tools and comprehensive assessment to identify nature of the current problems (as well as strengths)	• + being able to provide specialist assessment that integrates substance use, mental health and other issues e.g. housing, risk	• Examples from practice • Evidence of knowledge of appropriate screening tools and assessment proformas

Capability 4 - Clinical management (medication, physical health, detox)

Level 1	Level 2	Level 3	Evidence
• Be aware of the physical risks associated with alcohol/drug withdrawal. • Ensure that people get access to emergency medical and/or psychiatric treatment.	• Be able to demonstrate safe and effective skills in medicines management, psychiatric crises, supporting detoxification, and promoting general physical health and safety	• Be able to advise on the safe management of clinical problems (within remit of own job) but be aware of the need for an integrated approach to the clinical management of mental health and substance use.	• Examples from practice • Testimonies • Patient safety information

Capability 5 - Care planning / coordinating care

Level 1	Level 2	Level 3	Evidence
• Being aware of the nature of the care plan in place and your role within this (if relevant)	• Be able to work in partnership with the person (and carers if relevant) to formulate a care plan using SMART goals. • Goals should integrate all aspects of a persons life that they wish to be included (integrating substance use and mental health and recovery goals) • To regularly review plan • Be appropriately flexible	• Be able to support your colleagues to develop care plans in collaboration with service users and their carers. • Promote an integrated, recovery approach to care plans	• Examples of care plans • Being able to articulate role

Capability 6 - Using evidence-based psychosocial interventions

Level 1	Level 2	Level 3	Evidence
• Active listening skills, sign-posting to services that offer specific interventions.	• Be able to demonstrate core skills of active listening, empathy and unconditional positive regard • Be able to use brief interventions focusing on health behaviour change. This should be appropriate to motivation stage and include harm minimisation. • Evaluate and review care in agreement with service user	• + be able to deliver 1:1 interventions that use behaviour change strategies in accordance with the level of motivation and mental state of the person. • Other therapies related to skill base and qualifications (CBT, family work, group work, harm reduction, motivational interviewing)	• Care plans • Records of meetings

Capability 7 - Commitment to development of DD capabilities

Level 1	Level 2	Level 3	Evidence
• Commitment to training and supervision regarding DD	• Ensure that all learning opportunities are maximised including attendance at Leeds DD Network Practice Development sessions, 6 monthly Network Events, other relevant networks, supervision, further training, reading policy and evidence	• Ensure that your team are aware of developments in DD (locally in Leeds + nationally), changing patterns of substance use e.g. NPS/legal highs, make resources available, deliver in house training as appropriate to role, active membership of Leeds DD Network	•Training and presentations attended (or delivered) • Portfolio of DD information

Implementation Statement/Action Plan

A capability Framework serves as a template to inform individuals of the expectations in working with people with COMHSU.

The next stage requires a Leeds wide implementation plan.

This should include:

- The development of a personal self-assessment tool of the capabilities
- A baseline assessment of service level capabilities benchmarked against the capability framework
- A review of training provision and alignment of learning outcomes to the capability framework
- Identification of other local learning and development opportunities to access to develop specific capabilities (examples could include- job swops; shadowing someone from another service; attendance at the DD network; how to ensure that the network content is aligned to the needs of the local workforce)
- Biannual review of capability development across the city key mental health and substance use services.