# *Developing good practice in assisting those who are homeless or vulnerably housed and have Dual Diagnosis Issues*

# *Evaluation report of the Kerrigan Project - a joint venture between Bridgend County Borough Council, Gwalia and other key stakeholders*

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## Executive summary

*There is a plethora of literature and policy guidance advocating for mental health, substance misuse, and offender management whilst recognising the inequalities that exist within to complex health and social care systems including access to quality housing and integrated care networks. This guidance is often developed on a basis of joint needs across various statutory and non-statutory health and social care organisations nationally throughout England and Wales but rarely fosters joint ownership at the point of delivery.*

*Many attempts have been made to co-ordinate and incentivise agencies to work across professional boundaries such as through Payment by Results (England) and recovery pilots, aimed at encouraging integrated care and subsequent improvement in outcomes for the more complex, vulnerable and chaotic members of society. These are often the people who pose the greatest challenges, and indeed financial burdens on independent agencies.*

*Despite this however, data and research suggests that there are still a vast number of service users who continue to slip through the system due to unmet needs. This is resulting in unnecessary pressures on health and social care services through duplication of assessments, a lack of joint ownership, and subsequent 'revolving door' type scenarios through hospitals and prisons alike.*

*The Kerrigan Project Pilot (Bridgend) commissioned in 2013 by Bridgend County Borough Council Supporting People looks at conceptualising the guidance, and by utilising a multi-agency model of local identification and early intervention, has developed a collaborative wrap-around model integrating the services of health, social and probation to meet the needs of those service users who present as vulnerable and chaotic.*

*To date the project has already been able to produce some key meaningful outcomes for service users suggested through early intervention and engagement, whereby contributing to the overall projected outcomes and demonstrated in the report through a case study approach. It is acknowledged however through an evaluative exercise that Kerrigan is a 'positive work in progress', with clear recommendations in this report for supported continuation of the original proposals.*

# 1. Background to the project

Feedback from a Cymorth/Public Health Wales learning exchange event held in February 2012 highlighted that provision for homeless or vulnerably housed service users who also exhibited dual diagnosis (mental health and substance/alcohol misuse) was patchy and in some areas non-existent, meaning that often these service users "fell through the gaps" of service provision.

Next steps aimed to identify:

- Examples of good practice in Wales and further afield and disseminate this in a 'learning exchange' exercise
- The development of pilot studies across 4 diverse Local Authorities in conjunction with Local Health Boards and other service providers, supported by consultant input, in order to develop Welsh good practice examples.

It was planned that the pilots would be showcased to all Local Authorities at a further event at the end of the 12 month study period to share the emergence of good practice. The overall aim was to develop a series of models which could be adapted and utilised by a variety of Local Authority areas across Wales in order to improve the provision for homeless service users with dual diagnosis needs. The project was intended to support key outcomes identified within the Welsh Government strategy *Together for Mental Health - A Strategy for Mental Health and Wellbeing in Wales* in the following ways:

- To reduce inequalities for vulnerable groups with mental health needs, ensuring equitable access and provision of mental health services.
- To ensure that public services work together to provide an integrated approach.
- To ensure substance misuse co-occurring with mental health problems is managed effectively.
- To reduce homelessness and help people with mental health problems sustain tenancies.

A tender exercise in March – April 2013 invited key agencies to 'bid' for an opportunity to host a pilot project. The tender did not offer participants any direct funding of the pilots, moreover the opportunity to share local developments with other regions. In addition JMB Health Consultancy Ltd was commissioned to provide a facilitative and evaluative role to the pilots and is the producer of this report.

# 2. Introduction to the Bridgend pilot

One of the four successful pilots was that of Bridgend County Borough Council following internals extensive assessment of the needs of clients who had previously engaged with housing, health, prison and probation services. The project was developed as a collaborative commitment by Housing departments, Supporting People, Children and Young Persons' Services, Adult Care Services, Mental Health Services and Community Safety (see appendix one)

The project tender commissioned by Bridgend County Borough Council's Supporting People Planning, recruited Gwalia as the successful provider of the specification named 'The Kerrigan Project'. A detailed service specification was developed (see appendix two) upon which it was agreed that the scheme would be based at a single location and provide 6 units of high level supported accommodation plus one emergency access bed. It was envisaged that duration of stay would be around 3 months for the 6 bed-spaces and 3 days for the emergency bed. The target client group was proposed as males or females over 18 years old with primary needs associated with dual diagnosis (substance misuse and mental health) housing and offending behaviours.

The key aims of the project where to:

- Provide high level support with a focus on assessment by all the relevant services in order that appropriate move on could be arranged to the best supported accommodation.

- In addition to the single accommodation model were proposals that 'floating support' would be attached to any move on arrangements to ensure continuity of services.

- To provide in-reach services *prior to admission* working with prisons, hospitals and the like in order to build relationships with clients. This would be undertaken by support staff recruited by Gwalia specifically for the Kerrigan project prior to admission wherever possible (NB, naturally this would not apply to the crisis bed)

Overall outcomes of the Kerrigan project were anticipated as improvement in physical health; reduced use of alcohol and illicit drugs, thereby leading to:

- Reduced hospital admissions
- Improvement in mental and emotional health
- Reduction on incidence of offending and/or police interventions
- Access to sustainable housing with [in the longer term] supported then independent living
- Improvement in social and life skills
- Access to education, employment and training opportunities

# 3. Aims of the report

The aim of this report is to provide a progress update in relation to the joint work undertaken by Bridgend County Borough Council (BCBC) in conjunction with Gwalia thus far through:

- Describing the project group, involvement and implementation
- Discussion and evaluation of progress to date
- Recommendations for future working

The report is produced on the basis of a variety of methodology including:

- Demographics of the project
- Consideration for local and national policy drivers
- A literature review and description of processes and good practices elsewhere in relation recovery, dual diagnosis, housing and offending behaviours
- Key stakeholder recognition including roles, responsibilities and individual expectations/outcomes of the project
- Progress to date
- Stakeholder analysis
- A future action plan

# 4. The demographics of Bridgend

Bridgend is located in the heart of South Wales, with borders to Neath Port Talbot, Rhondda Cynon Taf and the Vale of Glamorgan. Bridgend County covers a total land area of 28,500 hectares (www.bridgend.gov.uk). Forming part of the Cardiff and South-Wales-Valleys metropolitan area (European Union, 2010), Bridgend is one of the largest towns along with Maesteg. It is closely socially and economically integrated with the Welsh capital through commuting. The seaside resort of Porthcawl is also part of the County, which is a popular tourist destination. With its Bristol Channel coastline and mix of urban and rural communities, its land area stretches 20km from East to West and occupies the Llynfi, Garw and Ogmore Valleys.

The Welsh Index of Multiple Deprivation (WIMD) developed to identify relative area based concentrations of deprivation, ranks each Lower Super Output Area (LSOA) in Wales using a complex scoring methodology with nine of Bridgend County's local areas (11%) being in the top 10% most deprived LSOAs in Wales in 2011. This is greater than that of both Wrexham (6%) and the Vale of Glamorgan (6 %), but fewer than Neath Port Talbot (15%).

'Communities First' was the Welsh Government's flagship programme to improve the living conditions and prospects for people in the most disadvantaged communities across Wales. In 2002 four wards in the Bridgend County (Caerau, Bettws, Blackmill and Llangeinor) were granted 'Communities First' status (Welsh Government). They were identified by their rank among the 100 most deprived wards in Wales, as measured by WIMD (2000). WIMD 2005 highlighted smaller 'pockets' of deprivation in LSOAs with Brackla 3 (Brackla Meadows), Morfa 2 (Wildmill), Cornelly 4 (Marlas) and Sarn 1 LSOAs entering the programme in 2007.

On the 30 June 2010, Bridgend County had a recorded population of 134,564 which represents 4.5% of the total population of Wales. The population density is 5.4 residents per hectare, making it the eighth most densely populated county in Wales (ONS, 2010). The projected population over the next 20 years is expected to rise steadily to a total of 151,619 residents by the year 2032 which is a 10.5% increase.

The existing population consists of 49.1% males and 50.9% females and has shown very little proportional change over the last three years. The percentage of residents aged 0-15 years has declined slowly while the proportion of those aged 65 years and over has increased slightly. There has been little change in the proportion of working aged people, with overall data shown over at chart 1.

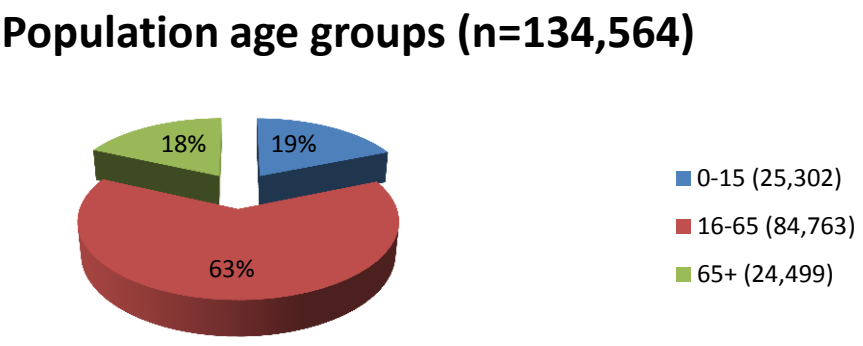



*Chart 1: Number of people by age group, 2010*
Source: Mid-year population estimates, ONS

### 4.1 The Health of Bridgend

Life expectancy is consistently slightly lower for both males and females in Bridgend County, however a slightly higher life expectancy than Neath Port Talbot, for both genders, with Wrexham and the Vale of Glamorgan having higher life expectancies than Bridgend County.

Limiting Long Term Illnesses (LLTIs) which are defined as '*conditions that can be managed but in most cases cannot be cured'* include conditions such as diabetes, heart disease, asthma, arthritis, epilepsy and stroke. Over a quarter (29%) of Bridgend County's residents surveyed in 2009/10 reported having a LLTI. This is slightly higher than Wales as a whole (27%) and higher than in Wrexham and the Vale of Glamorgan, but lower than in Neath Port Talbot.

### 4.2 Substance Misuse

In 2010, a health needs assessment (www.bridgend.gov.uk) published that 48% of people in Bridgend County drink alcohol at a level above published guidelines with 30% reporting that they 'binge' drink, however it should be noted that this has decreased from previous years.

Alcohol related deaths have increased steadily since 2002-04 in Bridgend County and in 2008-10 were at 19.3 per 100,000 which is notably higher than comparator authorities and indeed compared to 14.96 for the whole of Wales. In recognition of this, key areas of concern are suggested as both the level of consumption and the rate of alcohol related deaths which have risen significantly in the period 2002-04 to 2008-10. Bridgend County has moved from a position of being below the overall Wales rate to being significantly above.

The rate of recorded incidences of drug misuse in Bridgend County for 2010-11 was 245 per 100,000 population (approximate total 329 i.e. 0.25%). This figure is slightly lower than that of the whole of Wales which is at 278 per 100,000.

### 4.3 Mental health and well-being

Statistics from the overall joint health needs strategy (www.bridgend.gov.uk) highlighted that 13% of people in Bridgend County were being treated for a mental illness compared to 10% across Wales. At 31 March 2011, there were 388 adult clients with mental health issues receiving services from Bridgend County Borough Council, 154 of these had dementia. The vast majority of these clients were being supported in the community with 201 clients aged 18-64 receiving services, which equates to 18% of all clients aged 18-64 receiving services, however it is not clear what these services are.

### 4.4 Homelessness

The Welsh Government has described homelessness as one of the most extreme forms of social exclusion. Homelessness is however not just about those who are sleeping on the street; an individual or family may be regarded as homeless if he/she/they are staying with friends, staying in a hostel or living in overcrowded or unsuitable accommodation (Welsh Government, 2011), often referred to as 'sofa surfers'. With a local focus on reducing numbers through active homelessness prevention, the number of families determined as homeless and in priority need in Bridgend County has fallen over recent years from 2008-09 and 2010-11 as per chart 2 below.

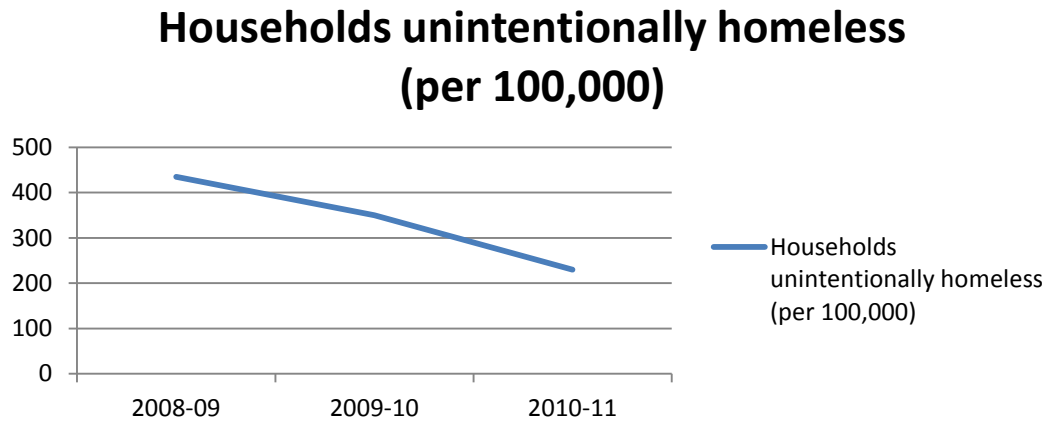



*Chart 2: The number of household's eligible, unintentionally homeless and in priority need by year in Bridgend County*

### 4.5 Future implications of health and social care.

The Welsh Government's Social Services Framework for Action identifies numerous challenges that face contemporary social care services and considers the impact of issues such as alcohol and drug misuse within the context of economic pressures as a result of the financial climate.

# 5. A review of policy, guidance and practice locally and elsewhere

## 5.1 Local priorities

Although the use of literature reviews and shared good practices in any evaluation provide a useful reference, service development needs to be considered within the context of local and national drivers and policy implementations. It is therefore advised that the following sections describe projects and driver elsewhere, and should therefore be read in conjunction with the following key documents:

- ✓ BCBC Adult Social Care Commissioning Plan 2010-2020 "Living Independently in Bridgend in the 21st Century"
- ✓ BCBC Adult Social Care Learning Disability Strategy and Commissioning Plan 2013-2016
- ✓ BCBC Community Safety Partnership 2012-14 Domestic Abuse Strategic Action Plan
- ✓ BCBC Health, Social Care and well-being strategy
- ✓ BCBC Bridgend County Community Safety Partnership Crime & Disorder Strategy and Action Plan 2011 – 2014
- ✓ County Borough of Bridgend Supporting People Local Commissioning Plan 2014-17
- ✓ Proposed Mental Health (Wales) Measure (2010)
- ✓ Supporting People Wales Outcomes Framework Guidance 2012
- ✓ Welsh Government (2012) '*Together for Mental health A strategy for Mental Health and Wellbeing in Wales (2012-2016).*
- ✓ The Strategy for Older People in Wales 2013-2023
- ✓ Wales probation *Protecting the Public and Reducing Re-offending in Wales: Strategic Plan 2013-2016*.
- ✓ Working Together to Reduce Harm: The Substance Misuse Strategy for Wales 2008-2018

## 5.2 Policy, guidance and incentives elsewhere – a literature review

### 5.2.1 – The dual diagnosis challenge

Supporting someone with combined mental health and alcohol and/or drug problems (dual diagnosis) remains one of the biggest challenges facing frontline health and social care services (DoH, 2002). The complexity of issues involved often makes diagnosis, care and treatment difficult, with service users being at higher risk of relapse, readmission to hospital and serious harm, even suicide.

Dual diagnosis affects at least a third of service users admitted to mental health units; over half of substance misuse service users and around seventy per cent of people in prison (Mental Health Network Briefing, 2009). Service users with a dual diagnosis typically use NHS and other health, social and statutory services more and subsequently cost more as a result. This co-morbidity is associated with a number of adverse consequences, including poorer quality of care for the physical health conditions, reduced adherence to treatment, increased costs and poorer health outcomes (NHS Confederation, 2011). The economic and financial impact of co-morbidity can therefore be very significant, with research demonstrating that service users with a dual diagnosis typically use NHS services more and cost more

One study of services in South London found a greater proportion of patients with dual diagnosis used the support of community psychiatric nurses, inpatient care and emergency clinics, with analysis that dual diagnosis patients had significantly higher 'core' psychiatric service costs (a difference of £1,362) and non-accommodation service costs (£1,360) than patients without a dual diagnosis. That is before we start to calculate the economic impact on other agencies, and the untold social and psychological costs to service users and their families.

### 5.2.2 Relevant trends across England

Alcohol misuse is often co-existent with common mental disorders, such as anxiety or depression, as well as with misuse of other substances. High levels of hazardous and dependent drinking have been recorded in people under treatment for serious mental health problems.

Alcohol dependence is more common amongst particularly vulnerable groups, such as homeless people and the prison population. In the general population 9.3 per cent of men and 3.6 per cent of women are classified as being dependent on alcohol. 3.4 per cent of adults showed signs of dependence on drugs in the past year, including 2.5 per cent who were dependent on cannabis and 0.9 per cent who were dependent on other drugs (Mental health Network, 2009).

Rates of dependence vary with age and gender. Currently of men aged between 16 and 24, 13.3 per cent showed signs of dependency on drugs (MHN, 2011). Compared with 15 years ago, rates of drug dependency have almost doubled (from 2.2 per cent of the population in 1993 to 4.1 per cent in 2007). There has been a big rise in the number of young people dependent on cannabis, from 7.7 per cent in 2000 to 10.4 per cent in 2007.

When combining the knowledge of long-term trends on drug and alcohol misuse with what is known about increasing prevalence of common mental disorders, such as anxiety and depression, it could be inferred that the numbers of people likely to have a dual diagnosis is also likely to have increased. The proportion of the English population meeting the criteria for one common mental disorder increased from 15.5 per cent in 1993, to 17.6 per cent in 2007 (MHF, 2009) .

### 5.2.3 Dual Diagnosis is prisons

Research suggests that in excess of 70% of the prison population has two or more mental health disorders (Social Exclusion Unit, 2004), quoting Psychiatric Morbidity. In addition, male prisoners are 14 times more likely to have two or more disorders than men in general, and female prisoners are 35 times more likely than women in general (Social Exclusion Unit, 2004). The suicide rate in prisons is almost 15 times higher than in the general population: in 2002 the rate was 143 per 100,000 compared to 9 per 100,000 in the general population. (DoH, 2004) (

Good practice for dual diagnosis patients is therefore particularly crucial in the prison setting, with a definitive gap in services to help people involved with the criminal justice system who have mental health problems and learning disabilities. This was a key focus of the Prison reform document *Too Little Too Late* (Edgar & Rickford 2009) which made recommendations for the organisation of effective liaison and diversion arrangements along with the services needed to support them. In addition the report called for the urgent development of improved services for prisoners who have a dual diagnosis, for all courts to have access to liaison and diversion services, and a Government investigation into how defendants with a dual diagnosis are currently served by all courts. The review also called for better links between prisons and community mental health providers to better support people leaving prison with mental health and dual diagnosis problems.

### 5.2.4 The challenge for services (England)

The management and treatment of people with this condition and services provided for their carer's and families therefore remains an area of concern and one of high priority across mental health policy and good practice – both nationally and locally (DoH, 2010). In 2010 the National Drugs Strategy (DoH, 2010) placed recovery at the heart of it and placed more responsibility on individuals to seek help to overcome dependency with a renewed emphasis on holistic approaches to addressing issues associated with addiction such as housing, employment and offending. Power and accountability was placed in the hands of local communities to reduce drug related harm.

The Government's mental health strategy in England 'No *Health without Mental Health*' (DoH, 2011) was launched and outlined a framework stating '*good mental health and resilience are fundamental to our physical health, relationships and achieving our full potential*'. One in four people in the UK will experience some form

of mental health problem in their life time, thus making it the business of everyone working in health and social care.

The National Alcohol Strategy (DoH, 2012) reinforced the ambition to support full recovery by educating individuals to make informed choices about treatment, and encouragement for drinking alcohol in a more responsible way. The aim was also to increase effective treatment for dependent drinkers in order to reduce alcohol related hospital admissions, many of whom experience co-morbid mental health problems.

The National Dual Diagnosis Good Practice Guidance (DoH, 2002) highlighted the need for mental health and drug and alcohol workforces to be better equipped to work effectively with individuals who have dual diagnosis. The development of a training strategy with opportunities to share skills across these groups was aimed at improving confidence and competence when working with this complex condition, which is considered paramount in delivering appropriate services and levels of intervention for this group (Hughes, 2006).

People with a dual diagnosis are often perceived as 'hard to engage', 'chaotic' and 'difficult' by the nature of their complex needs however some services still feel that it is not part of their role to work with substance use as well as mental health, and perceive it to fall under another services remit. This can and does lead to people falling through the 'gaps' in services, which was best described by a service user:

*"I was pushed around like a tennis ball. The alcohol people said I had a mental health problem, and the mental health people said I had an alcohol problem. None of them helped me."*
*(Pillar to Post video produced by Mind in Croydon)*

The nature of the relationship between mental health conditions and substance misuse or alcohol problems is complex, though possible mechanisms include:

- a primary psychiatric illness precipitating or leading to substance misuse
- substance misuse worsening or altering the course of a psychiatric illness
- intoxication and/or substance dependence leading to psychological symptoms
- substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses

Historically, the provision of mental health and drug and alcohol services has evolved separately. This presents providers and commissioners with some challenges when it comes to providing appropriate and effective services for this group of people. While there are some good examples of innovative and joined-up services in this area, good practice needs to be spread more widely across the NHS and social care, perhaps mandatorily.

One of the main challenges to providing quality care with effective outcomes for individuals and their families is to avoid fragmentation across the service system. This is often apparent due to a lack of 'ownership' and motivation from services to work with people with dual diagnosis. This needs to be overcome by promoting integration across all the agencies involved in an individual's care. The Dual Diagnosis Good Practice Guidance actually provides frameworks to strengthen services by ensuring the workforce are confident and competent to work with this complex client group.

In 2007, the first national assessment report was produced, which collated information and data from across England (Care Services Improvement Partnership, 2007). Key areas of good practice and action were recommended under the following areas:

- Definitions and integration of services
- Resourcing and planning
- User satisfaction and user outcomes
- Public awareness
- Skills and capabilities of staff
- Workforce development and training
- Effective joint working and commissioning
- Meaningful service user and carer involvement
- Awareness and understanding across all services including primary care, prisons etc.

The Department of Health National Dual Diagnosis Program in England ended in 2010. Since then there has been no additional national policy guidance within the UK around dual diagnosis. However, the original policy guidance is still relevant within the current climate nationally, and the intention to mainstream dual diagnosis across mental health and drug and alcohol services should therefore remain the ultimate aim for local services seeking to achieve productive and cost effective outcomes, in addition to the best possible care for individuals with this complex condition, alongside their carers and families (DoH, 2002).

Whilst this is particularly helpful in describing how to address the issue of fragmentation, it needs to be coupled with incentivised and locally developed approaches that can turn guidance into good practice on the ground.

### 5.3 Payment by Results

Payment by Results (PbR) is described as a transparent rules-based payment system in the NHS in England. Through this approach commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient's healthcare needs. In effect, PbR aims to promote efficiency, support patient choice and increasingly incentivise best practice models of care (DoH, 2006).

There are five key principles for any PbR scheme which are:

- To define a clear purpose
- Highlight full understanding of risk
- To develop a well-designed payment and reward structure
- Ensure sound financing of the whole scheme
- Effective and robust measurement and evaluation tools

The initial proposals within PbR highlight some significant challenges for commissioners, providers, and patients and there are inevitable difficulties involved in setting payments for outcomes with a complex group of patients such as those with dual diagnosis. However, well-designed local PbR schemes have the following potential incentives for providers and commissioners (see table 1 below):

| **Benefits for providers** | **Benefits for Commissioners** | **Longer term benefits** |
|---|---|---|
| -A Range of outcomes<br>-New ideas<br>-Greater freedom<br>-Fairer distribution of risk | -Savings<br>-Deferred costs<br>-New resources<br>-Improved outcomes<br>-Transferred risks<br>-Clearer accountability | -Convergence of care provision to guidance and best practice<br><br>-Framework for outcomes and quality measures<br><br>-Workforce modelling and planning<br><br>-Currencies from which to develop national PbR tariffs and benchmarks |

*Table 1 – Potential stakeholder benefits of PbR*

Developments of PbR outcome frameworks are already underway across England through various pilot sites within both mental health (DoH, 2007b) and substance misuse services (DoH, 2011). However, more recently it has been indicated that the processes are driven by two different sets of commissioning arrangements and priorities delivered through a variety of providers, often based upon local agenda's, with variations in outcome tools and measurements.

For service users whose recovery is dependent upon being supported by more than one agency it will be crucial to develop incentives for joint working to deliver meaningful and person-centred outcomes.

### 5.4 Substance Misuse recovery pilots (payment by results)

A review of the Drug Strategy (Home Office, 2011) changed the incentives for treatment providers through the development of a new and innovative pilot *Payment by Results for drug and alcohol services* (PbR) to be implemented within eight geographical pilot areas within England.

This approach aimed to build upon past successes, taking recovery from dependence, beyond the treatment system and statutory services (Health organisations, Local Authorities, Police and probation) to include employers, social housing landlords, educational establishments, 3rd sector social services and others who could impact on the success of recovery through:

- Challenging the stigma that can be associated with dependence and that can often act as a barrier to successful recovery;
- Supporting commissioners to grasp the opportunity of joined up recovery services as the budgets from central government in England were pooled and devolved to local, accountable decision makers;
- Supporting the development of funding models that incentivise the best outcomes for both individuals in treatment and wider society (PbR)

Taking multi-agency working one step further by financially incentivising recovery, the PbR pilots focused on the following high-level outcomes:

- Free from drug(s) of dependence
- Offending (and re-offending) behaviours
- Health and well-being

Although the pilots used the same definition for each of the outcome domains, weighting of payments for each outcome was left to local development; allowing individual areas to reflect their different circumstances and focus on specific outcomes, so for example one of the pilots in Wigan Lancashire, retained an employment marker despite this target being dropped from the original PbR outcomes.

Overall, the PbR proposals represented payment of commissioned activity with a percentage ‘retention’ of the overall value of activity, paid for achieving a set of specific outcomes, based upon five key areas:

1) Abstinence from all presenting substances
2) Successful completion (of a treatment pathway) – free from dependence
3) Resolved Housing Issues
4) Stopped Injecting
5) Improved quality of life

In addition, there was also a reduced reoffending measure, which Wigan and Leigh Substance Misuse Service had to meet. By way of a measure, each outcome included an initial and final measure to enable the system to reflect benefits and successes as they occur to users, services and to society.

### 5.4.1 Pilot outcomes to date

These five outcomes were reviewed to see how the performance of PbR areas compared to the rest of the country. For each outcome the performance over the previous 11 months (April 2012 to February 2013) was measured across all of the pilot areas and compare to the aggregated performance for the rest of the country over the same period. The data was broken down by the five complexity groups with alcohol reported separately to ensure as far as possible that like-for-like clients were compared.

### 5.4.2 Summary of PbR Substance Misuse

The following analysis relates to 9,663 clients engaged in PbR since April 2012 and breaks down to 6,582 primary drug clients and 3,081 alcohol clients and although it is too early to judge the overall performance of the pilot areas, performance thus far has been mixed. The improvement in abstinence from illicit drug use lays the foundation for clients to leave treatment successfully and sustain their recovery. The improvement in housing for some groups was also positive; though it is unfortunate it was not across all the client complexity groups. While quality of life fell from the same period of the previous year, it was still above the level in other areas of England. However, the fall in the successful completion of treatment performance was perhaps not such a positive start to the pilots and it is particularly concerning that this was consistent across all the five complexity groups and included a significant decrease for alcohol clients.

Arguably, one of the most significant problems with the drug and alcohol recovery pilots is the fact that service users' first contact with the treatment system is typically a comprehensive assessment, the purpose of which is to classify via a complexity scale which determines the level of payment that successful outcomes will attract.

Although it is clearly right that payment is much greater for a long term, dependent poly drug user with mental health problems than for an occasional binge drinker, it means that the first contact is not with a helping service but moreover a payment system. The substance misuse field has spent much of the last 10-15 years striving to make access to services quick and easy and removing duplicate assessments which arguable now makes this double process necessitated by PbR as a serious backward step.

There is also the potential similar double assessment process within the new reoffending system wherein probation officers undertake a preliminary risk assessment for the primary purpose of determining whether an offender should be managed by themselves or a new provider (high risk cases stay with the probation service, medium and low risk go to the new providers).

In addition, organisations operating PbR services could potentially be met with suspicion, for example, when declining to accept a referral on the grounds that the individual drug user was not currently interested in recovery, the decision may not actually be seen as a clinical one, but moreover a financial on i.e. refusal to accept on the grounds that it will affect outcomes and ultimately payments.

It therefore seems that PbR has a long way to go in achieving the overall aims, and demonstrating that financial incentiviation for outcomes is one of complexity when pursuing recovery from substance misuse as they overall driver.

### 5.5 Payment by Results – Mental Health

Despite progress of PbR across acute sector health providers within England, currency development in PbR mental health services has proved elusive and as a result of this failure to date, the bulk of mental health services continue to be funded on a historical 'block contract' basis. This approach does not provide incentives for efficiency, effectiveness or quality or for improved outcomes for patients. 2012/13 was intended as the introductory year for what was to be a major change in the way that mental health care was currently funded in England, with a shift from block grants to PbR currencies, to be focused on individual service users and their interactions or pathways within mental health services. It is therefore disappointing to note that despite long-term predictions, nationally PbR mental health has further been delayed by changes in commissioning landscapes, with the major change in contracts being a standardisation across the NHS regardless of specialism.

As a post-implementation and readiness phase of PbR MH, all service users accessing mental health care (post GP or other referral pathway) that had traditionally been labelled working age adults, including Early Intervention in Psychosis (EIP) services from age 14, and older people's services have been allocated to a 'Mental Health Care Cluster', (pathway). This was intended as the contract currency of the future with local prices agreed between commissioners and providers, and not set at a national level (DoH, 2009).

Defining dual diagnosis and subsequent caseloads within the context of PbR clustering offered commissioners and providers the perfect opportunity to develop joint working across services. Potentially this could deliver a more integrated approach to recovery for those service users with complex morbidities such as those clustered as dual diagnosis, however at the date of this report, PbR mental health still remains a 'flavour of the future'.

## 5.6 Recovery programmes in Justice Systems

PbR and recovery programming is not currently defined as a generalised currency within the justice arena, however it seems important to be able to learn lessons from other fields such as drug and alcohol recovery pilots. It is also suggested that justice PbR pilots actually have a potential advantage, partly because reconvictions can be easily and (pretty) reliably measured via the Police National Computer; whilst the definition and measurement of recovery outcomes from both mental health and substance misuse is much more complex and subjective.

The Peterborough Prison resettlement project was however a pilot aimed at addressing this (One Project, 2011) and funded by Britain's first Social Impact Bond. The project funded from across 17 private investors in the UK and USA costs in the region of £5m, which if successful in cutting the re-offending rate of the 3,000 short term prisoners it is designed to help over a six year period, will generate a return on their investment funded by the Ministry of Justice and the Big Lottery Fund. The overall objective is to reduce re-offending rates by 7.5% in order to make a return. Critically, for the ONE project, re-offending is measured by a frequency measure – the combined number of reconviction events.

In a separate work-stream, HMP Doncaster payment by results scheme launched on 12 October 2011 is also designed to reduce re-offending rates, but will be measured on a binary basis, simply whether released prisoners offend or not within the year following their release.

Formal outcomes measures for the ONE project will not be available for a up to four years from launch (2011) to allow for one year post-release, the time for any court cases to take place and data to be collected, therefore the first annual report used within this literature review is more of a profile of the prisoners the project is working with, as opposed to good practice outcomes.

It is established thus far that the project has succeeded in assessing 473 of the 537 prisoners who were released from HMP Peterborough in the 12 months to 9 September 2011. However there were a further 73 prisoners pre-release who have subsequently become ineligible for the scheme because they were transferred to another prison or were sentenced to more than 12 months. It is suggested that the fact that there will be no payment for working with these prisoners under a PbR approach could be an important factor for less generously funded projects.

Thus far, only half of the 537 prisoners have been released to the Peterborough area – immediately presenting the project with a major challenge to ensure that the remaining 48% also receive a co-ordinated resettlement service.

The interim report makes it clear just how challenging it is to provide an effective resettlement service to short term prisoners – and how important the ONE project could potentially be.

Of those who were assessed:

- 93% had an accommodation need
- 82% had an employment, training or education need
- 82% had a finance, banking or debt need
- 68% had a substance misuse problem
- 50% had a health need

What has emerged thus far is that the window to engage with clients in prison – the key to developing an effective aftercare plan – is relatively small with this group of short term prisoners serving an average of seven weeks. Nonetheless, the report succeeds in bringing the scheme to life by presenting views from a number of partners and offenders. Two key points advocate:

- The fact that the project is securely funded for a six year period means it has time to become fully integrated into local provision and for prospective clients to become aware of it and take up opportunities for a recovery pathway.

- The project is not subject to onerous monitoring of all its inputs and processes – it merely focuses on its primary goal of successful resettlement and the reduction of re-offending. This potentially allows clients to make progress at a speed that suits them and to find the form of support, and helping agency, which best meets their needs.

A further report is imminent wherein it will be interesting to follow progress.

### 5.7 Summary of research

In essence, overall it will be interesting to follow the performance of all justice, substance misuse and mental health recovery pilots as they become fully established in order to discover whether the issues discussed are merely teething problems or potential risks to a PbR-funded approach to recovery.

If implemented to its full capacity, PbR could potentially provide the opportunity to incentivise providers to work across services in order to further develop multi-agency working by taking a shared ownership for delivering outcomes for service users with dual diagnosis and offending behaviours.

There is also an opportunity for integrated working and bridging the gap between primary care and secondary care health services. Investing in access pathways to primary care psychological therapy services for people with Dual Diagnosis (substance misuse and anxiety disorders) to include specialist therapies open to referrals from professionals supporting dual diagnosis pathways would allow for mirrored incentives similar to those recommended for secondary care services.

In theory, what is required is a fully inclusive and clear commissioned pathway across all providers providing clarity of roles and responsibilities, incentives and outcome based rewards delivered through payment of a journey for dual diagnosis by specifying:

- The pathway into services
- A pathway out of services
- Evidence of outcomes and person centred goals that consider all health needs in addition to housing, employment, health and well-being delivered by multi-agencies
- A well-documented and communicated plan of care identifying ‘who does what and when’, that is accessible to all agencies providing support
- Relapse prevention and strategies to prevent admissions to hospital
- Agreement for the value of the pathway and cost of incentives

# 6. Organisation and Kerrigan Partnership membership

## 6.1 Organisational Lead

Bridgend County Borough Council (Cyngor Bwrdeistref Sirol Pen-y-bont ar Ogwr) is the governing body for Bridgend County Borough, one of the Principal Areas of Wales. Supporting People (SP) is a central government funding programme which commenced in April 2003. The legal framework is governed by Section 93 Local Government Act 2000 with guidance published by the Welsh Assembly Government (WAG). The SP funding framework is in place to deliver housing related support services to vulnerable people aged 16 years and upwards who live in the community and meet identified needs by offering vulnerable people the opportunity to improve their quality of life.

The programme focuses on the planning, commissioning, and monitoring of non-statutory housing related support services including supported accommodation. Housing related support is delivered through a range of schemes, managed by different providers across all tenures, including local authorities, housing associations, voluntary and charitable organisations. The total budget for the SP programme in the County Borough of Bridgend is £6.15m, with £3.45m of this relating to Supporting People Grant services (BCBC, 2011).

In October 2013, Welsh Government's draft budget announcement indicated that the Supporting People Programme was likely to investment of £134.4m across Wales in 2014/15, which unfortunately represents a 1.5% reduction on 2013/14. The investment has however been cushioned by £5.5m mitigation against planned cuts.

The decision to protect the budget for preventative services, including the Supporting People Programme which offers vital help and support to thousands of vulnerable people across Wales, is an acknowledgement that such services are essentially a "spend-to-save" investment and, in the long term, actually save money by relieving pressure on statutory services such as the NHS, Housing and Social Services.

The 2011/12 operational plan for Bridgend County Borough Council's Supporting People identified the following key and critical priorities:

- High needs for service development for those with dual diagnosis (or co-occurring) substance misuse and mental health issues.
- Scope to commission services across the Abertawe Bro Morgannwg University Health Board area to repatriate out of county placements
- A desperate need for an increase in floating support for those with dual diagnosis to support move on of service users into more independent living in the community.

- Scope to remodel some provision to low level ongoing support due to a potential over provision of supported accommodation.
- There is currently Low provision of support for substance misuse clients
- Identify opportunities to adopt a regional collaborative approach for the provision of a wet-house (supported accommodation for those abusing alcohol)
- Service development for those with dual diagnosis (or co-occurring) substance misuse and mental health issues.
- Scope for developing specialised substance misuse floating support
- A need for services that offer intensive high support for substance misuse and or dual diagnosis
- There is currently no dedicated support for ex-offenders and people with criminal justice issues with a very high ex-prisoner population, potentially as a result of having a prison based locally; therefore service provision should be commissioned specifically for this client group.
- There is a recognised link between mental health, substance misuse and being homeless or potentially homeless.
- There are explicit links with criminal justice, substance misuse, vulnerable young people, people affected by mental health issues

Supporting People BCBC is the key lead in the Kerrigan project proposals.

## 6.2 Core Group Partnership/key stakeholders

***Gwalia Care & Support***

Gwalia are a housing and care services provider across South and Mid Wales, and were the organisation who successfully secured the tender for the Kerrigan Project. Gwalia currently employ around 1500 staff across the business and manage over 10,300 units of accommodation and over 2,700 units of care. In 2013 the total group income exceeded £64m which was an increase of 22% from the previous year.

Gwalia business covers housing and support for all sectors of the community including:

- General rented properties.
- Social rented housing.
- Sheltered accommodation, extra care accommodation, residential care and home care services for people over 55.
- Specialist dementia care.
- Care and support services for a wide range of client groups including young people, families, ex-offenders, people with learning disabilities, people with physical disabilities, people with mental ill health, victims of domestic abuse and people with alcohol or substance misuse issues.
- Student accommodation in Aberystwyth, Bangor, Cardiff and Swansea.
- Commercial properties.
- The support of housing and tenant related charitable causes via the Gwalia Housing Trust.

***Valleys to Coast***

Valleys to Coast (V2C) are a not for profit housing association who invest in communities with a core mission statement *to provide homes in communities where people feel safe and want to live.*

Developed in 2003, V2C was the first housing association in Wales to be formed by the large scale transfer of houses from a Local Authority. V2C now has a portfolio of owning and managing over 6,000 homes across a diverse mixture of valley and town locations within the County of Bridgend including management services to 780 leaseholders.

V2C is funded by a consortium comprising of Nationwide and Principality Building Societies and the European Investment bank with plans to invest £65m in 2014 ti improve the condition of the homes which are owned.

***Youth Offending Service***

Bridgend Youth offending service (YOS) is a multi-agency team made up of representatives from Social Services, Police, Probation, health and voluntary agencies and sits within *Safeguarding and Family Support* of Bridgend County Borough Councils Children's Services.

YOS provide information and support function for children who are in trouble with the police, in addition to support for young people who are victims of crime to encourage participation in restorative justice. Since its' inception in 1999, Bridgend YOS has also engaged in a number of community projects.

It was established within the early stages of the project that due to the project criteria (aged 18) and the likelihood that the services user of the YOS would be unlikely to have a diagnosis of mental illness, that there involvement would be based on an inclusivity and informative basis.

***Probation***

Bridgend probation services operate within a cluster/regional model part of Probation Wales across the Counties of Swansea, Neath Port Talbot and Bridgend. The key focus is to work with and manage offenders and oversee the smooth transition of young offenders into the adult justice system in addition to the transition of offenders in custody back to the community. Working closely with judges and magistrates the probation service ensure that the offenders brought before the court receive appropriate sentences to punish them for the crimes they have committed whilst ensuring they receive rehabilitation packages to deter them from re-offending

At any one point they support 2,900 offenders within the locality through multi agency working with the police, local authorities and voluntary organisations with some staff co-located within other agencies to support success. Rehabilitation packages are also offered to offenders ranging from group-work programmes to address offending behaviour, substance misuse in addition to assistance to gain employment and accommodation. A 'Community Payback' team ensure that those

offenders who are sentenced to punishment and reparation through unpaid work undertake such work in a way that is helpful and meaningful to local communities.

***Community Mental Health Team***

Abertawe Bro Morgannwg Mental Health Directorate is responsible for providing a range of adult and older people's mental health services across the Swansea, Neath Port Talbot, Bridgend, Western Vale of Glamorgan and Ystradgynlais areas.

***Community Drug & Alcohol Team***

Abertawe Bro Morgannwg Substance Misuse Directorate is responsible for providing Services for people with Substance Misuse issues provided from the Community Drug and Alcohol Teams (CDATs), based in Bridgend (which provides a range of substance misuse services for Bridgend and Neath Port Talbot) and Cwmbwrla (Swansea). Services are provided to the Swansea, Neath Port Talbot and Bridgend localities but not to the Western Vale of Glamorgan.

The service provides access to detoxification via 5 inpatient beds at Neath Port Talbot Hospital and a range of other services, these including:-

- Needle Exchange Services
- Home Detoxification Programme
- Substitute prescribing
- Assessment Service
- DGH Substance Misuse Liaison
- Low Threshold Prescribing Service
- Young Person's Substance Misuse Service
- Psychosocial interventions
- Relapse Prevention
- Dual Diagnosis consultancy

Staff from the Bridgend Community Drug and Alcohol Team also work with Ogwr DASH to progress a local waiting list initiative. Substance Misuse Services in Bridgend have been commended by Health Inspectorate Wales on the good practice taking place with regard to service user involvement in the planning, design and delivery of services. Service users have helped to facilitate relapse prevention groups in the locality and

***Community Safety Partnership***

Since 1998 the Safer Bridgend Community Safety Partnership has involved various agencies from the public, private and voluntary sector to work together to reduce crime, disorder and fear of crime locally. The aim is to improve the quality of life of local communities and create a safer living and working environment for those who live in, work in and visit the county borough of Bridgend. The partnership now also includes a dedicated Service User Officer post within substance misuse services funded by the Bridgend Community Safety Partnership.

***South Wales Police***

Bridgend Police are a local division of South Wales Police supporting multi-agency working across communities. As the criteria for the project is reflected by those who have offending behaviours, it is anticipated that the future tenants will be known to local police services, involvement of local policing is seen as key. Bridgend Police are represented within the stakeholder group through a named officer for continuity.

***Just Ask Plus***

Just Ask Plus provides Information, advice and guidance to young people aged 16-25. The project meets the needs of young people through one to one support as well as signposting and supporting access to services and agencies within Bridgend County through a "one stop" shop model for youth support services. The intention of the service is to provide immediate support where needed and specialist support based on the identified needs of each young person, whilst removing the need to present to a range of services, in different places and tell the same story.

Just Ask Plus provides a range of services to young people under one roof. Information, advice and guidance including:

- A range of information resources including leaflets, books, magazines and internet.
- One to one support with the issues that matter the most, taking into account all of the young person's needs.
- Support with gaining employment and access to training and education opportunities, including on-going support with maintaining placements and job preparation skills.
- Access to a quiet room within which young people can access counselling or talk confidentially to an information worker or representative from an appropriate, specialist agency such as a substance misuse worker or tenancy support worker.
- Sexual health and relationship education including where appropriate the provision of free condoms.
- Accredited courses on a range of topics such as confidence building, preparation for work, money management and learn direct.
- Access to a key worker to provide on-going support and help co-ordinate the involvement of other services.

***Integrated Offender Interventions Service***

The Integrated Offender Interventions Service provided by Group 4 Justice Services (G4S), went live on the 1st April 2012 and incorporates DIP (Drug Intervention Programme), DRR (Drug Rehabilitation Requirements), ATR (Alcohol Treatment Requirement) and AAR (Alcohol Activity Requirement) as one new service. Working in the community the organisation provides substance misuse interventions and case management of service users referred from the Police, Probation and Prison Services and provides a range of interventions and services including police custody arrest referral, court reports, drug and alcohol rehabilitation, clinical treatment services, prison link and management of released prisoners.

The service is responsible for the comprehensive assessment, care planning and case management of substance misusers seeking to enter the South Wales IOIS. To provide drug arrest referral, through case and aftercare, support and assertive outreach services to substance misusers identified through contacts in Police custody, courts, prison or the community. To manage and report on offenders who have statutory orders made by the Court for treatment of substance misuse under the DRR, AAR and ATR requirements.

***HMP Parc (Transitional Support Scheme)***

HM Prison Parc is a Category B male private prison and Young Offenders Institution, located in Bridgend. HMP Parc is operated by G4S, and is the only privately operated prison in Wales.

The Transitional Support Scheme (TSS) aims to provide 'through the gate' mentoring support for short sentence prisoners up to 12 weeks following their release from HMP Parc custody. Specifically, TSS is designed to address the practical resettlement needs of short-sentence prisoners who are returning to Wales, and who are experiencing on-going substance misuse problems. The primary focus is upon increasing access to drug treatment and subsequently reducing/ceasing drug consumption. The scheme also aims to address additional problems which have been shown to increase the likelihood of offending including homelessness; relationship problems; finances; low educational attainment; and unemployment. Mentors are expected to enhance the motivation of offenders to address their offending behaviour through the application of cognitive/motivational techniques.

There is an understanding that resettlement underpins the work of the whole establishment, supported by strategic partnerships in the community and informed by assessment of prisoner risk and need.

# 7. Project delivery

### 7.1 Project specifics – Initial stages (July 2013)

Following the successful commissioning by Supporting People Bridgend of Gwalia as the provider of support services and managing agent and Valley to Coast identified as the housing provider and landlord to whom the core rents would be due, there were a number of tasks required in order to facilitate the initial stages which included:

- Employment of a support team specifically for the Kerrigan Project
- Identification of two properties that would be suitable to meet the specification in terms of unit numbers, but that also considered location, access to services including public, health etc..
- Property/location neighbourhood consideration and consultation

### 7.2 Identification of core service user group

In order to ensure that the project got off to the best start early consideration was given to the potential clients. An initial exercise was undertaken to compile the cohort of clients considered as requiring this type of project, with Bridgend County Borough Council Supporting People being the sole referral route and gatekeepers of access into the project. It was communicated that the Housing Solutions Team Leader would be the collator of all potential service user referrals,

Some early issues in relation to referrals into the project were identified, not least because a key task of Gwalia's initial work was to engage with clients *in advance* of their moving into the project. It was important therefore that the identification of clients considered only those with whom Gwalia could start to work with immediately (subject to the referral being confirmed by BCBC).

There was a request for names and locations of potential clients to be sent to supporting people for consideration, anticipated as being those were currently

- In prison
- In hospital
- In unsatisfactory accommodation

A potential opening date of the project was September 2013.

### 7.3 Stakeholder Group - Terms of reference

In relation to the stakeholder Group, an initial meeting was held in July 2013 and chaired by supporting people wherein a terms of reference document for the group was established (see appendix three). The group identified core membership with an overarching responsibility to provide joint ownership and a multi-agency approach to the support and other interventions provided to the cohort of service users to be supported by the Kerrigan Project.

Partner representatives were asked to:

- Positively promote the work of the Kerrigan Project
- Facilitate opportunities for discussion/debate in your organisation/department and ensure effective 2-way communication.
- Ensure information about Kerrigan Project is fed back to individual organisations/department.
- Influence the aligning of other resources to the work of the Kerrigan Project where this is appropriate.
- Help to ensure key stakeholders are consulted and involved in decisions taken that may affect them.

Logistically, it was agreed that this group would meet on a quarterly basis.

### 7.4 Outcome measures

The primary outcomes measures for the project are in line with the *Supporting People Wales Outcomes Framework* (2012). The Purpose of the Framework is threefold; to adopt a system to collect meaningful outcome information; to utilise the information to measure; maintain and improve the quality of service provision; and to recognise the effectiveness of the Supporting People Programme.

The framework is intended to be utilised as a consistent outcomes gathering tool that can be widely used across Wales, upon which future service developments will be measured and commissioned. The tool also contributes to the development of a skilled and valued workforce within the programme. From a national perspective, the tool allows for evidence of the effectiveness of the programme to be shared in order to help shape future policy development

Outcomes need to be recorded on a spreadsheet every six months and / or when a service user exits a scheme or has their support withdrawn which is based around 4 key outcome areas (see appendix four). Exit information should include all service users including those who exited or had their support withdrawn in an unplanned way.

## 7.5 Initial cohort of referrals

An early update was provided to the group in relation to identification of the first group of potential referrals and the work Gwalia had undertaken to date (see table two below):

| No. | Initials | Referrer | Date of referral | Referral specifics | Referall outcome |
|---|---|---|---|---|---|
| 1 | **RR** | Probation | 23/07/2013 | This lady was known to all stakeholders due to chaotic lifestly and repeated admissions to Prison. Following assessment, this lady was sentenced to further a custodial period until October 2013, however it was agreed that Gwalia would continue to build relationships with this lady, with a view to engagement following release | Considered suitable |
| 2 | **C** | Integrated Offender Services | 23/08/2013 | Following receipt of referral, this lady had returned to custody and on release would not be subject to statutory supervision, making engagement difficult. An appoitnment was made to meet with her following release however she DNA's. Following many further attempts to engage, it was advised this lady was 'sofa-surfing' and not contactable. | On-going |
| 3 | **SF** | Probation | 04/09/2013 | Following initial assessment it was anticipated that this gentleman would be suitable for a floating support model. | Accepted |
| 4 | **SD** | BCBC | 19/09/2013 | Successful engagement and assessment. Considered suitable for floating support | Accepted |
| 5 | **KJ** | CMHT | 30/09/2013 | Assessment date agreed | Pending |

*Table 2: First cohort of referrals and referral outcomes (Sept 2013)*

# 8. Dual Diagnosis project management

### 8.1 The Consultant role

The initial aims identified at the commencement of this project were that the Consultant would provide expert project management in the field of dual diagnosis and work with the successful provider (Gwalia) to:

- Set outcomes which were stakeholder driven incorporating full multi-agency involvement and SMART (Specific, Measureable, Achievable, Realistic and Time-bound)
- Develop bespoke packages of learning for dual diagnosis that were accessible across the Bridgend footprint (including accessibility for Gwalia)

The key objective of the consultant intervention was to support the project to demonstrate positive outcomes of the pilot for both service users and key stakeholders and to identify any barriers making recommendations to support improvement.

The methodology for the Bridgend Project was suggested as:

- Meeting with key stakeholders to identify one key strategic objective per organisation for the deliverable outcomes of the pilot (total of 4 or 5 maximum including health, substance misuse, probation and housing). This was aimed at supporting and promoting a multi-agency agreement for collaborative buy-in and co-ownership of this core group of service users.
- To monitor progress of the outcomes
- Following a period of 'settling in' for the new scheme, to convene an engagement group of Gwalia staff to establish what is working well and identify any barriers to progress based upon the key strategic objectives
- To adopt a case study methodology to describe examples of outcomes for two Kerrigan project service users
- Provide a report that summarises progress and makes recommendations for future
- To support development of a suite of e-learning around dual diagnosis that Gwalia can access as mandatory for the staff within the scheme
- To present findings at the follow-up conference in March 2014

## 8.2 Consultant timescales

The Consultant engagement was proposed as table 3 below

| PROJECT TITLE | Pilot 2 - Bridgend / Gwalia | | |
|---|---|---|---|
| AREA OF FOCUS | INTERVENTION | TIMESCALES | PROPOSED COMPLETION |
| 1. Fieldwork | To meet with Key Stakeholders and staff in Gwalia | 5 days | June 2013 to Jan 2014 |
| 2. Administrative | Report writing Preparing Presentation | 12 days | Feb-14 |
| **TOTAL** | | **17 days** | **Mar-14** |

*Table 3: Consultant engagement and timescales*

## 8.3 Setting outcomes

As advised, it was a core function of the consultancy to develop a set of key outcomes which were stakeholder driven incorporating full multi-agency involvement and which were SMART (Specific, Measureable, Achievable, Realistic and Time-bound). At an early stakeholder project meeting, the Consultant asked stakeholders to consider one or two outcomes based upon key organisational objectives (see appendix five).

## 8.4 Meeting participation

The consultant engaged in a series of meetings with various stakeholders during the initial stages of the project to understand multi-agency roles and responsibilities. This was within the determined project timeframes and where it was considered an effective use of the time allocation. There were also interim milestone meetings with commissioners of the review at Swansea.

### 8.5 Engagement

Despite several requests to the stakeholders, response participation was as can be seen below at table 4:

| ORGANISATION | CONTACT NAME | COMPLETED FORM RECEIVED |
|---|---|---|
| Youth Offending Service (Ops and Housing) | Daniel Morgan | Received |
| Probation Service | Deanne Martin | Received |
| Community mental Health Team (ABMU) | Zoe Wallace | |
| Community DAT | Gavin Thomson | |
| South Wales Police | Ralph Harris | Received |
| Community Safety Partnership | John Davies | |
| Just Ask plus (Childrens) | Jane Cullen | Received |
| Integrated offender Service (IOIS) | Neil Harding | |
| HMP Parc (transitional support scheme) | | |

*Table 4: Stakeholder participation in objective setting*

### 8.6 Setting stakeholder outcomes

The stakeholders provided objectives and priorities as below at table 5

| Key objective description | Key priorities of Kerrigan for your organisation? |
|---|---|
| A) Research has proven the necessity for suitable accommodation as a key element in the reduction of reoffending & impact on local communities. The focus on vulnerable and chaotic service users is key.<br>B) The IOM team deal with the most persistent offenders in the borough and therefore often the most vulnerable & chaotic members of society. Our hope is to work with the Kerrigan Project to assist us in managing the risks these individuals poses to our local community. | 1) That the Kerrigan Project works closely with the IOM team to identify potential service users and in the on-going management during placement at the project.<br>2) That the Kerrigan project are clear and confident in making IOM nominations/referrals given the likely cross-over of service users<br>3) Ensure that IOM and Kerrigan Project engage in the compilation of formal Risk Management Plans and through high quality partnership working |
| C) To assist in managing prolific and repeat offenders back into the community in order to reduce their offending behaviour and break the cycle of reoffending.<br>D) Work in partnership with agencies within the project to achieve this objective.<br>E) Promote the work of the Integrated Offender management team within the project and with our partners | 1) To have the correct partners involved in the decision making from the beginning, mental health are a key partner to this process.<br>2) A clear definition of 'vulnerability' and clear criteria for referrals.<br>3) The setting up of a 'Referral Board' that is made up of, The referee, Police (IOM team), probation, BCBC, mental health and the team manager. This will allow for a transparent process around the decision making.<br>4) Clear communication between the staff at ground level and the steering group. |
| F) A multi-agency approach to ensuring that care leavers make successful transitions into adulthood | 1) Ensure there is suitable accommodation available to meet the need of young people leaving care.<br>2) There is a multi-agency support available for young people leaving care to support them with independent living?<br>3) There is a single referral route to access provision/support that is agreed and understood by all stakeholders and young people.<br>4) Multi-agency rapid response for young people if they are in crisis. |

*Table 5: Stakeholder objectives and priorities of Kerrigan project*

The outcomes of the above are discussed in detail in section 9.

## 8.7 Developing Capable Practitioners (Dual Diagnosis)

Mental health services have, historically, often evolved separately from drug and alcohol services. Many staff, therefore, working in mental health services are not trained to assess and treat substance misuse, and vice versa in the case of drug and alcohol services.

Workforce development to support delivery of effective services is key. The NHS Litigation Authority (NHSLA) has for some time now recommended the development of staff training in substance misuse management in all mental health trusts. Effective management of service users with a dual diagnosis is one of the criteria for meeting clinical care standards within the NHSLA risk management framework for mental health and learning disability providers.

The Department of Health recommend that specialist teams of dual diagnosis workers, where possible, provide support to mainstream mental health services; that staff in assertive outreach teams are trained and equipped to work with dual diagnosis; and that there are adequate numbers of suitably trained staff in crisis resolution, early intervention, community mental health teams and inpatient services. The assessment and management of drug and alcohol misuse should be considered to be core competences required by clinical staff in mental health services.

A 2008 review on dual diagnosis recommended that workforce capabilities in this area be strengthened, using existing resources such as the dual diagnosis capability frameworks. In view of this, the Consultants recommended and provided a link to the national Dual Diagnosis e-learning suite. This would allow Gwalia to identify education opportunities which were informative and relevant to their workforce, and potential service user needs within Kerrigan.

See diagram 1 overleaf.

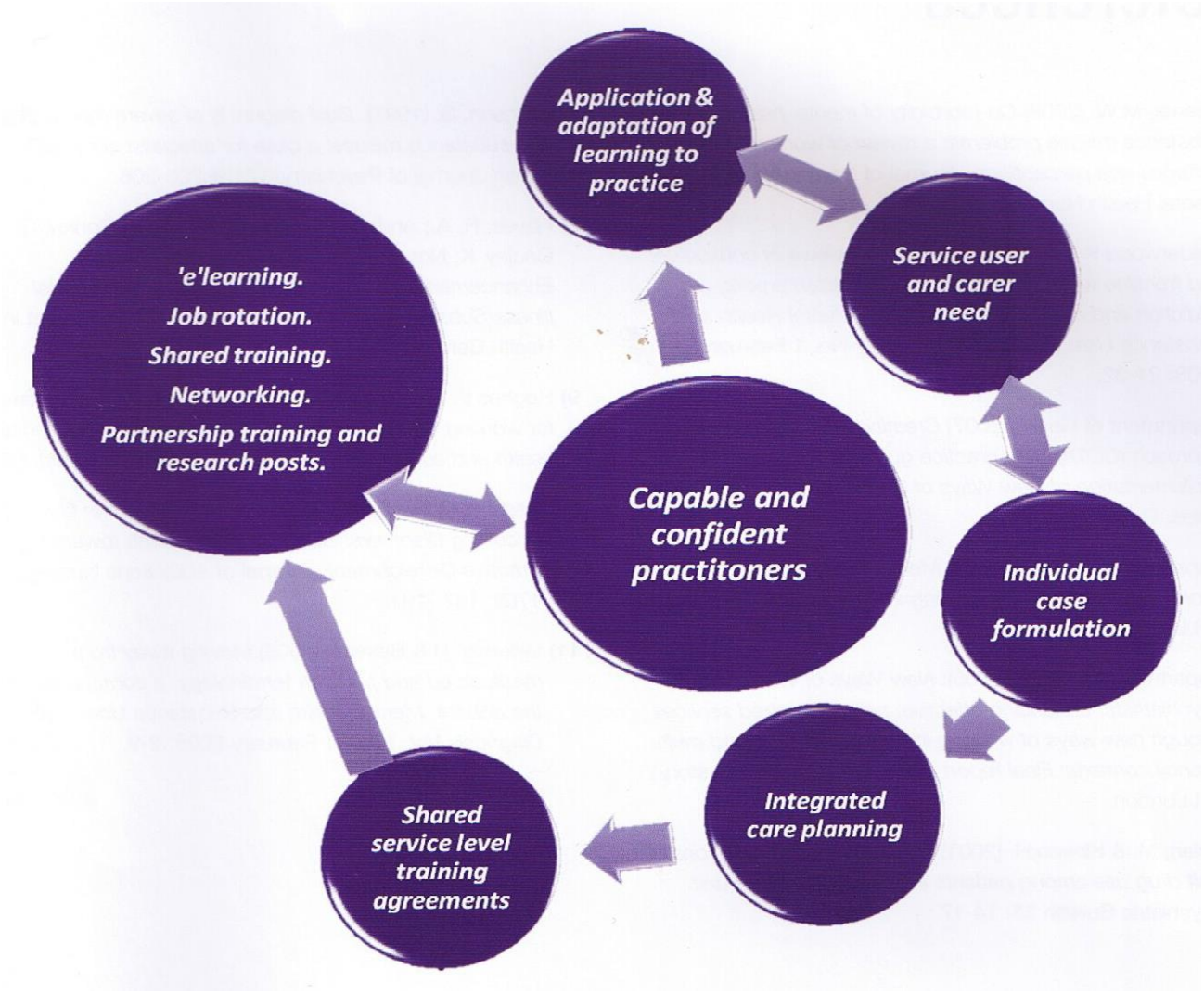



*Diagram 1 - Adapted from "Dual Diagnosis: Developing capable practitioners to improve services and increase positive service user experience"*

**http://www.dualdiagnosis.co.uk/National_e-learningHub.ink**

# 9. Measuring outcomes – progress to date

### 9.1 Performance caveat

The original project plan had expectations that following a 12 month period, a progress report would be produced that:

- Measured implementation and performance against original stakeholder objectives
- Provided two case studies to demonstrate progress
- Explored engagement with Gwalia staff to identify what was working well and any potential barriers to progress
- Make recommendations to overcome

It should be noted that at the date of writing the report, the single unit model had yet to be commissioned, with floating support being provided as an interim alternative. This was noted to be in relation to the various problems encountered in the procurement of a property, and although not included in this report, was to form a 'learning cycle' for Gwalia. There have been several potential properties put forward, all of which were regarded as unsuitable by Council members. The property that was eventually purchased by V2C late 2013 was removed from the project (again my council members) as it was questioned whether correct protocols had been utilised in relation to engagement and consultation with local residents. In view of this, V2C felt unable to continue as the prospective social landlord at this time due to an unusable property they need to re-sell.

#### 9.1.1 Changing the parameters of the evaluation

It was therefore decided between the consultants and commissioners of the work at Swansea, that evaluation and progress would now be scoped by:

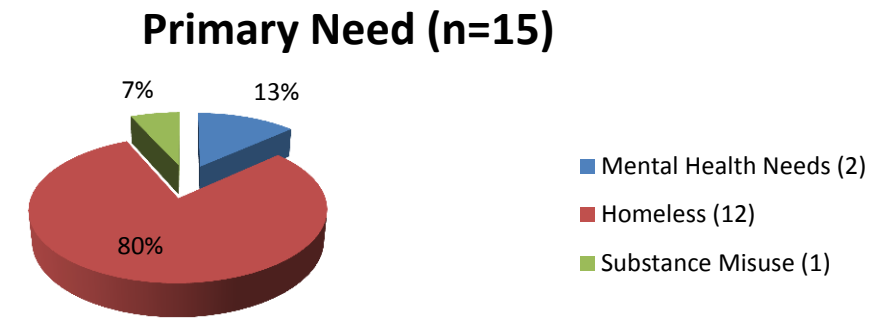
- A review of the floating support element in the context of the original proposals and referrals
- An evaluation of stakeholders perceptions of the model to date and future expectations
- The use of two case studies
- An evaluation of the use of the e-learning suite by staff in Gwalia

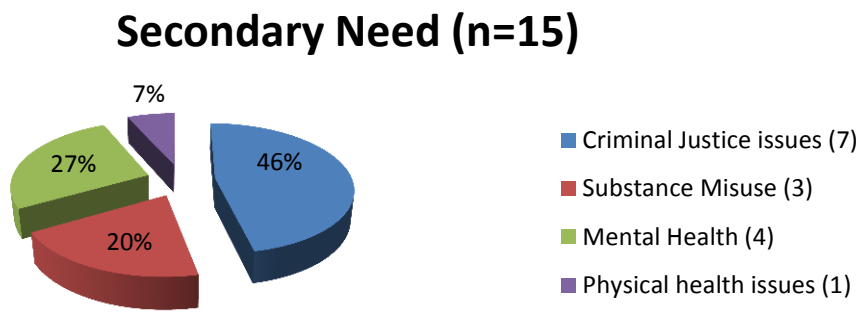
### 9.2 Kerrigan Floating Support service user analysis by need

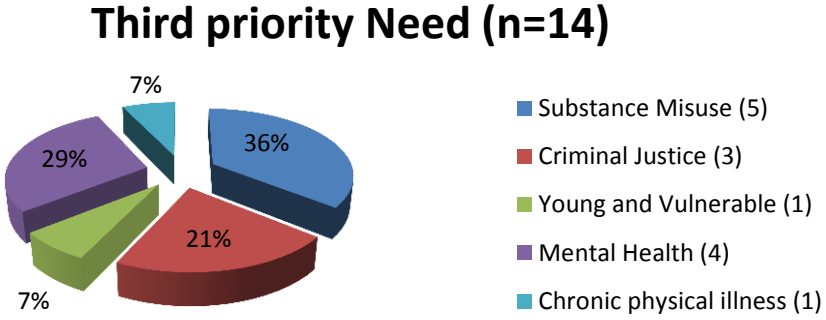
The following data is based upon extractions of the most recent submission by Gwalia of supporting people framework (January 2013) which is a mandatory submission required every 6 months.

### 9.2.1 Analysis of need

The Charts below summarises the needs of those currently accessing floating support as part of the Gwalia project as a) Primary need, b) Secondary need, c) third priority need based on 15 service users currently accessing services at the time of review:-



Of the 15 service users the key points to note are:

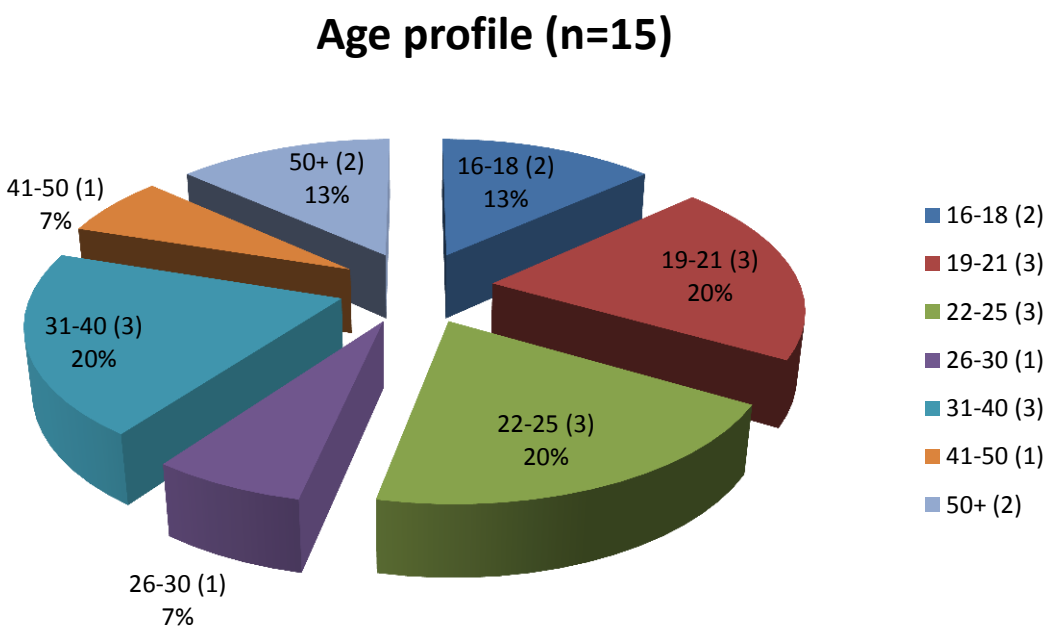
- 80% (n=12) had a primary need around housing/potential homelessness
- 20% (n=3) were not deemed to have a potential housing problem as either a primary secondary or third priority need
- 66% overall (n=10) had a mental health problem as either a primary, secondary or third priority need
- 36% (n=5) had a mental health problem and substance misuse problem which suggests over a third of those receiving support have a 'dual diagnosis'
- 60% (n=3) of those with a dual diagnosis (n=5) also had criminal justice issues
- 100% of those receiving floating support meet the criteria for accessing services from Kerrigan based on their primary need.

**Summary of need**

As is suggested within the literature, there are close links between mental health and co-occurring substance misuse problems in addition to criminal justice issues and potential homelessness. This early data suggests that the floating support provided by Gwalia, is filling a short term gap that exists in terms of support needs, albeit not through a single unit model, which in some respects counter-intuitively overlooks the primary identified need around housing and potential homelessness.

### 9.2.2 Age profiling

The chart below highlights the age profiling of those currently receiving support from Kerrigan staff:




**Key points to note**

60% of those receiving a service are under 30 years of age, with 13% being aged 18 or under.

### 9.2.3 Other key information

- Of the 15 service users accessing support, one has subsequently been discharged
- Of the original referrals at the start of the project (n=5), 3 of those have been offered floating support

### 9.3 Stakeholder analysis of original objectives

Due to the change in model compared to the original specification from a single unit to that of floating support, it was difficult to make comparisons, however the development of an online questionnaire loosely based upon original objectives was developed (see appendix six). This was disseminated electronically to the stakeholder group (n=13) with a disappointing response of 23% and results as follows:

| | | |
|---|---|---|
| **Potential respondents** | **13** | |
| **Actual respondents** | **3** | **23%** |

| **Q1 - Has your organisation made referrals to Kerrigan project?** | | |
|---|---|---|
| Yes | 2 | 67% |
| No | 0 | |
| Yes but they have been declined | 1 | 33% |
| My referral doesn't fit floating support | 0 | |
| My organisation doesn't make referrals | 0 | |

| **Q2. Has the Kerrigan project has worked closely with your organisation in assessing and managing your service users?** | Actual | % |
|---|---|---|
| Yes | 2 | 66.67% |
| No | 0 | |
| Not applicable | 1 | 33.33% |

| **Q3. Have Kerrigan project staff been involved in the compilation of formal risk management plans within your organisation?** | Actual | % |
|---|---|---|
| Yes | 1 | 33.33% |
| No | 0 | |
| Not applicable | 2 | 66.67% |

| **Q4. Do you feel the accommodation is of your current clients in Kerrigan is suitable?** | Actual | % |
|---|---|---|
| Yes | 0 | |
| No | 0 | |
| Not applicable | 3 | 100.00% |

In relation to question 4, respondents were asked to provide a rational for their answer with results as below:

| **Q4. If you answered No, please can you specify why?** |
|---|
| *"The core house is not available yet"* |

| **Q5. Do you feel the Kerrigan project is effective in managing risk and re-offending behaviours?** | Actual | % |
|---|---|---|
| Yes | 0 | |
| No | 0 | |
| Don't know | 3 | 100.00% |

| **Q5. If you answered No, please can you advise how this could be improved?** |
|---|
| *"This will clearly improve when the core house is on stream. Currently work is being carried out by providing floating support in other accommodations which are dispersed"* |

| **Q6. Do you feel the Kerrigan project is appropriately resourced to support successful transitional arrangements from children's to adult services?** | Actual | % |
|---|---|---|
| Yes | 2 | 66.67% |
| No | 0 | |
| Don't know | 1 | 33.33% |

| **Q6. If you answered No, please can you advise the rational for your answer** |
|---|
| *"This is based on start-up period and current floating support provision"* |

| **Q7. Thinking about the Kerrigan Stakeholder Project Group, do you think the correct partners have been involved in the decision making?** | Actual | % |
|---|---|---|
| Yes | 2 | 66.67% |
| No | 0 | |
| Not sure | 1 | 33.33% |

| Q8. Do you think that a clear definition of what constitutes 'vulnerability' has been provided by the Kerrigan stakeholder project? | Actual | % |
|---|---|---|
| Yes | 2 | 67% |
| No | 0 | |
| Don’t know | 1 | 33% |

| Q9 Is there a clear criterion for referral to the Kerrigan Project and do you know the process? | Actual | % |
|---|---|---|
| Yes | 2 | 67% |
| No | 0 | |
| Don’t know | 1 | 33% |

| Q10. Do you feel the Kerrigan Project inclusivity criterion is appropriate? | Actual | % |
|---|---|---|
| Yes | 1 | 33% |
| No | 1 | 33% |
| Don’t know | 1 | 33% |

| Q11. Do you feel 'Dual Diagnosis' is a key priority for the project? | Actual | % |
|---|---|---|
| Yes | 2 | 67% |
| No | 0 | |
| Don’t know | 1 | 33% |

| Q11. If you answered No, please can you advise what the priority is? |
|---|
| *"There is no comparable service in Bridgend"* |

| Q12. Do you feel involved in the decision making process for accessing services from the Kerrigan Project? | Actual | % |
|---|---|---|
| Yes | 2 | 67% |
| No | 1 | 33% |

| Q.13 Do you feel communication is effective within the stakeholder steering group and supporting people? | Actual | % |
|---|---|---|
| Yes | 2 | 67% |
| No | 0 | |
| Don't know | 1 | 33% |

| **Q14. Do you feel the stakeholder group has embraced the concept of multi-agency working?** | Actual | % |
|---|---|---|
| Yes | 2 | 67% |
| No | 0 | |
| Don't know | 1 | 33% |

| **Q15. Do you think that a floating support model is sufficient for the needs of your client group** | Actual | % |
|---|---|---|
| Yes | 0 | |
| No | 3 | 100% |

| **Q 16. Overall, how successful has the Kerrigan Project been in meeting with your expectations and original objectives? (Please select all answers that apply.)** | Actual | % |
|---|---|---|
| Excellent | 0 | |
| Good | 0 | |
| Poor | 1 | 33% |
| This is a work in progress | 3 | 100% |
| Not applicable | 0 | |

| **Q17. Please could you select a statement below that you feel applies** | Actual | % |
|---|---|---|
| *"I would be interested in being involved in further projects like this"* | 1 | 33% |
| *"There continues to be a gap in our area for projects like this for vulnerable and chaotic people"* | 3 | 100% |

| **Q18. Finally, we understand that the project is not yet being delivered from a 'single unit' and that floating support is the model being offered at present. Please could you provide any comments in relation to the project so far, and any thoughts or future considerations?** |
|---|
| *"I look forward to the core house being established which appears imminent"* |
| *"From my perspective we have not been able to progress any placements at the project and despite Gwalia currently offering floating support , this was not the service commissioned and I am not aware that any of the prospective tenants we have referred to the scheme are benefiting from it at present"* |

**Summary data analysis**

The questionnaire was disseminated to 13 possible respondents which included the individual referral stakeholder group and supporting people representatives, and as can be seen, the response rate was disappointingly low at 23% (were n=13). This could potentially be due to the fact that the model is not functioning to the full original specification of a single core unit; however, the e-mail disseminated did advise respondents that the evaluation was based upon **progress to date**.

On the whole, of those respondents who had made referrals, and who had clients utilising the floating support model, they felt that staff at Kerrigan had worked closely with them in the initial stages, but where unsure if they were effective in delivering effective risk and re-offender management strategies. There was however an acknowledgement that Kerrigan appear to be appropriately skilled to facilitate the transition between adolescent and adult provision. The rational for the minimal effects on risk and re-offending was advised as the lack of a core house model upon which to commence constructive work.

There was a recorded lack of clarity upon which respondents could relate to what the key priorities of the project were; the definitions or dual diagnosis; referral process and referral criterion, suggesting gaps in multi-agency communication and collaboration despite regular meetings and timely minutes. Respondents also indicated that they did not feel involved in communication, decision making or overall access to the service.

All respondents agreed that the floating support model was insufficient to meet the core needs of their client group with current accommodation provisions remaining inappropriate. There was an acknowledgement that there was still no alternative 'single unit' model within Bridgend despite this being highlighted through demand analysis and the core objective of the project.

One respondent rated the Kerrigan project as 'poor' in delivering the specification to date, but 100% of respondents agreed with the statement that this was a 'work in progress' indicating recognition for maintaining involvement. Furthermore, 100% of respondents agreed with the statement that there continues to be unmet needs for those who are classed as vulnerable and chaotic within society. In addition, qualitatively there appeared to be a continued hope that the single unit model would be imminent and that this still has the potential to meet original objectives.

## 9.4 Training analysis

It was recommended as an early part of the project that all staff who had been recruited to work within the Kerrigan Project would be asked to undertake the dual diagnosis e-learning basic level modules introduced by the consultancy.

As part of the project management evaluation stage, it was agreed that staff would be asked about their experience of the training modules in addition to its usefulness within the context of the Kerrigan project.

A link to an on-line questionnaire was provided to the staff recruited to Kerrigan to date, (n=5) in order to gather feedback about the training and staffs' experiences of the project to date, and through maintaining anonymity, encourage participation (see appendix seven) with results as below:

| | | |
|---|---|---|
| Potential respondents | **5** | |
| Actual respondents | **4** | **80%** |

| Q1 - What is you role? | | |
|---|---|---|
| Manager | 1 | 25% |
| Support worker | 2 | 50% |
| Team Leader | 1 | 25% |

| Q2 - Have you undertaken the e-learning training | | |
|---|---|---|
| Yes | 1 | 25.00% |
| No | 0 | |
| I have yet to undertake it | 3 | 75.00% |
| I am not aware of it | 0 | |

| Q3 - Please rate the usefulness of the training | | |
|---|---|---|
| Excellent | 0 | |
| Good | 1 | 100.00% |
| Poor | 0 | |
| I have not undertaken it | 3 | 75.00% |

| Q4 - How appropriate are the referrals to your project | | |
|---|---|---|
| Appropriate | 3 | 75.00% |
| Not Appropriate | 0 | |
| I don't know | 1 | 25.00% |

| Q5 – Do you feel supported by referring agents | | |
|---|---|---|
| Yes | 4 | 100.00% |
| No | 0 | |
| Sometimes | 0 | |

| Q6 - Please advise which agencies are effective in Providing on-going support to your clients? | | |
|---|---|---|
| Mental health teams | 2 | 50.00% |
| Social Workers | 0 | |
| Substance Misuse | 4 | 100.00% |
| Probation | 4 | 100.00% |
| Police | 1 | |
| Other | 1 | 25.00% |

| Other |
|---|
| BCBC Housing |

**Key points to note:**

- Of those recruited to undertake work specifically connected to the Kerrigan project, disappointingly only 1 of the 4 respondents had undertaken the dual diagnosis training e-learning suite.
- The one person who had undertaken the training rated it as good on a scale of excellent to poor.
- Of those responding, 75% (were n=4) felt that the referrals to date had been appropriate
- 100% of respondents felt supported by the agents making the referrals to them
- 100% of respondents advised that both substance misuse and probation services were effective in engaging in on-going support for their clients.

## 9.5 Case Studies

The original consultant project plan made recommendations for a case study methodology to illustrate how the use of a single unit model improved outcomes for those considered 'difficult to engage' and 'vulnerable' compared to a standard floating support model provided in isolation from housing.

As has been discussed, this model is not yet fully commissioned, however it was felt important to demonstrate how early engagement by Gwalia staff has already started to support recovery improvements on the health and well-being of the first cohort of referrals.

The names have been replaced by pseudonyms in order to protect identity.

**CASE STUDY 1**

*SD is a 19 year old female with a dual diagnosis (managing substance misuse and mental health problems) and also an offending history with criminal justice systems. SD was referred to Kerrigan through the supporting people gatekeeping team from IOM in September 2013 and commenced receiving support from Gwalia in October.*

*Following assessment SD was initially receiving weekly support in areas identified as above in addition to support with developing the skills needed to manage her tenancy, support with budgeting to prioritise expenditure and also with managing her physical health needs by accessing required help from medical professionals. Support for SD is now taking place fortnightly as requested by SD but remains flexible and will increase with any change in SD's needs.*

*Progress to date*

- *SD has been given support to attend ongoing hospital appointments to ensure SD was able to attend as the long term effects of not attending would be detrimental to her overall physical health and mobility.*
- *SD had initially felt that she did not require support maintaining regular contact with floating support, however due to outside influences (in her own tenancy) her substance misuse has escalated. It is proposed that a single unit with 24 hour support could help to reduce this.*

*Key service user recovery pathway outcomes*

- *SD has started attending some hospital appointments and G.P appointments where this was not a priority in the past.*
- *SD is developing money management skills and still wants further support to help her manage her money more effectively.*
- *SD is gaining in confidence and is working towards being able to look at enrolling in* college this September (2014).

**CASE STUDY 2**

*SF is a 36 year old male of NFA with substance misuse and also a long history of contact with criminal justice system. SF was referred to Kerrigan from Wales Probation Trust in September and following assessment commenced floating support engagement the following week. Support sessions with SF have been once or twice a week depending on his support needs that week and flexible to his needs. Initial goals were to find suitable accommodation and access appropriate support to manage his mental health and substance misuse issues.*

*Progress to date*

- *The project has supported SF to establish his ESA claim and budget his finances taking into account direct deductions which are being taken. SF says he is a lot happier now he knows what he is paying and why, which in the past had never been explained to him. Support was also provided to put together a bond referral which has since been accepted.*
- *SF has appeared in court at the end of 2013, but with the intervention of support and longer term recovery goals, he received a suspended sentence.*
- *Since the trail, through close working with Kerrigan good progress has been made through engagement with Drugs services and SF is currently awaiting a medical assessment to commence prescribed substitute medication for his substance misuse problems.*
- *Weekly contact with IOM, drugs and mental health services to keep all parties up to date with progress being made has ensured a multi-agency partnership to access support in a co-ordinated way and gain best possible outcomes for SF*
- *SF is attending regular GP appointments around his physical health*

*Key service user Recovery pathway outcomes*

*SF has worked hard to achieve his goals and has now started to address his substance misuse which was a priority issue and had not been addressed before.* ***SF has not taken any substances for 3 weeks and which have been confirmed by negative drug tests carried out by the IOM unit****. This has motivated SF to continue with his prescribed substitute medication as he feels this has been effective so far.*

*SF now feels able to address his mental health needs with support from Kerrigan and local mental health services and is looking forward to finding suitable accommodation to set up a stable home. SF has indicated that he is much happier and feels Kerrigan has benefited him greatly.*

# 10. Summary and conclusions

It would appear from the review, that there is a vast range of local and national agendas and policy drivers across both health and social care within Wales, aimed at improving outcomes for those with complex mental health problems, substance misuse problems (dual diagnosis), offending behaviours and who are potentially at risk of homelessness. It seems therefore that this vulnerable group within society present similar challenges to both health and social care services as with those of the rest of the UK.

Both existing and historical practice suggests that services continue to function, albeit effectively, somewhat in isolation, whereby providing service users with a 'map of complex and disconnected junctures and pathways' upon which to negotiate a road to recovery.

The proposals of the Kerrigan Project pilot are therefore a testimony to the multi-agency stakeholder group within Bridgend who have taken policy implementation one step further by developing a unified pathway for those with dual diagnosis, offending behaviours and potential homelessness. The strategy demands the collaboration of multi-agency working to wrap services and statutory obligations around individual and personal need to ensure one pathway.

It is unfortunate that to date, the project has been unable to achieve its original expectations of a single unit of multi-disciplinary input, however the original proposals are imminent, and to date, the alternative floating support service offered by Gwalia has already started to make some inroads through early engagement and intervention, suggested through the case studies as:

- Preventing Prison sentencing and reducing offending behaviours
- Support for substitute substance misuse maintenance and harm reduction
- Engagement with primary care and management of physical health
- Budget management
- Re-entry into education
- Managing mental health
- Multi-agency co-ordination

This is in addition to strategic opportunities for reflection and lessons learned in by all agencies in determining and planning the next steps towards a single unit.

In essence the project has the potential to provide a long term focus on health awareness and the impact upon lifestyle and choices. With a multi-agency driven model, that has one set of outcomes, one care plan/risk management plan to meet all needs that is developed jointly by health, social, probation and housing and provides the opportunity and motivation for engagement and crisis planning through pre-identified roles and responsibilities.

In addition to improved outcomes for service users, and equal access to service provision, strategically the use of a project such as Kerrigan in essence provides an opportunity for financial incentiviation through a reduction in re-admissions to both health services and penal systems, and focuses dependence away from multi-agency input through accountability of agencies in relation to primary need.

Practically, outcomes are difficult to measure against the stakeholder objectives, with early analysis suggesting there are some hurdles to achieving improved communication and access to the service, with a need to ensure development to the full potential, and a criteria that is inclusive of those it aims to support.

Overall the Kerrigan project has started to address the overall aims and describe/plan for collaborative working with the potential of:

- Reducing inequalities for vulnerable groups with mental health needs, ensuring equitable access and provision of mental health services.
- Ensuring that public services work together to provide an integrated approach.
- Ensuring substance misuse co-occurring with mental health problems is managed effectively and remains a key focus.
- Reduce homelessness and help people with mental health problems sustain tenancies.

# 11. Recommendations and action plan

The following are a key set of recommendations as derived from the evaluative work undertaken so far, and provided to influence and ensure effective future service delivery suggested as:

1) Encouragement for continued multi-agency ownership to support continuation of the Kerrigan project pilot to the full potential (single unit model and access to crisis).

2) Any future properties to consider effective governance around neighbourhood engagement and consultation

3) On-going monitoring and regular evaluation of the project to ensure that any barriers to success that develop are effectively managed in a timely way.

4) To ensure that Gwalia link in with key commissioners on a regular basis.

5) The use of compulsory and regular multi-agency meetings to highlight frequent users of services and offenders to ensure timely access to Kerrigan. This should include representatives from mental health, substance misuse, and colleagues from primary care, probation, police, and voluntary agencies.

6) Joint early assessments between mental health, substance misuse and probation/offender services for people, co-facilitated by Gwalia in order to develop a single care plan and risk management strategy supporting all individual service users' needs with clear roles and responsibilities of each party (see dual diagnosis quadrant on page 53 as a suggested model).

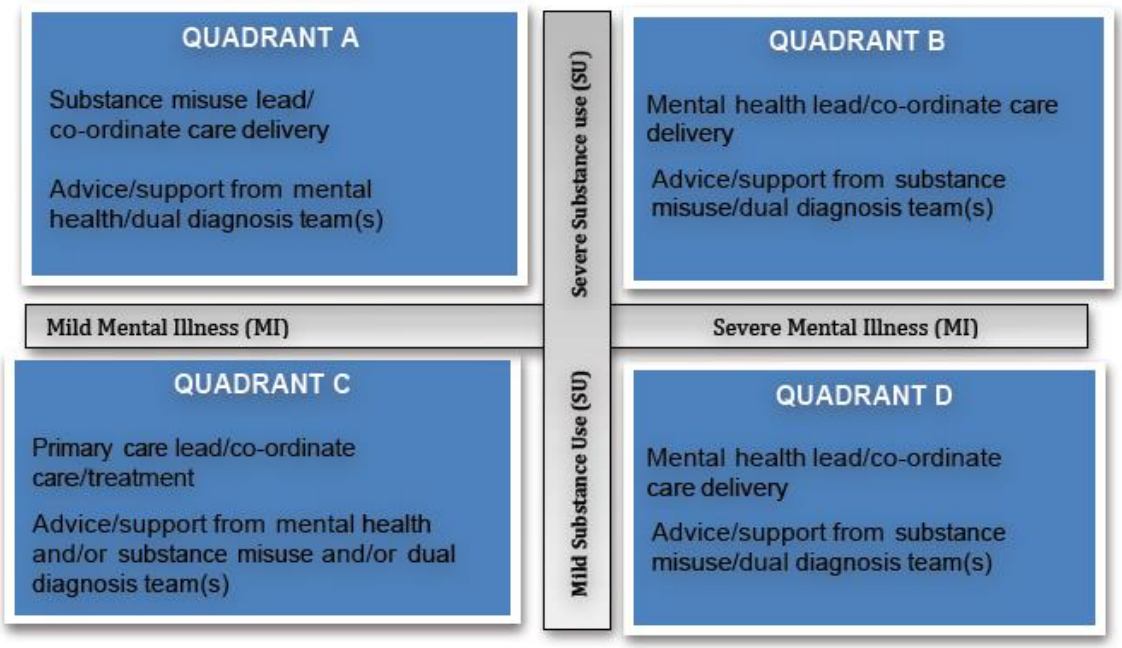
7) Develop a joint training strategy between all agencies that can be implemented realistically and includes mandatory completion of the dual diagnosis e-learning suite/programme.

8) Develop a Dual Diagnosis Link Worker Forum where staff from across all agencies can meet to discuss current practice issues, problem solve difficulties in multi-agency Working, inform service and system development, etc.

9) Develop a dual diagnosis governance structure, of commissioners and providers, with service users and carers at the heart of all service improvement and future development.

10) To ensure the project is independently evaluated within 6 months of the single unit being up and running so as to measure early outcomes and champion success

# DUAL DIAGNOSIS QUADRANT




**Example 1:** A person with schizophrenia who is also regularly smoking cannabis may be best helped within mainstream mental health services and the mental health staff should be able to **assess** and provide some **harm reduction** interventions regarding the cannabis use (health education, motivation, specific strategies if the client wants to reduce their drug use, or signpost to other help). **Quadrant B**

**Example 2:** a person with a history of injecting heroin, and on a methadone maintenance programme who has symptoms of post-traumatic stress disorder (PTSD) will be best placed within **community drug treatment service**, but would also benefit from some input from a clinical psychologist around PTSD symptoms. **Quadrant A**

*Adapted from Department of Health (2002) Mental Health Policy Implementation Guide Dual Diagnosis Good Practice Guide*

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**Web resources**

http://www.bridgend.gov.uk/web/groups/public/documents/report/023364.pdf

http://wales.gov.uk/topics/housingandcommunity/regeneration/communitiesfirst/?lang=en

htttp://wales.gov.uk/docs/desh/publications/110330housingwhqsen

http://www.dh.gov.uk/health/2011/07/drug-and-alcohol-recovery/#1

***Acknowledgements***

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- Craig Smith
- Staff from Gwalia involved in Kerrigan Project
- Ian Hibble
- Geoff Walker
- The Kerrigan project stakeholder Group

## *About the Author*

***JMB Health Consultancy Ltd*** is led by **Julie Butterworth** (RMN, DipHE, BSc Hons, MSc)

With almost two decades of experience as a registered practitioner in mental health, Julie's experience is drawn from the clinical environment, managing and developing services, and more recently as a mental health commissioner within a Primary Care Trust.

Julie has specific experience in:

- Mental Health (adolescent, adult and older adult)
- Substance misuse
- Offender health
- Acquired Brain Injury
- Dual Diagnosis

With particular interest in service and pathway evaluation / review and redesign, and developing value for money strategies in order to commission effectively for meaningful outcomes Julie has worked across the UK (and internationally) supporting both NHS organisations and the Private Sector. With an Honours Degree in Health and Social care, and an MSc in Contemporary Health and Social Care (Leadership and Management) Julie is an associate lecturer at a local university and also undertakes research projects.

Julie is the Director of JMB Health Consultancy and is working freelance as an Independent consultant.

***For more information about how we can help your organisation visit***

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## APPENDIX ONE

## Developing good practice in assisting those who are homeless or vulnerably housed and have Dual Diagnosis Issues

## Expression of Interest

### Please give details of all partners who will be involved and the lead contact:

Bridgend County Borough Council (involving the commitment of Housing, Supporting People, Children and Young Persons' Services, Adult Care Services, Mental Health Services and Community Safety)
Probation Service
ABM Health Service

The lead contact will be Geoff Walker, Housing Options and Supporting People Manager. The lead, and sole funder, on the new project will be Supporting People, Bridgend

### Please describe what services already exist in your area:

There is no current dedicated Dual Diagnosis service.
Assistance is provided in a fragmented way via Health, Psychology, Mental Health and Housing services from several teams and geographical ,locations
The various teams have done their best to join together.

This is why, through the Supporting people Planning Group it was agreed, following gathering of supporting evidence on potential clients, to provide a service for very Vulnerable and Chaotic clients on a single, or two joined-up, sites.

## Please give a brief description of what it is you intend to do or develop:

The project will be funded by Supporting People Bridgend
It will be based at one or two locations (at the discretion of the Provider)

6 units of high level supported accommodation plus one emergency access bed will be provided
Duration of stay will be normally be around 3 months for the 6 bedspaces and 3 days for the emergency bed

The target client group will be:

- Over 18 years old
- Primary needs groups are substance misuse, mental health and offending behaviours

The high level support provided will focus on assessment by all the relevant services in order that appropriate move on can be arranged to the best supported accommodation.
There will be Floating Support attached to the move on arrangements.

An important part of the project will be inreach services *prior to admission* working with prisons, hospitals and the like; relationships will therefore have been built with clients by support staff prior to admission wherever possible (this would not apply to the crisis bed)

Similarly Floating Support will ensure that continuity of service exists when clients move on to the next stage.

This project has been commissioned by Bridgend's Supporting People Planning Group following extensive assessment of the needs of clients who had previously engaged with housing, health, prison and probation services.
All these services support the project and will form part of the ongoing monitoring

**We are expecting to go out to tender imminently – March 2013**

## How do you envisage working with the consultants to develop you idea?

We need advice on how to:

- Co-ordinate the relevant services – health, social care, criminal justice and housing before admission, during residence, and after discharge from the project
- How best to carry out the assessment of these clients whilst they are in residence – "who does what, and when?"
- How to arrange ongoing support after discharge and how that will look
- Timescales – we have no experience of the length of commitment likely to be required for these clients

The availability of expert advice we see as vital to this project.
We feel that existing services have failed many of these clients so far and the new project will prove the best opportunity that Bridgend can to provide a way forward

## How will your pilot idea benefit service users in your area?

- Improvement in physical health; reduced use of alcohol and illicit drugs, leading to:
- Reduced hospital admissions
- Improvement in mental and emotional health
- Reduction on incidence of offending and/or police interventions
- Access to sustainable housing with, in the longer term, supported then independent living
- Improvement in social and life skills
- Access to education, employment and training opportunities

**What are your desired outcomes for your pilot study idea? How will you measure your success?**

| |
|---|
| We feel it is appropriate to use the measures described above (benefits to service users) to measure the success of the project |

**Please submit completed expressions of interest to:**

**Claire Cunliffe,**
**Housing Options,**
**17 High St, Swansea.**
**SA1 1LF**
**(01792 533126).**

**claire.cunliffe@swansea.gov.uk**

**by Friday 22nd February.**

**Thank you.**

**APPENDIX TWO**

Bridgend County Borough Council
Cyngor Bwrdeistref Sirol Pen-y-bont ar Ogwr
www.bridgend.gov.uk

## Kerrigan Project Overview

| Area | Overall Service Specification |
|---|---|
| **Projects & sites included in this Specification** | 6 Units of shared Supported Temporary accommodation, plus 1 emergency access bed space provided at sites central to Bridgend Town.<br><br>Up to 12 units of floating support to facilitate the smooth and seamless transition to move-on and/or sustainable permanent accommodation within the wider community.<br><br>Year 1 of the project provides up to 6 units of floating support.<br><br>Year 2 and beyond of the project will provide up to 12 units of floating support. |
| **Primary Client Groups** | • Homelessness. This will include clients with multiple needs and whom, it is expected, will primarily be hospital and/or prison leavers<br>• Mental Health issues<br>• Substance Misuse issues<br>• Offending behaviour |
| **Additional needs** | Service Users may present with a range of complex needs which may include one or more of the following;<br>• Learning disability<br>• Physical disability<br>• Experiencing Domestic Abuse |
| **Gender** | All |
| **Age range** | Over 18 years old |
| **Model of Service** | Supported Temporary Accommodation Scheme with Floating Support<br><br>7 units (to include one emergency unit) of high quality accommodation which provide high level support with shared facilities, such as communal lounge and kitchens, for people experiencing homeless and with very complex support needs; the scheme will be complimented by up to 12 units of floating support available to Service Users who are moving from the project into the community to promote the maintenance of their |

| | |
|---|---|
| | tenancies and assist with social integration and development of dependant living skills. Support will be available on a 24 hour basis and be able to accept referrals to the emergency 'bed' throughout this period.<br><br>It is expected that after referral to the emergency bed an assessment will be undertaken immediately and move-on take place within 72 hours of emergency admission.<br><br>The Licence to occupy will be issued with the understanding that the Service User will be encouraged to engage in the support to access suitable accommodation and increase independent living skills. Emphasis will however be placed on an expectation of each Service User to behave in an appropriate manner within the project with the appropriate support to help them achieve this and the Provider's method statement will reflect this |
| **Project Aims** | Provide appropriate levels of housing related support to people within the project and the community to develop the skills necessary to sustain a tenancy, to access permanent accommodation and become more independent and less reliant on support services.<br><br>Provide support to access accommodation social landlords and the private rented sector, to provide additional tenancy related support following move on as part of the support plan.<br><br>Provide support and encouragement to change patterns of behaviour in order to work more successfully with the Provider and other agencies in order to achieve sustained independence.<br><br>The project will provide temporary supported accommodation whilst clients are awaiting access to move-on and/or permanent accommodation through Private Sector Rental or Registered Social Landlords.<br><br>Comprehensive advice on housing related matters, including benefits, future housing options, budgeting and debt management. It will also include advice and help to access support in relation to non-housing matters, such as emotional problems, substance abuse, child care and legal problems. Service Users will receive support in developing and maintaining their relationships with health services and social care services.<br><br>Provide support, guidance and encouragement to access appropriate services to assist and promote recovery from substance dependence and address related mental health issues by accessing working with relevant psychology and related health services and voluntary organisations<br><br>Assistance to develop daily living skills. The project will provide support to Service Users in developing their daily living skills, including shopping, preparation of meals and looking after their home. Where this support is required on a long term basis, the project will ensure that the Service |

| | |
|---|---|
| | User has access to support from other agencies.<br><br>Advocacy. The project will assist Service Users to exercise their rights to both mainstream and specialist services. It will advocate with and on behalf of services users in benefit appeals tribunals, social services case conferences, and Adult protection and multi-agency public protection meetings.<br><br>Brokering of services. The project will support Service Users in accessing services and will act in a brokering role to ensure appropriate services are available to the Service User. This will involve close working and liaising with statutory and voluntary agencies to meet the identified needs of the Service User.<br><br>Dispute management and mediation. The project will support Service Users in dealing with neighbour and family disputes, providing mediation, advice and practical solutions. This will include accessing legal help where appropriate.<br><br>Community integration. The project will work with other voluntary and statutory agencies within the context of community integration to support tenants to resettle into their local community. This will involve supporting Service Users to identify options for meaningful day time activities with the aim of developing confidence and skills to access employment and educational opportunities and overcoming social isolation. |
| **Timescale of support / accommodation** | Withdrawal of support as agreed within the needs assessment and support planning process. Duration of support to be for the duration of the stay at the project and normally up to 12 months floating support In exceptional cases support will be provided for up to 2 years.<br>Provision will be made by Gwalia Care & Support for clients in receipt of Floating Support who may need to be considered for moving back to the project. |
| **Referral route** | Via Bridgend CBC Housing Solutions Team. All referrals should be assessed within an agreed referral framework timescale as agreed with the Housing Solutions Team assessment and referral procedure for statutory homeless Service Users. |
| **Pre-referral Support** | Pre-referral support will be provided to facilitate moves into the project, via prison and hospital in-reach services, and in order to maximise the potential for positive outcomes. |
| **Pre-tenancy / Support** | Pre-tenancy support will be provided to support move on and maximising positive outcomes through sustainable tenancies. |
| **Drug/alcohol/smoking policy** | The support plan will be taken in conjunction with individual management and monitoring arrangements.<br><br>Gwalia Care & Support will have a policy on smoking on the premises |

| | |
|---|---|
| | Gwalia Care & Support will have a policy on consumption of alcohol on the premises<br><br>The possession or consumption of illicit or illegal substances within the project and the wider local community is not permitted.<br><br>Gwalia Care & Support will have a policy on how to deal with sharps and other drug taking paraphernalia found on the premises |
| **Out of Hours when applicable** | The facilitation of an on call telephone arrangement to provide out of hours service and incident management and resolution.<br><br>Gwalia Care & Support to provide an appropriate out of hours policy to support this service.<br>This will include facilitating admissions to the emergency bed. |

| | |
|---|---|
| **Support outcomes** | Each Service User will have a Support Plan developed between themselves and Gwalia Care & Support; this must identify goals for each individual. Outcomes to relate to project objectives and the mandatory Welsh Government outcomes framework;<br><br>• <u>Promoting Personal and Community Safety</u><br>  ○ Feeling Safe<br>  ○ Contributing to the safety and wellbeing of themselves and of others<br><br>• <u>Promoting Independence and Control</u><br>  ○ Managing accommodation<br>  ○ Managing relationships<br>  ○ Feeling part of the community<br><br>• <u>Promoting Economic Progress and Financial Control</u><br>  ○ Managing money<br>  ○ Engaging in education/learning<br>  ○ Engaged in employment/voluntary work<br><br>• <u>Promoting Health and Wellbeing</u><br>  ○ Physically healthy<br>  ○ Mentally healthy<br>  ○ Leading a healthy and active lifestyle |

APPENDIX THREE

**Bridgend County Borough Council**
**Cyngor Bwrdeistref Sirol Pen-y-bont ar Ogwr**
www.bridgend.gov.uk

. **Kerrigan Project Stakeholder Group**

# TERMS OF REFERENCE 2013

| **Principle Roles and Responsibility of the group** | |
|---|---|
| 1 | Support the work of the Kerrigan Project in supporting chaotic and complex needs service users. |
| 2 | Provide joint ownership and a multi-agency approach to the support and other interventions provided to the cohort of service users to be supported by the Kerrigan Project. |
| 3 | Discuss and look to address any barriers to joint working in supporting clients within the Kerrigan Project. |
| 4 | Help to facilitate information sharing in respect of risk and support needs of current and potential service users to the Kerrigan Project. |
| 5 | As a Partner representative we ask you to:<br><br>• Positively promote the work of the Kerrigan Project<br>• Facilitate opportunities for discussion/debate in your organisation/department and ensure effective 2-way communication.<br>• Ensure information about Kerrigan Project is fed back to your organisation/department.<br>• Influence the aligning of other resources to the work of the Kerrigan Project where this is appropriate.<br>• Help to ensure key stakeholders are consulted and involved in decisions taken that may affect them. |
| **Membership** | |
| 1 | Representatives from the following partners will support the work of the Stakeholder Group:<br>• Gwalia Care & Support<br>• Valleys to Coast<br>• BCBC<br>• Youth Offending Service<br>• Probation |

| | |
|---|---|
| | • Community Mental Health Team<br>• Community Drug & Alcohol Team<br>• South Wales Police<br>• Community Safety Partnership<br>• Just Ask Plus<br>• ABMU<br>• Integrated Offender Interventions Service<br>• HMP Parc (Transitional Support Scheme) |
| 2 | Relevant additional members will be co-opted from time to time. |
| **Chair** | |
| 1 | Chair for the first year of operation will be from the BCBC Supporting People service. The position will be re-elected annually, when terms of reference are reviewed. |
| **Frequency of meetings** | |
| 1 | Meetings will be scheduled in September each year for the following 12 month period. |
| 2 | The Group may wish to hold additional interim meetings when required. |
| 3 | Scheduled meeting dates may be altered. |
| **Reporting Arrangements** | |
| 1 | Each member of the Group shall be responsible for reporting back to their organisation/dept. |
| 2 | Notes of meetings will be circulated to each member, present or not. |
| 3 | Project updates and developments will be reported to the Supporting People Planning Group on a six monthly basis. |
| **Review** | |
| 1 | Terms of reference will be reviewed annually by the Group. |

APPENDIX FOUR

## PRINCIPLES OF SUPPORTING PEOPLE WALES OUTCOME FRAMEWORK

### Outcome Areas

*Service users are*:

**Promoting Personal and Community Safety**

1. Feeling safe
2. Contributing to the safety and well-being of themselves and of others

**Promoting Independence and Control**

3. Managing accommodation
4. Managing relationships
5. Feeling part of the community

**Promoting Economic Progress and Financial Control**

6. Managing money
7. Engaging in education/learning
8. Engaged in employment/voluntary work

**Promoting Health and Wellbeing**

9. Physically healthy
10. Mentally healthy
11. Leading a healthy and active lifestyle

### What are the Measures of Achievement?

When assessing progress against agreed goals, the support worker and service user will identify where they are in relation to the following 5 'steps' (the steps have not been named to allow each service provider to use their own language to determine these steps):

**Step 1**

- The Goal for service provider at this stage is to prevent or minimise harm to service user & others and to develop trust with the service user.
- At this stage the service user may be unwilling to discuss this area of their life or may be difficult to engage with.

- Service users should be supported in preventing the situation from getting ‘any worse’ until progression in this area can begin.

**Step 2**

- Service users may be willing to discuss this area, however unclear of how to make progress and needs considerable support in order to take the next steps.
- The service is focused on supporting the service user to increase their stability and give access to resources that help set a goal in this area.
- Service users may need considerable support to accept that they can control this area of their life.
- This may be where support is in initial stages and due to a number of factors (e.g. risk, health, capacity, prioritisation) support worker may be taking lead in number of life areas

**Step 3**

- Service users will have started to believe they can make a difference/change to this area of their life & will accept use of specific time-bound goals in order to achieve expected outcome.
- This stage should focus on encouraging service users to work towards achievable goals on their own whilst providing support should they need it; but not doing it for them.
- Service users should be supported to reflect on what has gone well and positively supported when things have not gone well.

**Step 4**

- Service users should be supported to deal with difficulties themselves and to become more self-reliant and knowledgeable of how to seek support from an organisation without their support worker.

**Step 5**

- Service users should now be able to manage most issues in this area on own.
- Service users should be accessing services without support majority of time and supported to understand when/if they need extra support in this area.
- Service users should feel confident enough to start supporting themselves in dealing with issues in this area.
- In long-term services: service users will accept they may always need support in this area but they are maintaining their optimum level of independence in achieving their goal or preventing loss of optimum independence by having long-term support.

APPENDIX FIVE

## Kerrigan Project

## Setting Key Objectives – Bridgend CBC and Gwalia Care & Support

| |
|---|
| Name of Organisation |
| Lead Name |
| Lead Contact |
| Overall Strategic Aims of the Kerrigan Project for your Organisation |
| Key Priorities |

APPENDIX SIX

# Achieving objectives for the Kerrigan project

**1. Has your organisation placed any service users within the Kerrigan Project?**

- Yes
- No
- I have made referrals but they have been declined
- I currently have a referral being considered
- My referrals are not suitable for the floating support model
- My organisation is not responsible for making referrals

**2. Do you feel that the Kerrigan project has worked closely with your organisation in assessing and managing your service users?**

- Yes
- No
- Not applicable

**3. Have Kerrigan project staff been involved in the compilation of formal risk management plans within your organisation?**

- Yes
- No
- Not applicable

**4. Do you feel the accommodation is suitable for the clients it aims to support?**

- Yes
- No
- Not applicable

If you answered No please could you specify why?

## Achieving objectives for the Kerrigan project

**5. Do you feel the Kerrigan project is effective in managing risk and re-offending behaviours?**

- Yes
- No
- Don't know

If you answered No, please could you advise how this could be improved

**6. Do you feel the Kerrigan project is appropriately resourced to support successful transitional arrangements from children's to adult services?**

- Yes
- No
- Don't know

If you answered no to the above question, please could you advise a rational for your answer

## Achieving objectives for the Kerrigan project

**7. Thinking about the Kerrigan Stakeholder Project Group, do you think the correct partners have been involved in the decision making?**

- ◯ Yes
- ◯ No
- ◯ Not sure

If you answered No, please could you provide a rational for your answer

**8. Do you think that a clear defintion of what constitutes 'vulnerability' has been provided by the Kerrigan stakeholder project?**

- ◯ Yes
- ◯ No
- ◯ Dont know

**9. Is there a clear criteria for referral to the Kerrigan Project and do you know the process?**

- ◯ Yes
- ◯ No
- ◯ Don't know

**10. Do you feel the Kerrigan Project inclusivity criteria is appropriate?**

- ◯ Yes
- ◯ No
- ◯ Don't know

If you answered No, please could you advise why?

Page 3

## Achieving objectives for the Kerrigan project

**11. Do you feel 'Dual Diagnosis' is a key priority for the project?**

- ◯ Yes
- ◯ No
- ◯ Don't know

If you answered No, please can you advise what the priority is

**12. Do you feel involved in the decision making process for accessing services from the Kerrigan Project?**

- ◯ Yes
- ◯ No

If you answered no could you specify why?

## Achieving objectives for the Kerrigan project

### 13. Do you feel communication is effective within the stakeholder steering group and supporting people?

- Yes
- No
- Dont know

If you answered no could you advise your reasons for this

### 14. Do you feel the stakeholder group has embraced the concept of multi-agency working?

- Yes
- No
- Don't know

If you answered No to this question please could you advise why?

# Achieving objectives for the Kerrigan project

## 15. Do you think that a floating support model is sufficient for the needs of your client group?

- Yes
- No

If you answered no to this question, please advise why.

## 16. Overall, how successful has the Kerrigan Project been in meeting with your expectations and original objectives? (Please select all answers that apply.)

- Excellent
- Good
- Poor
- This is a work in progress
- N/A

Please provide a rational for your answer

## 17. Please could you select an answer below that you feel applies

- I would be interested in being involved in further projects like this
- There continues to be a gap in our area for projects like this for vulnerable and chaotic people

**18. Finally, we understand that the project is not yet being delivered from a 'single unit' and that floating support is the model being offered at present. Please could you provide any comments in relation to the project so far, and any thoughts or future considerations?**

Thank you very much for participating. That is the end of the survey. Your help and feedback is much appreciated.

APPENDIX SEVEN

# Kerrigan Project staff survey

**1. What is you role within the Kerrigan project?**

- Support
- Worker
- Team Leader
- Manager

**2. Did you undertake the on-line dual diagnosis eLearning suite**

- Yes
- No
- I have yet to undertake it
- I am not aware of this training

**3. If you have undertaken the dual diagnosis eLearning modules, please can you rate the usefulness of this**

- Excellent
- Good
- Poor
- Not applicable (I Have not completed it)

**4. How appropriate are the referrals received in line with the overall objectives of the project?**

- Appropriate
- Not Appropriate
- I don't know

# Kerrigan Project staff survey

**5. Do you feel supported by the referring agent when undertaking your assessments?**

- Yes
- No
- Sometimes

If you answered no or sometimes, please could you tell us why?

**6. Please could you advise which agencies are effective in supporting your service users.**

- Mental Health Teams
- Social workers
- Substance Misuse teams
- Probation
- Police
- Other

If you answered 'other' please could you advise who

**7. Please could you describe the positive aspects of the work you undertake with chaotic and vulnerable service users and what works well?**

## Kerrigan Project staff survey

**8. Please could you describe the Negative aspects of the work you undertake with chaotic and vulnerable service users and what doesn't work particularly well?**

**9. Finally, could you tell us what you think would help to improve experiences working within the Kerrigan Group at Gwalia?**

- ◯ Support from managers in Gwalia
- ◯ More training on Dual Diagnosis
- ◯ Support from wider the Mult-Disciplinary Teams (Health, social care etc..)
- ◯ Somthing else

If you ticked 'something else' please can you tell us what this might be?

THANK YOU FOR TAKING THE TIME TO COMPLETE - THIS IS THE END OF THE SURVEY