Newport Dual Diagnosis Pilot

Developing a local collaborative approach to working with co occurring mental health and substance misuse using e-learning

Prepared by: Ann Gorry
Independent Consultant
Port Business Solutions
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Executive summary

Much of the policy and good practice guidance relating to Dual Diagnosis (co occurring mental health and substance misuse) has focused on local areas developing a more integrated, joined up approach to working with this complex, often vulnerable and ever increasing population of service users.

The Newport co occurring pilot project has focused on this area in particular as a key challenge for a wide range of statutory and third sector agencies for service improvement and development.

Work on this project commenced in July 2013, and to date, due to a number of issues, has not been able to produce all the service improvements in line with the initial aims identified at the beginning of the pilot. This highlights some of the many challenges associated with working in this area, often due to the number of agencies involved in the treatment journey when working with this client group.

However, progress is being made, albeit slowly. And work is heading in the right direction and many of the aims of this pilot will be achieved as the work develops.

One of the original objectives of the Newport pilot has been fully met, namely the production of a suite of e-training modules on Dual Diagnosis, the challenge however is to ensure that relevant front-line staff are identified and encouraged to access the on-line training as appropriate.

Ann Gorry
Dual Diagnosis Service Improvement Consultant

1. Introduction and background

Co occurring mental health and substance misuse occurs in over half of acute in-patient admissions to mental health units; over one third of people with a diagnosed psychotic illness also misuses drugs and/or alcohol; and drug and alcohol services see a high number of people who also have mental health problems, between 50 to 80% in some services. it remains, therefore, an area of high priority across all sectors.

In the recent strategy *'Together for Mental Health' (2012)* the Welsh Government highlighted the need for an integrated approach to the delivery of care across substance misuse and mental health services. A key aim within this strategy was to:

'Bring services together to form a single, seamless, comprehensive system for addressing mental health needs across all ages"

The need for a co-ordinated and integrated approach was further reinforced by the Welsh Governments Substance Misuse Strategy, '*Working Together to Reduce Harm 2008-18'* which stated that:

'Services must collaborate if the needs of service users with both substance misuse and mental health problems are to be properly addressed and individuals are not to fall between gaps in services'

A conference organised by Cymorth Cymru/Public Health Wales, was held in Cardiff in January 2013, which highlighted some of the issues and inequalities in provision for homeless and/or vulnerably housed service users experiencing co-occurring mental health and substance misuse difficulties. It was noted that services were often patchy and non-existent in some areas; resulting all too often in service users being passed around and in-between services, and not receiving any meaningful interventions as a result of this.

The conference was well attended with a wide cross section of providers from across Wales represented. Discussion and debate identified and explored examples of good practice both nationally, internationally and locally. Expressions of interest were invited for local areas to 'bid' for an opportunity to become one of the pilots. This process did not offer any direct funding, but input from an independent consultant.

2. Introduction to the Newport Pilot

Following submission of an expression of interest protocol, (Appendix 1) one of the four successful bids was the Newport pilot. The identified pilot lead was Nigel Stannard, Supporting People Manager, NCC Social Services.

2.1 Background to the Project

Meeting the needs of people in Newport with co-occurring substance misuse and mental health problems is a challenge for partners in both statutory and voluntary sector services.

The number of people who have mental health and substance misuse problems is increasing. Due to their often complex needs and in order to provide effective care, it is vital that there is a co-ordinated approach to assessment and intervention, involving a range of partners. No single body or sector can meet the needs of people with co-occurring problems and there must be effective partnership working between health professionals in both primary and secondary care, Local Authority staff; the Third Sector and the Independent Sector. Most importantly service users and carers must be at the heart of decision making and care planning as far as possible, being in control of their treatment journey.

2.2 The key aims of the project:

- Identify the barriers to accessing pathways for those with co-occurring mental health and substance misuse difficulties.
- Support the 'up skilling' of key agencies to enable more effective working and co-ownership with this client group.

2.3 Outcomes of the Project:

- Increase the level of joint working resulting in a more integrated approach.
- Increase the quantity and improve the quality for service users accessing services at the right point and the right time across the pathway.
- Ensure frontline staff receives the appropriate level of training resulting in increased confidence and competence in dealing with people with co-occurring mental health and substance misuse difficulties.

2.4 Local services

St Cadocs Mental Health Hospital – 1 detox bed and in-patient wards
2 x Integrated Community Mental Health Teams
Mental Health Hospital Liaison Team
Assertive Outreach Team
Early Intervention Team
Home Treatment Team
Gwent Specialist Substance Misuse Service
Young Persons Specialist Substance Misuse Service
Barnardo's B@1 Project for young people with SM problems
Child and Adolescent Mental Health Service
Kaleidoscope Drugs and Alcohol services inc. open access, community prescribing, alcohol counselling and supported housing
ABHB Community Detox. ABHB Gastro Surgery Detox.
Dr James Leney – Substance Misuse lead GP for Gwent
Integrated Family Support Team intensive multi -agency support for families with SM and child protection issues
CRi DIP service and DRR testing
Solas Cymru supported housing alcohol/drugs/mental health schemes

Gwalia Care & Support supported housing and floating support drugs/alcohol and mental health schemes
Llamau young person's supported housing and floating support schemes
Julia Lewis Principal Public Health Practitioner substance misuse
ABHB Primary Care Mental Health Teams in GP surgeries
Gofal Cymru in-patient resettlement support at St Cadocs MH Hospital
Newport MIND, counselling, group work, day activities, supported housing, BME and floating support schemes
Public Health Wales senior officer with substance misuse specialism
SM Service User Group

3. Newport project proposals

3.1 The original proposals submitted for the pilot

- To develop an inter-agency referral pathway for service users with dual diagnosis to access appropriate services in a timely manner.
- To assess the existing Newport Drug and Alcohol Service information sharing protocol and widen the scope to include wraparound/lower tier services.
- To create a suite of e-training modules on dual/triple diagnosis for professionals and third sector workers.

3.2 Challenges and barriers to implementation

- General lack of engagement from Health.
- No substance misuse social worker in post in Newport Social Services throughout the pilot period. (Caerphilly Council has 3 SWs with approximately the same level of need as Newport, and they have had training in co-occurring mental health and substance misuse).
- The new Integrated Mental Health Service Manager (Health and Social Care) was in post for only part of the pilot period and left the post 3 months before the end of the pilot.
- In retrospect, the project lead should have been led by Health rather than Supporting People or Homelessness.
- The new Gwent Mental Health Strategy was in its very early stages, and the actions for people with co-occurring issues were yet to be clarified between that strategy and the emerging Gwent Substance Misuse Strategy, which is being developed by the newly formed Substance Misuse Area Planning Board (APB).
- The APB was still undertaking the needs assessment for alcohol and substance misuse services during the pilot period.
- Newport has recently completed a re-modelled provision for drugs and alcohol services – the Newport Drug and Alcohol Service (N-DAS). This includes the development of a 'single point of access' to all services and referral pathways for both adults and children. (www.ndas.mycommunityonline.co.uk)
- The adult referral pathway does note access to 'Tier 4' services, including residential and community detoxification and rehabilitation, but does not directly

consider treatment services for people with co-occurring issues.

- The lack of in-patient detoxification beds available in the right place at the right time**,** e.g. St. Cadocs Hospital (mental health unit) has only one dedicated detoxification bed available, and Social Services has a limited budget available for out of area residential provision for this service user group.
- Poor response to the project group's initial questionnaire.
- Over-ambitious in the scope of the project, as decisions on creating and implementing referral pathways could only be taken at a higher strategic/commissioning level in health and the local authority – who weren't represented in the pilot project group.
- Primary Care Mental Health Teams were only just beginning to be operational within local GP Practices during the pilot; therefore their effectiveness has not been evaluated. Acting as 'gatekeepers' these teams are able to refer service users on to statutory health and social care services including Gwent Specialist SM Service, CMHT's and prescribing and counselling teams etc. and are therefore crucial in this process.

4. Aim of the report

The aim of this report is to provide an overview and understanding of the project and track the progress to date. It is also hoped that the lessons learned, and progress made, will serve as an example of good practice as well as learning aid for dissemination across Wales.

5. Project Management

5.1. Role of the consultant

As outlined in the initial proposal, the role of the external consultant, in this instance Ann Gorry, was initially to provide guidance and expertise, then to support the development of the project to the agreed completion period (March 2014).

5.2 Initial timeline/project plan:-

Focus Area	Intervention	Timescales	Proposed completion
Fieldwork	Support the work of the task and finish group Meet with agencies to identify areas of good practice and potential barriers As part of the group work, to share e-learning resources and explore development of a training plan Follow up	3 days 2 days	July – December 2013
Administration	Monitoring Report writing Feedback/follow up	3 days	Jan – March 2014

It should be noted that due to barriers which will be explored later in the report, this initial timeline/project plan did not materialise as planned. However, despite a delayed start, and difficulties with engagement and leadership etc. the work is developing and it is hoped that there will be greater success throughout the coming year.

5.3 Meetings, participation and communication

A total of 7 meetings have taken place throughout the pilot period. 3 project groups; 3 questionnaire sub-groups; and 1 meeting with the project group and the Consultant. Unfortunately the project group meetings were poorly attended, partly due to short notice, with a small core group emerging to carry forward the project.

The questionnaire sub-group was carried forward by 3 members who took on the work relating to the questionnaire. (Appendix 2) Although the results of the questionnaire did not yield any new information, it did, however, corroborate the understandings and opinions of the wider project group – which was that key personnel needed to be involved in this project to bring about any change, and this would be difficult to do without support and approval from a higher, or more strategic level across several organisations.

As mentioned above, key people were unable to attend the meetings, or had left/changed their roles, or were not appointed during the pilot period, or saw the pilot as low priority compared to other work loads. This has caused many difficulties, and has been the most significant reason why this pilot has not progressed as initially expected.

6. The demographics of Newport and the Aneurin Bevan Health Board

Newport forms the gateway between Wales and England and is the economic motor for the south east Wales region. It covers a geographical area of just over 73.5 square miles. It is a vibrant, forward-thinking city steeped in a rich industrial heritage.

Newport is undergoing major changes with many parts of the city being redeveloped, in the hope of creating a better environment for people to live, work and of course to visit. The main aim of this development is to revive the centre and surrounding districts to make it a more sustainable city where people can live within closer proximity to their workplace and shopping, with the intention to encourage the use of public transport.

Newport has a key regional role within south east Wales and partner agencies are working together to regenerate the city into a thriving centre for business, leisure and living.

6.1 Population

The unitary authority area of Newport is the third largest urban centre in Wales. The latest estimates (2012) reported the population as 146,100 with an expected increase by over 4% between 2010 and 2020 (ONS 2012), with an increasing ageing population. Estimates report 23,700 people (aged 65 and over) are now living within the authority area. This includes a greater proportion of people over 75years. The birth rate per thousand people

in 2009 was also slightly above the national average for Wales.
Newport is the second most diverse unitary authority in Wales after Cardiff, and the number of people from non-white backgrounds has continued to increase from 4.8% to an estimated 6.2% (8,700 people) in 2009. This is a higher proportion than for Wales as a whole. (Stats Wales) Newport also has a high rate of turnover for asylum seekers, which has changed from 30% in 2010 to approximately 90% in 2011 (source: Home Office)

7. Membership of the Co-occurring Strategic Development Group

Organisational Lead - Nigel Stannard, SP Manager

7.1 Key partners/Core group members

Name	Title /role	Organisation
Simon Rose	Housing needs manager	Newport City Council
Ian Price-Jones	Substance misuse lead officer	Newport City Council
Gill Phillips	Contracts and Review Officer (SM)	Newport City Council
Tirzah Anderson	Project Manager	Solas Cymru
Colin Jones	Project Manager	Gwalia Care and Support
Sian Chicken	Service Manager	Kaleidoscope Project
Mat Burns	Community Psychiatric Nurse	Community Mental Health Team
Dianne Watkins	Partnership Officer	Aneurin Bevan Health Board
Julia Osmond	Principal Public Health Practitioner	Public Health Wales
E-mail group		
Jamie Harrison	CMHT Manager	Newport Integrated Community Mental Health Team
David Bland	Director	Newport Mind
Nigel Spacey	Team Manager	Gwent Probation LDU
Dr. James Leney	GP/Substance Misuse lead	Aneurin Bevan Health Board

8. Review of relevant policy guidance and good practice

8.1 Context

Providing appropriate services and responses for people with co-occurring mental health and substance misuse problems remains a real challenge for frontline health and social care services. (DoH 2002) This group of Service users typically use health, social care, statutory and voluntary sector services much more, and subsequently cost more as a result. (NHS Confederation, 2011)
This co-morbidity is associated with a number of adverse consequences including:

- Poorer physical health outcomes
- Reduced compliance to medication and treatments
- Increased involvement with the criminal justice system

- Increased suicide rates

8.2 Trends across England

Since the Dual Diagnosis Good Practice Guidance in 2002, there have been several developments in this field, and good progress has been made despite a lack of 'must do' targets.

Research shows that alcohol dependence is more common in particular across vulnerable groups, such as homeless people and those involved with the criminal justice system. Across the general population 9.3% of men and 3.6% of women are reported as being alcohol dependant. Approximately 3.5% of adults are reported to be dependent on other drugs within the previous 12 months, with cannabis being the most common illicit drug within these classifications. (Mental Health Network, 2009)

Combining the information on long-term trends of misuse with what is known about increasing prevalence of common mental disorders, the overview suggests that the numbers of people likely to have a dual diagnosis of substance misuse and mental health is likely to have increased. The estimated percentage of the population across England meeting the criteria for one common mental disorder has increased from 15.5% (1993) to 17.6% in 2007. (MHF, 2009)

In addition to studies relating to prevalence, a Dual Diagnosis themed review took place in 2006/2007 which was the largest audit of NHS mental health provider services in England. The key recommendations reported from this review to provide modern, effective provision for people experiencing Dual Diagnosis (co-occurring mental health and substance misuse) featured the following:

1. There should be a clear designated individual responsible for the strategic development of services for this client group. Ideally a named individual who supports a forum for decision making.
2. There should be a clear local, agreed definition of the target population which should also include those with less severe mental illness and substance misuse.
3. Service users' views should be collected to understand satisfaction with services as well as unmet needs.
4. Workforce capabilities should be strengthened through appropriate resources.
5. Joint stakeholder ownership of local strategies in which the development and training needs of staff working with this client group are addressed.
6. Assessment and care co-ordination should include substance misuse problems and physical health care needs.
7. The recording of effective user defined outcomes should be encouraged leading to the development of a local outcomes framework.

8.3 Developing a capability framework for working effectively with people with co-occurring mental health and substance use problems

Throughout the last decade all the policy and good practice guidance has stressed the need

to improve the confidence and competence of practitioners working with this client group. Anecdotal evidence and research has repeatedly put lack of training, understanding and awareness as one of the main barriers to working effectively with this group, and at the forefront of the negative attitudes and stigma often associated with co-occurring mental health and substance misuse.

The Dual Diagnosis National Program commissioned a piece of work to begin to set out a competency framework for staff across Health, Local Authority, Statutory and Voluntary Sector organisations. 'Closing the Gap' (Hughes, 2006) was produced to address this deficit. The framework is divided into 3 sections: Values, Utilising Knowledge and Skills, and Practice Development. Within each section, there is a list of capabilities relevant to that area. Each capability is defined on three levels of competence.

Level 1: Core
Service User Needs: Service users who are at risk of developing long term problems with substance use and mental health. People with more severe problems who come into contact with these agencies and workers as first point of contact. People engaged with other agencies and for whom the worker plays a specific role in their care.
This level is aimed at all workers who come into contact with this service user group especially as first contacts to care.
Example: primary care workers, A & E staff, police, criminal justice workers, housing, support workers, health care assistants, non statutory sector employees, volunteers, service users, carers, and friends

Level 2: Generalist
Needs: People with moderate problems with a range of problems relating to substance use and mental health problems, also including potential physical and social needs.
This level is aimed at generic post-qualification workers who work with dual diagnosis regularly, but don't have a specific role with this group.
Example: mental health social workers, mental health nurses, psychologists, psychiatrists, substance use staff, occupational therapists, probation officers.

Level 3: Specialist
Needs: People with chronic long term and complex physical psychological and social needs. Aimed at people in designated senior dual diagnosis roles who have a responsibility to manage and train others in dual diagnosis interventions.
Example: Dual Diagnosis Development workers.

This structure has been replicated across England and serves as a framework for Dual Diagnosis training programmes and strategies in numerous localities. It is hoped that this can be utilised when the Newport co-occurring strategy develops over the coming months.

8.4 Developing capable practitioners

Mental health and substance misuse services have historically evolved separately and with differing philosophies towards treatment. This is one of the fundamental reasons why joint working and joint training has been fraught with obstacles and difficulties. It was therefore

a significant development when the Dual Diagnosis National Program in England commissioned a document which took the above Capability Framework a step further and began to address some of the wider issues in the publication *'Developing capable practitioners to improve services and increase positive service user experience' (CSIP, 2008).* The areas identified for development included:

- Training which engenders networking and integrated care pathways across organisational boundaries
- Developing protocols with Higher Education providers which identify work-based learning opportunities
- Developing regional support networks which promote open learning and shared opportunities to explore positive clinical work in dual diagnosis
- Work rotation and secondments
- Partnership commissioning and ownership of dual diagnosis posts
- Developing across-service level agreements to share learning opportunities
- Developing an electronic web based learning package and toolkit on dual diagnosis

The essence of the document provided for the first time a blueprint for practitioners across health, local authority and voluntary sector services working with this client group, to come together, share knowledge, skills and information as well as share training and secondment opportunities, with the overall aim of improving themselves as providers, the services they work for, and most importantly the assessment, treatment, care and intervention provided to service users and their families.

8.3 National perspective in Wales

In this country, 'Making the Connections' and 'Beyond Boundaries' set a clear context for public services in Wales. Within this framework, the strategic direction for health over the next decade is set through 'Designed for Life': *A Strategy for the NHS in Wales*, and for social care through 'Fulfilled Lives and Supportive Communities': *A Strategy for Social Services in Wales*. Most recently 'Sustainable Social Services' (2011) and 'Together for Health' (2011) set a new direction which placed emphasis upon:

- Working across organisations for the most effective use of public monies
- Improving health as well as sickness
- Developing one system to enable integrated care
- Pursuit of excellence in all areas
- Transparency on performance

In the Welsh Government strategy in 2012 'Together for Mental Health' the need for an integrated approach to service deliver for the care of people with co-occurring mental health and substance misuse problems was highlighted as a priority. This mirrored the 10 year substance misuse strategy in 2009 'Working Together to Reduce Harm' which also called for substance misuse services to collaborate if the needs of service users with co-occurring difficulties were not being properly addressed and individuals were falling between gaps in services.

The climate is right for change and improvement; hence these pilot projects have come about with a strong strategic backdrop underpinning this work now and in the future.

8.4 Local context

The Gwent 2012 Mental Health Strategy makes reference to individuals with substance misuse problems and states that Substance Misuse Services are planned and commissioned on behalf of Gwent area by an Area Planning Board (APB), and highlights the need to ensure that the needs of those with co-occurring mental health and substance misuse issues are responded to. Also the strategy states that they 'do not seek to duplicate the work that is on-going via the development of a substance misuse strategy for the area'.

This is, unfortunately all too common, and one of the barriers and the challenges of undertaking work in the mental health and substance misuse field. It is not a question of duplication, rather working together, and developing an integrated and co-ordinated approach to working with this service user group across all sectors.

To date a local 'substance misuse strategy' does not exist as the APB and is primarily concerned with the development of a comprehensive Needs Assessment and a subsequent Commissioning Plan – rather than a medium to long-term strategy. It is the APB Commissioning Plan and Mental Health Strategy that should link into the work of this pilot and consider how an integrated pathway can be developed for people with co-occurring mental health and substance misuse difficulties. It could also create an opportunity for a multi-sector working group to oversee the development and implementation of a more joined up approach to service provision. It is hoped that this will be addressed in the coming year as a result of this work.

Running parallel to this pilot, another local priority for Newport SP and Public Health Wales was to deliver a supported housing scheme for people with enduring alcohol problems. Following a presentation in 2013 the Newport Single Integrated Plan Board agreed to approve the development of a 24 hour supported housing scheme based on the 'Shoreline' model.

This model is based around working with a cohort of chaotic drinkers who share a project house together with an agreed framework and low key intervention from staff. The Wallich provide the support in the seven existing schemes in Cardiff (5) and Swansea (2) and have used their work with, and experience of, rough sleepers and street drinkers to positive effect in the houses and have produced some very positive outcomes. Many of the service users, as well as being chaotic drinkers, also suffer from mental health difficulties. Successful outcomes have been reported when service users voluntarily reduce their alcohol intake to the extent that their physical and mental health improves.

9. Project delivery and development

As mentioned earlier, there were some operational difficulties as the pilot progressed.

Practical issues such as organising people from a wide range of agencies to meet together proved to be a major stumbling block. This caused a considerable delay in the project getting started.

The first meeting of the Project Group did not take place until July, 2013, with a further meeting in October. Following discussion with the Consultant, it was decided and agreed that the initial aims were over-ambitious in the current climate. The decision was made to focus on:

1. Developing a questionnaire to establish a baseline across services and include the following information:

    - Total number of clients accessing your service in the last year (April 2012 – April 2013) who have a co-occurring substance misuse and mental health issue.
    - Of these clients how many were receiving treatment \ interventions from
    - Substance Misuse Services only?
    - Mental health services only?
    - Both ?
    - In your opinion what barriers exist for these clients when accessing services (please note this question relates to any type of service, GPs, specialist drug \ mental health services, housing, employment \ training etc.)
    - What do you consider to be the gaps in service provision for this client group?
    - What do you consider to be barriers for staff in working with this client group? (e.g. lack of appropriate services, training etc)

2. Rolling out the DD E-learning programme

3. Developing a directory of local services

9.1 Progress to date

Questionnaire

A questionnaire was developed (Appendix 2) and disseminated. Unfortunately the return rate was very poor, only 2 agencies returned questionnaires. However those provided useful information. Some of the barriers and gaps in services reported for staff working with this group were:

- Lack of appropriate services, training etc.
- Clearer pathways from service to service
- Health care directly tailored to IV users including those who use new emerging drugs

- Access to mental health services are problematic if both substance misuse and mental health are present – this is especially the case in relation to bespoke housing services for mental health needs
- Detailed mental health/substance misuse training for GPs and Primary Mental Health Team staff is needed to aid better service provision and awareness
- Employment related training opportunities specific to the needs of dual diagnosis clients
- Clients not getting the support that they need from mental health services, this is mainly because clients with substance misuse will not be assessed whilst they are still using drugs or alcohol. There is also a barrier within the substance misuse services, and clients with mental health issues will not get the support that they require, because staff have not been trained in the mental health field
- More services needed that can support people with dual diagnosis
- More training on mental health issues, for all staff dealing with substance misuse

It is the intention (and in the action plan below) that this questionnaire will be repeated when the appropriate agencies are 'round the table' and part of the steering group.

E-learning programme

The National Dual Diagnosis Programme in England commissioned the development of a Dual Diagnosis E-learning programme which is a basic Level 1 course with the following 4 modules:

1. Introduction to Dual Diagnosis (Co-occurring mental health and substance misuse)
2. Mental health awareness
3. Substance use awareness
4. Skills and interventions

At the end of each module a quiz must be completed successfully to allow continuation to the next module. There is a workbook which provides evidence to learning. Also additional materials are available to download to increase knowledge and information base. A printable certificate is available on successful completion of all 4 modules.

The WLGA with the assistance of the Public Health Wales Older People, Vulnerable Groups and Inequalities Team have modified the English version and re-hosted this robust package and embedded in the Welsh version are key NHS and Welsh Government documents and policies to aid and complement the overall learning experience. This programme is freely available on www.dualdiagnosis.co.uk

Local directory of services

This vital piece of work to promote joint working has been completed.

The original mental health directory (2007) is available on:

http://www.newport.gov.uk/stellent/groups/public/documents/plans_and_strategies/cont119574.pdf

Link to the new NDAS directory:

http://www.ndas.mycommunityonline.co.uk/public/services/

10. Recommendations

The following are the key recommendations relating to this pilot project. It is the intention that they will influence and promote support to progress the work to date, and continue to improve and develop this work in the future.

1. Appropriate leadership for this service improvement work is urgently required to ensure it is given the attention needed and at the appropriate strategic level.

2. Update the current Mental Health Service Directory and promote awareness of all current services within the area, and ensure information on access and service provision is available.

3. The Steering Group membership is widened, in particular to include key people from statutory health and local authority services, alongside probation and other key relevant agencies.

4. The roll-out of the E-learning programme is vital and will require the development of a training sub-group with good multi-agency representation, and training and skills based strategy/plan, to ensure a successful outcome.

5. Work is required to join-up strategies, commissioning and action plans for substance misuse and mental health service provision, to take into account and prioritise people with co-occurring problems. Service users and carers should be involved in this process.

6. Outcomes should be tested against the Care Pathway for Co-occurring Mental Health and Substance Misuse Problems (Appendix 3) included in the Welsh Government's document entitled 'A Service Framework to Meet the Needs of People with a Co-occurring Substance Misuse and Mental Health Problem (Sept 2007).

10.1 Action plan for Newport Co-occurring Pilot Project

Key area/issue	Action required	Timescale	Action by (identified person)
Leadership of the steering group and re launch	Identify senior person in Health to take on leadership of the group and this piece of work	ASAP	NS
Improve the competence and confidence of the workforce	*Promote the DD E-learning programme and roll out to relevant agencies *Send link to key personnel *Undertake a survey of usage, collate findings and submit feedback	Over the next 12 months	Steering group
Develop joint working across substance misuse, mental health and all other relevant local services	*Re-issue the questionnaire and disseminate across partner agencies Promote the Directory of local services *Develop a joint working agreement across mental health and substance misuse services	Over Summer 2014	
Improve access to and quality of service for service users and carers	*E-learning Training programme *Promoting this work across all agencies *Encourage wider group membership	Over the next 12 months	Steering group members
Encourage membership of steering group and promote the learning from the pilot Begin to develop an integrated referral pathway for people with co occurring mental health and substance difficulties	Organise a workshop to engage with a wider group of service providers Workshop	 Workshop to be arranged for Summer 2014	 NS

11. Acknowledgements

Thanks to Nigel Stannard for all his help in driving the pilot project to date, and his passion and motivation in helping to improve services for people with co-occurring mental health and substance misuse difficulties, their families and friends. Thanks also to the members of the steering group who attended regularly and continue to strive for service improvement in Newport.

Contact ***Nigel.Stannard@newport.gov.uk***

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'Making the Connections'

'Beyond Boundaries'

'Designed for Life': A Strategy for the NHS in Wales

'Fulfilled Lives and Supportive Communities': A Strategy for Social Services in Wales.

Welsh Government (2011) 'Sustainable Social Services for Wales: A framework for Action'

Appendices

Appendix 1
Expression of Interest

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:

NCC Social Services – Nigel Stannard, SP Manager & Lead Contact
Aneurin Bevan Health Board – Leah McDonald, Partnership Manager
Aneurin Bevan Health Board – Jamie Harrison CMHT Manager (West
NCC Social Services – Ian Price-Jones, Substance Misuse Lead Officer
NCC Housing Services – Simon Rose, Housing Needs Manager
Wales Probation Trust – Nigel Spacey, Team Manager, Gwent LDU
Gwent Specialist Substance Misuse Service – Andrew Hopkins, Manager
Young Persons Specialist Substance Misuse Services – John O'Sullivan
Kaleidoscope – Sian Chicken, Service Manager
Solas Cymru – Tirzah Anderson, Clarence Place Manager
CRI (DIP) Phil Lewis, Manager
Llamau – Sam Lewis, Head of Supported Housing East
Newport MIND – David Bland, Director
Gwalia Care & Support – Colin Jones, Newport Manager
Barnardo's B@1 – Fiona Burton, Manager
NCC Social Services – Vicky Self, Manager Integrated Family Support
Public Health Wales - Julia Osmond, Principal Public Health Practitioner
Aneurin Bevan Health Board – Julia Lewis, Adult Psychiatry
Gwent Police – Inspector Stefan Williams, Partnership Inspector
Gofal Cymru – Aimee Nelson, Hospital to Homes Worker

Please describe what services already exist in your area:

St Cadocs Mental Health Hospital – 1 detox bed and in-patient wards
2 x Integrated Community Mental Health Teams
Mental Health Hospital Liaison Team
Assertive Outreach Team
Early Intervention Team
Home Treatment Team
Gwent Specialist Substance Misuse Service
Young Persons Specialist Substance Misuse Service
Barnardo's B@1 Project for young people with SM problems
Child and Adolescent Mental Health Service
Kaleidoscope Drugs and Alcohol services inc. open access, community prescribing, alcohol counselling and supported housing
ABHB Community Detox. ABHB Gastro Surgery Detox.
Dr James Leney – Substance Misuse lead GP for Gwent
Integrated Family Support Team intensive multi -agency support for families with SM and child protection issues
CRi DIP service and DRR testing
Solas Cymru supported housing alcohol/drugs/mental health schemes
Gwalia Care & Support supported housing and floating support drugs/alcohol and mental health schemes
Llamau young persons supported housing and floating support schemes
Julia Lewis Principal Public Health Practitioner substance misuse
ABHB Primary Care Mental Health Teams in GP surgeries
Gofal Cymru in-patient resettlement support at St Cadocs MH Hospital
Newport MIND, counselling, group work, day activities, supported housing, BME and floating support schemes
Public Health Wales senior officer with substance misuse specialism
SM Service User Group

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

1. To develop an inter-agency referral pathway for service users with dual diagnoses to access appropriate services in a timely manner.

2. To assess the existing Newport Drug and Alcohol Service (NDAS) information-sharing protocol (treatment services) and widen the scope to include wrap-around/lower tier services.

3. To create a suite of e-training modules on dual/triple diagnosis for professionals and third sector workers

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

1. For the consultants to become members of a multi-agency Project Group to advise on referral pathways, provide information on best practice models and help develop bespoke pathways for Newport, based on current services and demand.

2. For the consultant to review the current NDAS information-sharing protocol and investigate the feasibility of incorporating wrap-around tier 1 and 2 type services or assisting in the production of a new Information Sharing Protocol under the Welsh Government's WASPI process via NCC's Communications Officer.

3. For the consultant to produce a suite of e-training modules for professional and other staff working in the field of co-occurring morbidity/dual –triple diagnosis and assist in the launch of this programme.

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

Service users will have clear and up-to-date information on all services in the area and how to access them/ know what the access criteria are.

Service users will have clearer idea of how to access appropriate higher-level services through identified 'gateways'. – a 'route map'.

Work on the referral pathways will identify barriers/obstacles to accessing treatment in a timely manner and propose ways to address these.

Timely responses to crises, treatment and homelessness = prevention of need for more expensive intervention

More consistent approach from each agency

The sharing of information should lead to faster access to services/less assessments/better tracking of service users through the mental health and substance misuse agencies' services.

Services should work better together acquiring a better understanding of each others' roles and providing a more timely and co-ordinated treatment and aftercare service for clients and a seamless journey through the different tiers of intervention.

Improved information gathering/statistics/monitoring will inform future demand for services and commissioning priorities

N.B. As a result of the implementation of the Welsh Government's Mental Health (Wales) Measure, ABHB are currently rolling out Primary Mental Health Teams into GP surgeries across Gwent - so the impact these services will have during the pilot period will be important to consider.

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

Desired Outcomes:

1a. Increased level of joint working > more integrated service delivery.

2a. More s/users accessing services at the right time

3a. Fewer hospital admissions and homelessness presentations

4a. Frontline staff received appropriate level of training on DD through e-training modules

5a. Development of follow-on floating support services through the Newport Gateway and other 'wrap-around' services

6a. Timely interventions from the Primary Mental Health Teams leading to more appropriate referrals to Community Mental Health Teams and treatment/counselling services

Measured by:

1b. Staff surveys and feedback from service users

2b. Nos. s/users accessing services and agency feedback

3b. Numbers admitted to hospital/accepted as homeless with a DD compared to historical data

4b. Number/% of frontline staff completing e-training modules versus total number of frontline staff

5b. Number of successful referrals to floating support and other services post-intervention

6b. Primary Mental Health Team data and reports

Appendix 2

Dual Diagnosis Questionnaire

1. Organisation :
2. Department:
3. Name of Person Completing Form:
4. Job Title:
5. Please state the total number of clients accessing your service in the last year (April 2012 – April 2013) who have a co-occurring substance misuse and mental health issue.
6. Of these clients how many were receiving treatment \ interventions from

    a) Substance Misuse Services only?
    b) Mental health services only?
    c) Both ?
7. In your opinion what barriers exist for these clients when accessing services (please note this question relates to any type of service, GPs, specialist drug \ mental health services, housing, employment \ training etc.)

8. What do you consider to be the gaps in service provision for this client group?

9. What do you consider to be barriers for staff in working with this client group? (e.g. lack of appropriate services, training etc)

Please return
by email to tirzah.anderson@solas-cymru.co.uk
by post to Tirzah Anderson, 11 Devon Place, Newport, NP20 4NP

Returned questionnaires

Organisation : Solas

Department: Community Living – Clarence Place

Name of Person Completing Form: David Chapman
Job Title: Deputy Manager

Please state the total number of clients accessing your service in the last year (April 2012 –April 2013) who have a co-occurring substance misuse and mental health issue. **12**

Of these clients how many were receiving treatment \ interventions from

Substance Misuse Services only? **4**

Mental health services only? **0**

Both ? **8**

In your opinion what barriers exist for these clients when accessing services (please note this question relates to any type of service, GPs, specialist drug \ mental health services, housing, employment \ training etc.)

- Financial barriers including arrears – preventing access to specific housing
- Access to mental health services are problematic if both substance misuse and mental health are present – this is especially the case in relation to bespoke housing services for mental health needs.
- Detailed mental health/substance misuse training for GPs is needed to aid better service provision and awareness
- Employment related training opportunities specific to the needs of dual diagnosis clients

What do you consider to be the gaps in service provision for this client group?

- Long term housing provision
- Clearer pathways from service to service
- Health care directly tailored to IV users including those who use new emerging drugs

What do you consider to be barriers for staff in working with this client group?

- lack of appropriate services, training etc

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by post to Tirzah Anderson, 11 Devon Place, Newport, NP20 4NP

Organisation : GWALIA

Department: IN2CHANGE

Name of Person Completing Form: Odette Steele

Job Title: Support worker

Please state the total number of clients accessing your service in the last year (April 2012 –April 2013) who have a co-occurring substance misuse and mental health issue. 6

Of these clients how many were receiving treatment \ interventions from

Substance Misuse Services only? **4**

Mental health services only? **0**

Both ? **2**

In your opinion what barriers exist for these clients when accessing services (please note this question relates to any type of service, GPs, specialist drug \ mental health services, housing, employment \ training etc.)

Clients are not getting the support that they need from mental health services, this is mainly because clients with substance misuse will not be assessed whilst they are still using drugs or alcohol. There is also a barrier within the substance misuse services, and clients with mental health issues will not get the support that they require, because staff have not been trained in the mental health field.

What do you consider to be the gaps in service provision for this client group?

- More services who can support people with dual diagnosis.
- More training on mental health issues, for all staff dealing with substance misuse.

What do you consider to be barriers for staff in working with this client group? (e.g lack of appropriate services, training etc)

- Lack of training, lack of appropriate services e.g Dual diagnosis.

Please return
by email to tirzah.anderson@solas-cymru.co.uk
by post to Tirzah Anderson, 11 Devon Place, Newport, NP20 4NP.

Appendix 3

(Source: 'A Service Framework to Meet the Needs of People with a Co-occurring Substance Misuse and Mental Health Problem (Welsh Government. Sept 2007).