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

DEVELOPING STRATEGIC PARTNERSHIPS FOR DUAL DIAGNOSIS – THE WESTERN BAY COLLABORATIVE

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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. The Western Bay Supporting People Collaborative proposals

One of the four successful pilots was that of Western Bay wherein the Regional Collaborative Committee had identified in their Regional Commissioning Plan those with Complex Needs as a shared priority for commissioning activity; the Complex nature of need being characterised by co-occurring Mental Health and Substance Misuse (Dual Diagnosis), with emerging personal care needs. These complex and vulnerable individuals were identified as spanning the age groups from 16 to 60 plus

A paper identifying some of the issues around the needs of this group with co-occurring comorbidities was presented to the Substance Misuse area planning board in 2012, and identified some local issues which defined the group as

> "*The greatest numbers of those clients supported by colleagues in homelessness organisations have problems so complex and entrenched that they have already slipped through the social care net; such as to the point that they have become roofless or are existing in highly insecure accommodation. It would be fair to say that they are the most vulnerable individuals and the least likely to access services".*

The concept of '*tri-morbidity'* was readily applied to this group.

Within the tender proposal, Western Bay Collaborative identified some specific provision that would assist this group:

- There is a general Homelessness Nurse in place in Swansea.
- The Health of Homeless and Vulnerable Groups Steering Groups established is led by Health. The Swansea Locality group has secured funding for a Mental Health Outreach nurse in place.
- There is one year temporary funding in place for a dual diagnosis nurse approved by Abertawe Bro Morgannwg University Health Board (ABMUHB) Mental Health Directorate.
- Supporting People Programme Swansea is funding a Complex Case Coordinator for individuals who are vulnerably housed and have substance misuse and exhibit chaotic (undiagnosed or diagnosed mental health issues) and have emerging personal care needs which will be based within the Community Resource Team.
- There are a range of supported housing services and floating support services in place across the region providing accommodation and support to individuals with dual diagnosis.
- There is a single assessment service for substance misuse AADAS in place.

3. Western Bay project proposals

3.1 The Consultant role

Within the original tender, the Western Bay Collaborative identified that they would utilise the dual diagnosis consultants of JMB Health Consultancy Ltd to ensure the various key partnerships collaborate to identify and understand the issues regionally and within localities which are potential barriers to achieving the outcomes. This would hopefully therefore make recommendations for what could be done differently within existing resources of each partner agency in order to achieve the overall outcomes.

The tender requested that the use of the consultant time would focus on:

- Developing a shared understanding of partners and of the perceived barriers to accessing appropriate services and improving individual and service outcomes
- Identifying the resources which partners can influence
- Identifying where the focus/criteria for access to these resources currently leave gaps.
- Developing a plan on how those gaps could be addressed within existing resources and embracing collaborative working
- Identify key indicators for monitoring improvement performance
- Monitor the implementation of the plan.
- Individuals with co-occurring Mental Health & Substance Misuse issues having access to appropriate services
- Individuals will have improved outcomes

An early methodology was suggested that the consultancy would undertake a collective performance review with stakeholders i.e. a joint planning/development 1 day or two 1/2 days with the key relevant partnerships e.g. Regional Mental Health Commissioning Group & the SMAT Area Planning Board & Western Bay Supporting People Regional Collaborative Committee with provider organisations and service users.

3.2 Proposed outcomes of the pilot

The pilot aimed to link the work involved at a regional level around dual diagnosis, co-occurring mental health and substance misuse issues with those in supported housing, vulnerably housed or homelessness to ensure that the needs of these service users are supported holistically or in a joined up way across agencies and that:

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- Partnerships are strengthened and clear goals are identified
- An improvement plan will be produced to deliver transformation
- Key indicators will be in place to monitor improvement

4. Project delivery

4.1 Project specifics – Initial stages (May 2013)

A meeting was proposed for 8th May 2013 at St David's Bay wherein all pilot leads were invited to attend a one to one meeting with the Consultants to discuss the pilot and out together initial project plans. Unfortunately the project lead was on annual leave and unable to attend, however two representatives from the mental health teams attended in her absence. These plans were then presented the following day to the Supporting People leads in Cardiff.

4.2 Project plan for Western Bay

It was suggested at the meeting that the Consultants would:-

- Undertake a service mapping exercise through a collective performance review'
- Identify and share best practice
- Undertake a gap analysis and identify barriers to progress
- Identify areas requiring improvement and make recommendations

5.3 proposed project timescales

PROJECT TITLE	**Pilot 4 – Western Bay**		
AREA OF FOCUS	INTERVENTION	TIMESCALES	PROPOSED COMPLETION
1. Fieldwork	Initial meetings in Cardiff Service mapping session Service user case studies Support to establish a network/service directory Gap analysis Follow-up	6 days 2 days	May 2013 – Jan 2014
2. Administrative	Monitoring Report writing Feedback	4 days	Feb 2014 March 2014
TOTAL		**10 days**	

4. Early Findings

4.1 Strategic issues (multi-agency)

One of the key problems suggested by the attendees at the meeting in May 2013 was there were a number of key strategies developed individually within Swansea, Neath Port Talbot and Bridgend (Western Bay collaborative) for:

- Homelessness
- Supporting People
- Substance Misuse Teams
- Adult Mental Health Strategy
- Children's Mental Health
- Probation

The staff therefore felt it was difficult to collaborate a pathway with differing priorities and felt it would be useful to have a mapping exercise where key members of each of the organisations across the 3 regions came together to champion good practice that could be shared.

A service mapping exercise was suggested for late summer 2013.

4.2 Operational difficulties (dual diagnosis)

In addition to the strategic needs of those delivering key agendas, there were also key barriers identified that affected the service users who accessed the individual agencies which could be discussed.

In considering the needs of the client group, it was suggested that the greatest number of those clients supported by homelessness organisations have such complex and entrenched problems, that they have often already slipped through the 'social care net', to the point where they have become either roofless, or are existing in highly insecure accommodation. It is therefore fair to suggest that they are the most vulnerable of individuals, and the least likely to access services with the concept of tri-morbidity readily applied to this group; co-occurring problems of physical health, mental health and substance misuse.

In considering how to improve the quality of Substance Misuse Services (SMS) to homeless people, there needs to be an acknowledgement of the depth of support needs required of homelessness workers who are intended to provide much of the day-to-day support that will help keep this group of vulnerable and often chaotic clients engaged in dual diagnosis services.

The Dual Diagnosis lead was able to identify the following practical barriers and issues at the start of the project:

The Single Assessment Service

It was acknowledged that the situation had improved since the inception of Abertawe Alcohol & Drug Assessment Service for adults (AADAS). However, this is most productive when an AADAS staff member can be accessed instantly, due to the opportunistic style of intervention required of the homelessness worker. When the worker is unable to get through on the telephone, the opportunity can be lost; but person-to- person contact means that agreed outcomes can then be facilitated and supported. Letters sent to homeless people were seen to be of little value, and equally, few homeless people have telephones.

Appointments

Notification of appointments made in relation to homelessness issues conveyed by letter are of extremely limited value, however, if homelessness agency staff, (with the client's permission) are copied into any correspondence, support to attend is therefore facilitated

Time, Distance and the Cwmbwria Methadone Dispensing Machine

It was reported that there were problems for people being able to get to an agency on a daily basis, particularly if there were long distances to travel. Community Pharmacies were suggested as substitute prescribing venues, offering flexibility, and were seen as the generally preferred option.

There were however additional difficulties associated with the Cwmbwrla Dispensing Machine. One of these was distance; for example, a 'floating venue' Night shelter arrangement exists in Swansea; sometimes this will be in the Lyndon Church, West Cross, which is several miles away from Cwmbwrla. The period during which Cwmbwrla could be accessed was also seen as a problem with 'strict times' suggested by some, and often set for morning attendance. This frequently conflicts with other agency issues, such as the daily registering for emergency beds, which must be done before 12.30pm. Also, some service users may have spent the night in custody. Where homeless patients are required to attend Cwmbwrla daily, one suggestion for improvement is to offer afternoon appointments

Dual Diagnosis

Although recognised as being more of an issue for Mental Health Services rather than SMS, access to treatment for mental health problems when homeless was seen as unacceptable. It was estimated by the dual diagnosis lead that 75% of the group had either diagnosed mental health problems, and/or issues with self-harm, suicide and drug-related mental health issues. It was perceived that Statutory Agencies were reluctant to 'take the lead' in co-ordinating care for such individuals, with mental health services unable to assess someone whilst under the influence of drugs or alcohol. This in turn leads to a referral to SMS, which typically results in being put on the waiting list, despite mental health needs often being acute. In addition, where homeless people have been discharged from Cefn Coed hospital this was reported as generally being to Bed and Breakfast type accommodation, with issues such as the exclusion of this client group from mental health Crisis Intervention and Home Treatment Team

Alcohol

It was stated that by far the biggest substance misuse issue for the client group was in relation to alcohol, but SMS was often perceived as being around the needs of opiate misusers. It was also noted that homeless people, including those in hostels and night shelters, were limited to hospital-based detox only due to NFA for community treatments.

Discharge for Non-Compliance

It is recognised that patients who fail to turn up for several dispensing appointments will require re- assessment for medical reasons. However, in terms of discharge, and in view of their unique problems, it would be helpful if more flexibility could be afforded to homeless people (where it is safe to do so) who sometimes fail to meet contractual obligations with prescribing services.

Dedicated Homelessness Staff in Commissioned Services/ Professional Input by Homelessness Agency Staff

It was noted that as the situation currently exists, there were no SMS staff with a brief specifically dedicated to the needs of homeless people, whether nursing, medical, social work or SMS agency worker. It was felt that the existence of such a post would lead to a more holistic approach that would help pull all of the strands together and lead to the creation of formal care pathways. It is recognised that homelessness agency staff were quite typically involved as co-professionals with statutory services in areas of child protection, but not in areas of substance misuse and mental health. It was requested that the opportunity for them to attend multi-disciplinary meetings concerning mutual clients and contribute to the delivery of holistic care be considered.

5. Project summary

Although some key barriers and project groundwork had been presented early on in the project, the consultants were unable to pursue the project further due to the following issues:

- Although a service mapping exercise was proposed by those attending the meeting in May, it was suggested in July that this information was in fact already available and therefore not a productive use of the consultants time

- A follow-up e-mail was sent in August 2013 to request clarity on the next steps for the consultants however no further response was received.

A pilot interim update report was issued in January 2014 by Homelessness and Supporting People Networks Co-ordinator wherein it was suggested at this late stage that the project in Western Bay was unlikely to continue due to conflicting local pressures.

The focus of the time was therefore considered within the context of the other pilots.