Scrutiny Report on Dual Diagnosis

Report on Dual Diagnosis (of mental health and substance misuse problems)

A Introduction

1. The Scrutiny Review

1.1 This Scrutiny Review was instigated by Councillor Georgia Wrighton, who submitted a request for scrutiny to the Brighton & Hove Overview & Scrutiny Organisation Committee (OSOC). Councillor Wrighton suggested that a Scrutiny Panel should:

"investigate and suggest improvements to the provision of health, housing and support services for those in the community, who because of an actual or perceived co-existing substance misuse and mental health problem, fail to receive adequate medical and social care."[1]

1.2 OSOC agreed to form a panel to investigate this issue at its 14 January 2008 meeting.

1.3 Councillors Pat Hawkes, Keith Taylor, David Watkins and Jan Young agreed to become Panel members. Panel members elected Councillor David Watkins as Chairman of the Scrutiny Panel.

1.4 On May 15 2008 Councillor Young was appointed the Brighton & Hove City Council Cabinet Member for Finance. Members of the Council's Executive are not permitted to serve on Scrutiny Committees or Panels. Councillor Young was therefore required to resign her place on this Scrutiny Panel.

1.5 The Panel held five evidence gathering meetings in public. The witnesses included clinicians and managers from Sussex Partnership Foundation NHS Trust (the main provider of statutory mental health and substance misuse services in the city); officers of NHS Brighton & Hove[2] (the commissioners of citywide mental health and substance misuse services); officers of Brighton & Hove City Council (including those responsible for managing the council's housing strategy); officers of the Children & Young People's Trust; representatives of the main supported housing providers in the city; representatives of the non-statutory services operating in the fields of mental health and

[1] Cllr Wrighton's request for Scrutiny is reprinted in **appendix 1** to this report.

[2] NHS Brighton & Hove was formerly known as Brighton & Hove City Teaching Primary Care Trust and this title is used throughout this report.

substance misuse; and the families and carers of people with a Dual Diagnosis.

1.6 The Panel also welcomed evidence in writing and received one written submission[3].

1.7 In addition to the five meetings in public, the Panel also held several private scoping meetings to determine the structure of the review process and the witnesses to be invited, and to agree a report. In addition, members visited the West Pier Project, a supported housing scheme managed by Brighton & Hove City Council. The West Pier Project provides some accommodation for people with a Dual Diagnosis.

2. The Process of the Review

2.1 During the course of the review, Panel members heard a wide range of evidence from witnesses who often had differing perspectives on the problems of Dual Diagnosis. However, it soon became evident that there were a number of themes repeatedly identified as important, and the Panel has therefore chosen to focus on, and make recommendations around, these key themes.

2.2 Panel members wish to thank all the witnesses who came forward to give evidence in person or to provide written statements.[4] Members were most impressed by the knowledge and commitment of all the witnesses they encountered. While serious problems regarding Dual Diagnosis do exist, and while some problems may always exist, it is clear that this is not due to any lack of passion or ability on the part of those who deal professionally with the issue, nor due to any lack of commitment on the part of families and carers.

2.3 Panel members are grateful for all the evidence they were presented with, and the Panel has tried to take account of all the views expressed when making its recommendations. At times it may not have been possible to incorporate some evidence into the report recommendations, most commonly because, although a very important problem may have been identified, its solution would have been beyond the scope of the Panel's effective influence (for instance requiring a change in national rather than local government policy).

[3] Written evidence is re-printed in **appendix 6** to this report.
[4] A list of the witnesses who gave evidence in person can be found in **appendix 2** to this report.

3 Definitions of Dual Diagnosis

3.1 'Dual Diagnosis' is a term used to refer to people who have a mental health problem and who also use drugs or alcohol in a problematic manner.[5]

3.2 However, this definition may not, in itself, be all that useful, as the set of people with some co-existing mental health and substance misuse problems is very large indeed. So large, and potentially so disparate, is this group that it is difficult to see the utility in designating everyone in it as having a 'Dual Diagnosis'.

In consequence, the term tends generally to be reserved for those people who have the most serious problems, either because of the severity of their mental illness or substance misuse problem, or because the combination of the two types of problem presents particular challenges. Department of Health guidance defines Dual Diagnosis as involving *"severe mental health problems and problematic substance misuse"* .[6]

3.3 The following table illustrates the complex nature of Dual Diagnosis problems[7]. Individuals who fall in the lower right section of this matrix are most likely to be targeted by Dual Diagnosis services.

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[5] The term 'Dual Diagnosis' is sometimes used for other co-morbidities, such as the combination of learning disability and substance misuse problems. However, it is most commonly employed in the context of co-existing mental health and substance misuse issues, and this is how it is used throughout this report.

[6] Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide, Department of Health, 2002 (p6). Published works referred to in this report are listed in **appendix 4**.

[7] Taken from the Brighton & Hove and East Sussex Dual Diagnosis Needs Assessment (2002), p6.

	Low severity substance misuse	**High severity substance misuse**
Low severity mental illness	e.g. a recreational user of 'dance drugs' who has begun to struggle with low mood after weekend use	e.g. a dependant drinker who experiences increasing anxiety
High severity mental illness	e.g. an individual with bipolar disorder whose occasional binge drinking and experimental use of other substances de-stabilises their mental health	e.g. an individual with schizophrenia who misuses cannabis on a daily basis to compensate for social isolation

3.4 The set of people with *severe* mental health problems and *problematic* substance misuse (i.e. the set represented in the bottom right of the matrix) is much smaller than the set of people with *any* co-existing mental health and substance misuse problem, but it is nonetheless quite a large group. Some professionals appear content to work with a definition of Dual Diagnosis close to that quoted above, but others prefer to define it even more narrowly, identifying a 'typical' client as being someone with a very severe mental health problem (probably schizophrenia or a bi-polar disorder), plus substance misuse problems which are likely to feature heavy use of opiates and (often) the additional misuse of a wide range of other substances, including alcohol. Furthermore, such people are very likely to be rough sleepers or otherwise homeless, to present regularly to mental health services and to hospital A&E departments, and to be in regular contact with the police (generally for fairly low level offences concerned with anti-social behaviour and/or acquisitive crime).[8]

3.5 There is some potential for confusion here, as it is not always clear whether people who employ the term Dual Diagnosis use it in its very narrow, slightly broader or its very broadest sense. However, for the

[8] Evidence from Richard Ford, Executive Director (Brighton & Hove Locality), Sussex Partnership Foundation Trust: 29.02.08 (point 4.16 in the minutes to this meeting). Detailed minutes from the Dual Diagnosis Panel evidence gathering meetings are reprinted in **appendix 3 (A-F)** to this report.

Panel to insist on a single definition of Dual Diagnosis might have effectively excluded some interesting and important evidence. Therefore, whilst Panel members are clear that Dual Diagnosis should be taken to refer to severe rather than mild co-morbidities (as indicated in the table at **3.3**), they have not sought, in the context of this report, to define it any more narrowly.

3.6 It should also be noted that the term 'Dual Diagnosis' is not universally accepted as the best phrase to describe this set of problems. Some professionals prefer to refer to a *'co-morbidity of mental health and substance misuse problems';* others reject Dual Diagnosis in favour of terms such as *'complex needs',* arguing that 'Dual Diagnosis' implies that a person has only two types of problem, whereas in fact many people have a wide variety of needs, including mental health and substance misuse problems but also potentially encompassing general health needs, problems with criminal behaviour, homelessness and so on.[9]

3.7 The Panel recognises that the term 'Dual Diagnosis' is not entirely satisfactory, but it is the phrase most widely employed to describe co-existing mental illness and substance misuse problems, and therefore likely to be understood by more people than the alternatives. In consequence, it is the term preferred in this report.

4. Prevalence of Dual Diagnosis Problems

4.1 There is no accurate national figure for the number of people with a Dual Diagnosis. However, there seems to be broad agreement that between 30-50% of people with a *severe* mental health problem have a co-existing substance misuse problem.[10] Nationally, Community Mental Health Teams (CMHTs) report that 8-15% of their clients have a Dual Diagnosis.[11]

4.2 Inner city areas tend to feature very high incidences of Dual Diagnosis, and Dual Diagnosis is particularly prevalent amongst the homeless/rough sleepers and in prison.[12]

4.3 The prevalence of Dual Diagnosis within Brighton & Hove is uncertain, but professionals seem to be agreed that it is a major problem, with

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[9] Evidence from Andy Winter, Chief Executive, Brighton Housing Trust: 07.03.08 (point 19.3).

[10] Needs Assessment: services for adults with mental illness and substance misuse problems in Brighton & Hove and East Sussex, Brighton & Hove City teaching Primary Care Trust, 2002 (pp12,13).

[11] Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide, Department of Health, 2002 (p7).

[12] Ibid. (p67).

local rates almost certainly at the high end of the national spectrum.[13] There could well be a very high level of unmet need in the city also, as people with Dual Diagnosis may often be reluctant to present for treatment.[14] However, the nature of the problems associated with Dual Diagnoses means that this is scarcely an 'invisible' group: people with a Dual Diagnosis are generally well known to healthcare services, social care and the police due to their chaotic lifestyles.[15] If these people are not officially designated as having a Dual Diagnosis, this may be indicative of problems with the way in which city agencies record and share data rather than because a large number of people have effectively escaped attention.

4.4 The last systematic attempt to estimate the size of this problem in Brighton & Hove was the **2002 Dual Diagnosis Need Assessment for Brighton & Hove and East Sussex**. This assessment forms the basis for current city-wide Dual Diagnosis services.[16]

4.5 Dual Diagnosis is a city-wide problem, although rates of both substance misuse and of mental illness vary considerably across the city, so one would expect some wards to record lower than average incidences of people with a Dual Diagnosis and other wards to have much higher figures.[17]

4.6 Dual Diagnosis has traditionally have been associated with people of 'low' social status; but it is increasingly being viewed as a problem affecting all sections of society, particularly as widening drug and alcohol use mean that people from a broad variety of backgrounds begin to present to substance misuse services.[18]

4.7 It is unclear whether Dual Diagnosis is an equally significant problem for both sexes. It seems to be the case that men are more commonly diagnosed as having a co-morbidity of mental health and substance misuse issues, but it is hard to tell whether this is indicative of a greater male prevalence, or whether men are simply more likely than women to present to services where their condition will be accurately assessed

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[13] Mental Health Needs Assessment for Working Age Adults in Brighton & Hove; Alves, Bernadette; Brighton & Hove City teaching Primary Care Trust, 2007 (p47).

[14] Evidence from Simon Scott, Strategic Commissioner for Mental Health, Brighton & Hove City teaching Primary Care Trust: 07.03.08 (point 4.11 in the minutes of this meeting).

[15] Evidence from Richard Ford: 29.02.08 (point 9.2).

[16] Needs Assessment: services for adults with mental illness and substance misuse problems in Brighton & Hove and East Sussex, Brighton & Hove City teaching Primary Care Trust, 2002.

[17] Evidence from Simon Scott: 07.03.08 (point 4.4).

[18] Evidence from Dr Tim Ojo, Consultant Psychiatrist, Sussex Partnership Foundation Trust: 28.03.08 (point 20.9).

(for instance, presenting as homeless to a local authority).[19] There does seem to be some evidence to suggest that women are less likely to present for treatment than men (particularly for treatment of substance misuse issues); and there also seems to be a consensus that women are likely to manifest particularly severe Dual Diagnosis problems.[20] (This issue is addressed at more length in ***part 8*** of this report.)

4.8 There appears to be little evidence as to whether Dual Diagnosis is particularly prevalent in specific ethnic groups, or amongst people of a particular sexual orientation. However, any community with higher than average incidences of either drugs/alcohol use or serious mental illnesses might be assumed to be liable to feature relatively high incidences of Dual Diagnosis.[21]

4.9 As noted above (***point 3.4***), Dual Diagnosis is most typically associated with the misuse of opiates and other 'class A' drugs. However, there are also very strong associations with the misuse of alcohol, with problematic cannabis use and with the misuse of prescription drugs such as benzodiazepines.[22]

5. Reasons for the High Prevalence of Dual Diagnosis

5.1 It is not possible to identify a definitive cause of Dual Diagnosis problems, since this may vary from individual to individual. However, there do seem to be some generally accepted reasons why people with a severe mental illness so frequently have co-existing substance misuse problems.

5.1(a) The use/misuse of some substances may cause or trigger mental health problems. It has long been recognised that the use of some drugs, such as amphetamines and crack cocaine, can lead directly to mental illness. There is also increasing evidence that cannabis has a causal link with mental health problems for some users.

5.1(b) Whilst the misuse of other substances may not *directly* cause mental health problems, the lifestyle typically associated with prolonged drugs or alcohol use may be strongly associated with the development of mental illness. Thus, people engaging in acquisitive crime/prostitution

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[19] See evidence from David Allerton, Mental Health Placement Officer, Sussex Partnership Foundation Trust and Mike Byrne, Manager of the West Pier Project (a supported housing project which accepts clients with a Dual Diagnosis), Brighton & Hove City Council: 07.03.08 (point 11.9 in the minutes of this meeting).

[20] Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide, Department of Health, 2002 (p19).

[21] Ibid. (p19).

[22] Evidence from Simon Scott: 07.03.08 (point 4.5).

to fund long-term opiate or crack cocaine use are very likely to develop problems such as anxiety and depression as a result of their lifestyles, even if they do not do so as a direct consequence of their substance use.

5.1(c) There is a widespread phenomenon of 'self medication' amongst people with mental illnesses, whereby individuals will attempt to ameliorate the symptoms of their illness by using alcohol or non-prescribed drugs.[23] It is evident that some of those self medicating will develop problematic relationships with the substances they opt to use.

5.1(d) While the root causes of mental health problems are very complex and often not yet wholly understood, it is well established that traumatic events such as a history of abuse may cause or trigger mental illness. The experience of this type of event is also strongly linked to the subsequent use of drugs and/or alcohol (as a form of self-medication), and hence to the potential development of problematic substance use. For example, a woman who has experienced domestic violence may well develop some form of Dual Diagnosis, as prolonged abuse is strongly linked to both the development of mental illness and to substance misuse problems. (This may not necessarily be Dual Diagnosis in its most typical form [see ***point 3.4*** above], as the mental health problems may well be depression and/or anxiety rather than schizophrenic or bi-polar disorders. However, such Dual Diagnoses can be extremely serious, not least because they may be exacerbated by the very unstable environments experienced by women who are in or who have fled an abusive relationship.)[24]

5.1(e) Since Dual Diagnosis involves a co-morbidity of mental health and substance misuse issues, it obviously 'requires' individuals to develop a problematic relationship with drugs or alcohol. Drug use, in particular, is more prevalent in some geographical areas than in others, so it follows that areas with very high drugs use (and a consequently high number of problematic users) are likely to feature a higher than average proportion of people with a Dual Diagnosis. Similarly, if mental health problems can be said to cluster geographically (areas with particularly poor housing stock may, for instance, feature disproportionately high levels of mental illness), one might expect certain areas to produce higher than average rates of Dual Diagnosis.

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[23] This may well be due to the stigma still associated with mental health problems, which makes people with these issues more reluctant to present for treatment than those with general health problems. Much work is currently being done to reduce this stigma: for example, via the 'Time to Change' initiative.

[24] Evidence from Khrys Kyriacou, Brighton Women's Refuge Project: 28 March 2008 (point 21.2).

6. Problems Associated with Dual Diagnosis

6.1 Why is Dual Diagnosis considered such a problem? It has very serious implications, both for individual sufferers and for the broader community.

6.1(a) For individuals with a mental illness, a co-existing substance misuse problem can make the psychiatric condition much harder to treat, as people with substance misuse issues are likely to lead highly chaotic lives, meaning that they may not present for treatment, they may struggle to adhere to therapeutic programmes or to regularly take their prescribed medication, and they may experience problems with the criminal justice system, housing etc. which can make their treatment far more difficult to administer.

6.1(b) There are often also very serious physical results of long term substance and alcohol misuse (including HIV, Hepatitis B and C, Korsikoff's syndrome, emphysema etc). These are problematic in themselves, and they can also make effective treatment of mental health problems more difficult.

6.1(c) The misuse of substances may also have a direct, deleterious impact upon a person's psychiatric condition, worsening the effects of an illness and prolonging episodes of ill health.[25]

6.1(d) People taking non-prescribed drugs as well as prescribed psychiatric medications may also find that the efficacy of their prescribed medication is compromised or that there are undesirable side-effects produced by combining different substances.

6.1(e) People who use substances problematically may require considerable amounts of money in order to maintain their use (particularly so for users of opiates or crack cocaine). They may seek to obtain this money by criminal means, such as acquisitive crime, or they may become involved in sex-work. Involvement in the former is likely to lead to problems with the criminal justice system; involvement in the latter may well result in serious physical/sexual abuse as well as causing or exacerbating mental health problems.

6.1(f) For individuals with a substance misuse problem, a co-existing mental illness can make abstinence much more difficult, as abstinence programmes typically require a good deal of self-awareness and

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[25] Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide, Department of Health, 2002 (p9).

insight: abilities which are often significantly compromised by mental health problems.

6.1(g) The behaviour of people with major substance misuse issues, and, to some degree, that of people with severe mental health problems, can pose significant problems for the broader community, particularly in terms of anti-social activity. People with a Dual Diagnosis are very likely to cause problems within their community. Being effectively ostracised from one's community is likely to impact negatively on recovery from mental illness and on attempts to abstain from drugs or alcohol.

6.2 As well as impacting upon individual sufferers and, to some degree, on the wider community, Dual Diagnosis may also be profoundly damaging for the families of people with a co-morbidity of mental health and substance misuse problems. Although the 'typical' profile of someone with Dual Diagnosis may well be that of a young, single homeless male, it is important to be aware that by no means all people with a Dual Diagnosis fit this profile: many may have partners or dependant children whose needs must also be taken into account when planning services. Historically, health and social care services have not always been very effective at identifying and responding to the broader impact of Dual Diagnosis.

B Themes and Recommendations

During the course of its investigations, the Scrutiny Panel heard a good deal of evidence from a wide range of sources. However, it quickly became clear that certain themes appeared consistently in much of the evidence. The Panel has therefore focused on, and made recommendations around, these key themes[26]. The themes are enumerated below.

7. Supported Housing

7.1 People with a Dual Diagnosis are likely to experience difficulties with housing, due to problems commonly associated with both serious mental illnesses and problematic substance use. Thus, people may find it hard to obtain or maintain a tenancy due to their chaotic lifestyles, anti-social behaviour, inability/unwillingness to pay rents or claim the appropriate benefits, and so on.

7.2 Having an unsettled housing situation is almost bound to impact upon the efficacy of treatments for mental health problems and/or substance

[26] A digest of recommendations is included in **appendix 5** to this report.

misuse issues, as all treatments work best when the client is able to focus on them rather than on immediate problems of shelter.

7.3 People with a Dual Diagnosis living in general needs housing may evince types of behaviour which impact upon neighbours and the local community. This in turn may lead to these people being effectively ostracised by the community in which they are trying to live. People who cannot maintain tenancies may end up as homeless or rough sleepers, with concomitant costs to the broader community, both in financial and social terms.

7.4 There is therefore an obvious need for some kind of Supported Housing provision for many people with a Dual Diagnosis: to allow them to live in the kind of safe and secure environment which will best aid their treatment and recovery, and to ensure that the community does not suffer disproportionately from chaotic and anti-social behaviour.

7.5 A number of witnesses identified supported housing provision as a key aspect of problems associated with Dual Diagnosis in the city. More specifically, witnesses identified difficulties which included:

7.5(a) Temporary accommodation for people with a Dual Diagnosis. Patients discharged from residential healthcare (including people who have been detained in hospital 'under a section' of the Mental Health Act) may sometimes be placed in unsuitable accommodation (i.e. temporary Bed & Breakfast accommodation), with the concomitant risk that their recovery may be compromised by their environment.[27] One witness suggested that a possible solution to this problem would be for the Local Health Economy to have access to dedicated supported housing specifically for the purpose of providing a safe temporary living environment whilst suitable long-term accommodation is being arranged.[28]

People with a Dual Diagnosis accepted as being homeless have historically faced similar problems, with unsuitable Bed & Breakfast accommodation often being used as temporary housing. Brighton & Hove City Council has attempted to address this problem in recent years, procuring private sector rental accommodation to house people presenting as homeless (as well as offering this resource to mental health services seeking to house their clients). Whilst not an ideal solution, the use of this type of resource represents a significant advance on the use of general Bed & Breakfast accommodation for housing homeless people with mental health/Dual Diagnosis needs.[29]

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[27] Evidence from Richard Ford: 29.02.08 (point 7.1).

[28] Evidence from Sue Baumgardt: 25.04.08 (point 30.9).

[29] Evidence from Steve Bulbeck, Head of Single Homelessness and Social Inclusion, Brighton & Hove City Council: 07.03.08 (point 13.3).

Another problem here may concern the co-ordination between statutory mental health and housing services. The Panel heard that the council's Housing Strategy service might be able to provide appropriate housing for many people coming out of residential mental health care, providing it had sufficient notice. This might be in terms of getting advance notice of an intention to discharge an individual (in which case, the more time to arrange appropriate accommodation the better). It might also involve effective systems for alerting Housing Strategy when an individual was detained under a 'section' or was otherwise receiving residential services, since in such circumstances it might be possible to liaise with that individual's landlord in order to maintain their private tenancy for the duration of a stay in residential mental health care.[30]

7.5(b) An appropriate residential assessment facility to enable accurate evaluation of people who may have a Dual Diagnosis.

Witnesses noted that it was often difficult to make an on the spot assessment of someone's housing and therapeutic needs; particularly so in the case of clients with substance misuse issues, as the effects of drugs/alcohol use can mask the symptoms of mental illness. A facility which would enable people to stay in a safe and supported environment long enough (perhaps two to four weeks) for their real needs, including underlying mental health problems, to be determined, might therefore be of considerable value in terms of ensuring that people were given the right care package and were eventually housed in the most appropriate environment.[31]

7.5(c) Long term accommodation for people who refuse to engage with services.

The Panel was told that there was currently no provision in Brighton & Hove for housing people with a Dual Diagnosis who refused to engage with services. Such accommodation had formerly been available but had been discontinued (in line with recent Government advice). However, although the numbers involved might be small, the service could potentially be very useful, particularly as it would allow the effective segregation of those people who did try and engage with services from those who did not.[32]

7.6 Behavioural problems associated with housing people with a Dual Diagnosis.

People with a Dual Diagnosis can be difficult to house because their behaviour is likely to be very challenging. This is particularly so for

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[30] Evidence from Jugal Sharma, Assistant Director, Housing Strategy, Brighton & Hove City Council: 25.07.08 (point 36.14).

[31] Evidence from Andy Winter, Chief Executive, Brighton Housing Trust: 28.03.08 (point 19.12).

[32] Ibid. (point 19.14).

clients who are actively using drugs and/or alcohol. Housing these people requires very specialist services and a great deal of support (potentially on a 24/7 basis). In consequence, not all supported housing is suitable for people with a Dual Diagnosis, particularly if they are unwilling or unable either to be or to commit to being abstinent. [33]

The type of housing suitable for people with a Dual Diagnosis may also vary. Some witnesses noted that there were significant problems associated with housing a number of people with Dual Diagnoses together, since substance/alcohol misuse or anti-social behaviour by one client might effectively trigger similar behaviour from other residents.[34] Other witnesses noted that some clients with a Dual Diagnosis may thrive in a busy environment, providing the conditions were carefully controlled to ensure that conduct was monitored and appropriate behaviour encouraged.[35] There is no necessary contradiction here: it is clear that a range of supported housing is required to fit with a variety of clients (although there seems general agreement that relatively small scale housing is most useful).[36]

7.7 'Step Down' Housing.

Successfully housing people in appropriate accommodation is not the end of the story. People with a Dual Diagnosis can find that their condition improves significantly with treatment and a relatively stable environment. In such instances, a very high level of support may no longer be required, and it may make sense to facilitate a process via which clients can 'step down' to less intensively supported housing. Such a progression could free places in the most highly supported environments, would encourage the development of independent living skills and might effectively save money (as less intensively supported housing is liable to be a cheaper option).

Although the process of 'stepping down' may currently take place, there is no formal system to encourage it nor any effective system of monitoring placements to ensure that appropriate step downs are undertaken.[37] As there is a potential incentive for housing providers to retain rather than move on relatively trouble-free tenants (such tenants being generally easier to support), this may be an area which requires a more formal system in place. It should however be noted that no

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[33] Evidence from 29.02.08 (point 7.3).

[34] Evidence from David Allerton, Mental Health Placement Officer, Sussex Partnership Trust: 07.03.08 (point 11.7).

[35] Evidence from Mike Byrne, Manager of the West Pier Project: 07.03.08 (point12.6).

[36] Evidence from Dave Dugan, Residential Services Manager, Sussex Partnership Foundation Trust: 29.02.08 (point 7.7).

[37] Evidence from David Allerton: 07.03.08 (11.8); evidence from Steve Bulbeck: 07.03.08 (point 13.4).

witness identified any current supported housing provider as disinclined to 'step down' levels of support when appropriate; the problem may therefore currently be potential rather than actual.

7.8 Restrictions caused by 'pathways'.

The Panel also heard that the supported housing supply problem could be exacerbated by the system of 'pathways' employed to assess and house people. For example, clients who present with an urgent housing need due to their mental health problems may formally only be eligible for housing within a limited number of supported housing schemes to which the Mental Health Placement Officer is able to refer. Since the housing options accessible via this pathway include little if any accommodation suitable for people with a Dual Diagnosis who are unwilling to commit to current or future abstinence, it may be very difficult to meet certain clients' housing needs, even though suitable supported housing might actually be available in the city (but only formally accessible via the homeless 'pathway').[38]

In practice, the Panel learnt, it may be possible for agencies to steer a course around the formal restrictions of the pathways system, by working together on an informal basis to ensure that clients are directed to the most appropriate housing resource. However, a system which needs to be regularly circumvented in order to accommodate clients with as serious (and relatively common) a condition as a Dual Diagnosis is clearly not fully functional; there seems little point in having formal pathways of care if these pathways effectively complicate rather than facilitate the delivery of services. It may therefore be necessary to review the current pathways via which supported housing is accessed, in order to determine whether the pathways need adjustment, or whether a dedicated Dual Diagnosis pathway might be of use.

7.9 Supported Housing for People with a Dual Diagnosis and the issue of abstinence

Aside from the issue of the accessibility of appropriate supported housing via the formal homeless and mental health pathways, the Panel heard a good deal of evidence regarding the provision and type of supported housing in the city. There seemed to be broad agreement that there was an adequate stock of supported housing within Brighton & Hove, but rather less unanimity as to whether there was sufficient housing suitable for people with a Dual Diagnosis.

It seems evident that there are some significant differences of opinion regarding the stress that should be placed on abstinence in the treatment and support of people with a Dual Diagnosis. Some agencies (including Sussex Partnership NHS Trust and Brighton & Hove City Council[39]) are committed to a policy of 'minimisation', in which clients

[38] Evidence from David Allerton: 07.03.08 (points 11.2 and11.3).

[39] Evidence from Steve Bulbeck: 29.02.08 (point 7.5).

are encouraged to use drugs and alcohol in ways which reduce the likely harm to themselves and others.[40] This may include using sterile needles to inject drugs, and disposing of the used needles responsibly; moving from injecting drugs to taking them in other forms; moving from 'street' drugs to prescribed alternatives (e.g. from heroin to methadone); reducing drugs and/or alcohol use; switching from very hazardous to less hazardous substances (and patterns of use), and so on.[41] Although abstinence is a long term goal of all agencies involved in treating and supporting people with a Dual Diagnosis, clients are not necessarily required to be abstinent or to themselves commit to a goal of abstinence in order to receive treatment or support. It is considered that the imposition of abstinence may not be a realistic option for many people with a Dual Diagnosis, who might be incapable of making such a commitment or who might withdraw entirely from support services if the issue were to be made central to the provision of therapies[42].

Other agencies (notably Brighton Housing Trust) champion the idea of abstinence, believing that, sensitively handled, it should form the basis of treatment and support. Clients, in some initiatives at least, are actively encouraged to pledge abstinence as a long term goal, although not necessarily to immediately assume an abstinent lifestyle.[43]Abstinence may sometimes be defined so as to exclude people who take prescribed substitutes for 'street' drugs (e.g. methadone as a heroin substitute); the argument here is that many methadone users also use heroin and generally associate with current drugs users, so that they are typically not in any real sense themselves abstinent, and may disrupt the recovery of those who have genuinely committed to abstinence if housed alongside them.[44]

Panel members accept that there are valid grounds for adopting either of the above approaches to the support and treatment of people with a Dual Diagnosis, and note that these differences in the theory of treatment may not necessarily result in services which vary all that considerably from each other in practice. Panel members have no wish to make recommendations to clinicians and substance misuse professionals concerning the details of treatment of people with a Dual Diagnosis, but do believe that it is incumbent on all agencies involved to ensure that, whatever their differences in philosophy in terms of treating Dual Diagnoses, their approaches dove-tail sufficiently for the effective integration of services across the city.

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[40] Evidence from Richard Ford: 29.02.08 (point 7.6).

[41] Evidence from Mike Byrne: 07.03.08 (point 12.3).

[42] See evidence from Jugal Sharma: 25.07.08 (point 36.19).

[43] Evidence from Andy Winter: 28.03.08 (points 19.5, 19.8, 19.9).

[44] Ibid. (points 19.4; 19.5).

7.10 The West Pier Project

During the course of the review, Panel members visited the West Pier Project, a council-run supported housing scheme providing accommodation to a range of clients, some of whom may have a Dual Diagnosis. Although the West Pier Project is housed in period buildings which present significant challenges for running an effective service, Panel members were very impressed by the quality of services provided.

The Project accepts clients with a Dual Diagnosis and does not insist on abstinence, although residents must be willing to commit to minimising the damage that their substance or alcohol use can cause.

Panel members considered that the West Pier Project represents a model of the type of supported housing which should be more widely available for people with a Dual Diagnosis, particularly in terms of successfully integrating such a facility into the local community and of providing expert support for clients.

7.11 Recommendations

The Panel recommends that:

a) Consideration should be given to the feasibility of commissioning temporary supported housing provision to be used to accommodate people with a Dual Diagnosis in between their discharge from residential psychiatric treatment and the allocation of appropriate longer term housing. Housing people with a Dual Diagnosis in 'Bed & Breakfast' accommodation should only be considered as a last resort.

b) Consideration should be given to the feasibility of commissioning a residential assessment facility to be used to house people with a suspected Dual Diagnosis for a period long enough to ensure a thorough assessment of their mental health and other needs.

c) Consideration should be given to commissioning long term supported housing for people with a Dual Diagnosis who refuse treatment for their condition(s).

d) Brighton & Hove City Council Housing Strategy and the Sussex Partnership Foundation Trust should seek to agree a protocol requiring statutory providers of mental health services to notify the council's Housing Strategy department when a client has been admitted to residential mental health care (subject to the appropriate approval from clients). This would enable Housing Strategy to assess the risk of an individual being unable to access

suitable housing on their discharge from hospital, and to take appropriate action.

e) Consideration should be given to establishing a 'Dual Diagnosis pathway' to ensure that people with a Dual Diagnosis can be appropriately housed as quickly and efficiently as possible.

f) The West Pier Project represents an effective model for supported housing suitable for (some people) with a Dual Diagnosis. Serious consideration should be given to providing more such facilities within the city.

8. Women's Services

8.1 National guidance on Dual Diagnosis emphasises that women with a Dual Diagnosis may face particular difficulties and pose particular problems for support and treatment services.[45] Some of these problems are detailed below.

8.1(a) 'Under-presentation'
Women with a Dual Diagnosis may be reluctant to present for treatment (particularly women with dependant children, who may feel that their custody will be placed in jeopardy if they are diagnosed as having co-existing mental health and substance misuse problems). This can result in women not being treated at all for their substance misuse and psychological problems, or being treated at an advanced rather than a relatively early stage of the development of their condition – treatment at an early stage is strongly correlated with better and quicker recovery.

8.1(b) Histories of abuse
Women with serious substance misuse problems are very likely to have experienced sexual, physical and/or emotional abuse at some stage of their lives (much more likely than other women or men). This may complicate treatment and support programmes as well as making people less likely to present for treatment.

8.1(c) Women in sex work
Women who misuse some substances, notably heroin and crack cocaine, may engage in sex work to fund their lifestyles (very possibly being coerced into so doing; sex workers are also routinely coerced into taking drugs).[46] Such work carries a very significant risk of physical

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[45] Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide, Department of Health, 2002 (p18).

[46] Evidence from Khrys Kyriacou, Brighton Women's Refuge Project: 28 March 2008 (point 21.7).

health problems and of further abuse which may worsen both mental health and substance misuse problems. (Faced with a similar need for money, men with a substance misuse problem are more likely to engage in acquisitive crime than in sex work. This may cause its own problems, such as involvement with the criminal justice system, but it is perhaps less likely to impact so severely on an individual's physical and mental health.)

8.1(d) Domestic violence

Members heard evidence that many people who have been exposed to domestic violence, either directly as the victim of assaults, or indirectly (as a child witnessing its mother being assaulted, for instance) may well develop problematic substance use and/or mental health problems, either concurrent with the assaults or in later life (see ***point 8.1(b)*** above). Whilst the types of co-morbidity typically associated with women experiencing domestic violence may not always fit exactly with the 'classic' definition of Dual Diagnosis (see ***point 3.4*** above), the problems encountered may be just as severe, particularly when the physical danger women and their families may face, likely difficulties with income and with housing etc. are factored in.

The Panel heard evidence that services for women fleeing domestic violence, such as those provided by Brighton Women's Refuge Project, are not necessarily able to cope effectively with Dual Diagnosis problems. This has several aspects:

- The fact that Women's Refuge housing provides accommodation for families escaping abusive situations may mean that it is unsuitable for people whose behaviour is liable to be chaotic and/or aggressive. However, it can prove very difficult to facilitate moving women into more appropriate accommodation as social housing may not be available, and private sector housing is difficult to access without resources for a deposit. Access to grants or loans to provide this deposit money is typically not available to the women supported by the Women's Refuge, even though these women are legitimately entitled to receive dual Housing Benefit payments (both to maintain the tenancy they were forced to flee and to pay for their accommodation in the Women's Refuge). The Panel was told that a more flexible approach to the allocation of housing-related benefits in this instance might improve the situation for women with Dual Diagnoses and their families (and many other families) without necessarily costing any more than the current arrangement.[47]

- The Panel also learnt that the Brighton Women's Refuge Project is largely funded via Supporting People grants, and the conditions attached to this funding mean that the Women's Refuge is unable to provide support services which might benefit women with a Dual

[47] Ibid. (point 21.5).

Diagnosis and their families, such as services providing emotional support for women and the direct support of client's dependent children.[48] Better and/or more flexible funding would allow for more effective support of people with a Dual Diagnosis and their families, and might even aid the local authority in fulfilling its duties to families as set out in 'Every Child Matters'.[49]

- The Women's Refuge is, for legislative reasons, unable to house women under certain circumstances. For instance, it cannot offer housing to women receiving prescribed medications to manage substance misuse issues (e.g. women prescribed methadone as a heroin substitute). Whilst there may be no local solution to this type of problem, local agencies should be aware that Women's Refuge services are unable to support certain types of client, and should arrange alternative means of support to ensure there are no gaps in the system.

8.2 There seem, therefore, to be two types of problem specific to women with a Dual Diagnosis: difficulties in identifying and engaging with those in most need of support and treatment; and, even when women with a Dual Diagnosis have been identified, difficulties in providing appropriate services (perhaps necessitating working around inflexible, nationally set targets/funding streams).

8.3 Recommendations

The Panel recommends that

a) Any future Needs Assessment of city-wide Dual Diagnosis services must address the important issue of the potential under-representation of women, and must introduce measures to ameliorate this problem.

b) The problems highlighted by Brighton Women's Refuge are addressed (point 8.1(d) above), with assurances that local solutions will be found to ensure that an appropriate range of services is made available.

9. Children and Young People

9.1 Dual Diagnosis may be a particular problem for children and young people because many mental health problems typically begin to manifest in adolescents. Similarly, many people begin experimenting with drugs and/or alcohol in their teenage years. One might therefore

[48] Evidence from Khrys Kyriacou, Brighton Women's Refuge Project: 28 March 2008 (point 21.6).

[49] Ibid. (point 21.6).

anticipate a high rate of Dual Diagnosis amongst teenagers, as both mental health and substance misuse problems are likely to be prevalent within this group.

9.2 This problem may be exacerbated by an unwillingness to present to mental health services, which is an issue across mental health care, but may be a particularly acute one in terms of adolescents.

9.3 Teenagers and young adults are also, statistically speaking, very likely to appear in other groups associated with Dual Diagnoses, such as homeless/rough sleepers and people in trouble with the criminal justice system.

9.4 Children and Young people may also share a home with parents or siblings with a Dual Diagnosis, and are therefore likely to be affected by their family member's behaviour (and how it is managed). Children and Young People may also be responsible for caring for someone with problems including a Dual Diagnosis. The potential impact of living with and/or caring for someone with both a severe mental health problem and substance misuse issues should not be underestimated. It is very likely that children who grow up in such an environment will themselves require a good deal of support, particularly if they are attempting to act as carers.

9.5 Although the root causes of a Dual Diagnosis may be very complex, it is widely accepted that childhood trauma and/or abuse are strongly linked with the development of mental health and substance misuse problems in later life. By the same token, effective identification and treatment of both mental health and substance misuse problems in their early stages of development is strongly correlated with much better outcomes and more complete recovery. In seeking to reduce the impact of Dual Diagnosis it is therefore incumbent upon agencies to accurately identify children and young people in need of services and to effectively deliver those services. Intervention at an early age may be much more effective than intervention once a co-morbidity is well established.

9.6 The Panel heard evidence from a variety of witnesses on the subject of services for children and young people. These witnesses included officers from the Children and Young People's Trust (CYPT).

9.7 Panel members heard that the structure of the CYPT, combining in one organisation functions which had formally been the responsibility of several agencies, has enabled services for children and young people with a Dual Diagnosis to be effectively integrated (although this integration is not yet complete, and work remains to be done to establish the most effective alignment of some services).[50] Witnesses

[50] See evidence received at 25.04.08 meeting (points 29.4, 29.5 and 29.9).

and Panel members agreed that the good practice established by the CYPT might usefully be studied by agencies engaged in delivering services for adults with a Dual Diagnosis.[51] However, witnesses stressed that it did not necessarily follow from this that joint working between agencies responsible for adult Dual Diagnosis services was currently poor. On the contrary, Members heard that there was a good deal of effective co-working.[52] Neither did witnesses necessarily endorse formal integration of adult services.

9.8 One problem identified by witnesses concerned the progression of clients from the CYPT to adult services. Since adult services are not formally integrated in the manner of CYPT, there is inevitably quite a noticeable break in the continuity of service and in the client's experience of his or her support and treatment, even when adult services are on a par with CYPT services.

This is particularly problematic because so many people will develop Dual Diagnosis problems whilst they are users of children's services (see ***point 9.1*** above). Thus, the need to progress from children's into adult services is a normal rather than an exceptional circumstance. This is a nationally recognised problem and work is ongoing to explore the feasibility of offering 'transitional' services (e.g. for people aged 14-25). Other services which cater for both children and adults, such as services for people with Special Needs and services for Pregnant Teenagers, have already sought to mitigate this problem by extending their upper age ranges.[53]

9.9 Another problem associated with Dual Diagnosis in this client group is that clients are often very reluctant to present for treatment or to adhere to therapeutic programmes, particularly if these programmes require a commitment to abstinence. A formal diagnosis of a co-morbidity of mental health and substance misuse issues might consequently be more commonly made when clients are in their mid-twenties (and are typically evincing somewhat less chaotic behaviour).[54]

9.10 Members were told that there was a related problem in determining the extent of teenage alcohol and drug related problems, because the recording of such data was often incomplete. This is particularly so in terms of attendance at hospital Accident & Emergency (A&E) Departments: A&E does not always 'code' incidents as drink (or substance) related and does not necessarily alert CYPT services to the attendance of children and young people with possible alcohol or

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[51] Ibid. (29.10).

[52] See evidence received at 25.04.08 meeting (29.12).

[53] Ibid. (29.11; 29.16).
[54] See evidence received at 25.04.08 meeting (29.8).

substance misuse problems. (There are similar problems with the recording of A&E attendances which might potentially relate to mental health problems.)The high turnover of A&E staff due to training requirements means that it is difficult to develop effective informal working relationships between A&E staff and the CYPT. There is ongoing work to develop a Care Pathway via which A&E could refer into the CYPT. This pathway would potentially include target numbers of referrals.[55]

9.11 In terms of the substance misuse aspect of Dual Diagnosis amongst younger people, members learnt that a wide variety of substances were used in a problematic way. However, witnesses expressed particular concerns regarding the misuse of alcohol, both because there were specific problems associated with this (including high levels of criminal/anti-social behaviour and the potential of very serious physical side-effects of prolonged use), and because children's services for alcohol are generally poorly funded.[56]

9.12 In terms of interventions into families where there might be a parent with a Dual Diagnosis whose actions place dependant children at risk, the Panel heard evidence about a programme called POCAR (Parents Of Children At Risk). POCAR provides interventions and support to parents who are problematic drugs users *and* at risk of having children taken into care. POCAR services for women are run by the Oasis Project, and for men by CRI (Crime Reduction Initiative). To date it seems that many more women than men have agreed to take part in POCAR programmes.[57] Panel members welcomed the work of the POCAR initiative, but noted that this addressed only one aspect of a the much broader issue of support for the families of people with a Dual Diagnosis. For instance, POCAR focuses on parents who retain formal custody of their children, but there are a number of situations where parents may no longer have custody, but where there is still a strong and potentially problematic relationship with their children. It is important that services are aware of such situations and can offer appropriate levels of support to all families affected by Dual Diagnosis.

9.13 Members were also told that there may be an opportunity to 'spend to save' in terms of providing Public Health education which aims to steer young people away from problematic drugs and alcohol use, thereby reducing the long term impact of these problems on individuals and the broader community. The Panel was told that any calculation regarding the funding of Dual Diagnosis services should consider this preventative role rather than simply focusing on the provision of

[55] Ibid. (29.14).

[56] See evidence received at 25.04.08 meeting (point 29.14).

[57] Evidence from Jo-Ann Welsh, Director, The Oasis Project: 28.03.08 (points 22.2, 22.5 and 22.6).

services for people already diagnosed with a co-morbidity of mental health and substance misuse problems.[58] However, the Panel was informed that recent years had seen a reduction in substance misuse Public Health information specifically targeting young people.[59]

9.14 Recommendations

The Panel recommends that:

a) The integrated services for Dual Diagnosis offered by the CYPT are studied by agencies responsible for co-working to provide adult Dual Diagnosis services. Where agencies are unable to formally integrate, or feel that there would be no value in such a move, they should set out clearly how their services are to be effectively integrated on a less formal basis.

b) Serious and immediate consideration must be given to introducing a 'transitional' service for young people with a Dual Diagnosis (perhaps covering ages from 14-25). If it is not possible to introduce such a service locally, then service providers must demonstrate that they have made the progression from children's to adult services as smooth as possible, preserving, wherever feasible, a high degree of continuity of care.

c) Serious consideration needs to be given to the growing problem of problematic use of alcohol by children and young people (including those who currently have or are likely to develop a Dual Diagnosis). It is evident that better support and treatment services are required.

d) The development of a 'pathway' to encourage A&E staff to refer young people attending A&E with apparent substance or alcohol problems should be welcomed. There may need to be targets for referrals to ensure that the pathway is used as efficiently as possible.

e) Public Health education encouraging abstinence/sensible drugs and alcohol use is vital to reducing the incidence of Dual Diagnosis in the long term. Effective funding for this service must be put in place. Public health education encouraging mental wellness is equally important.

f) Dual Diagnosis can have a profound and ongoing impact upon the families of people with a co-morbidity of mental health and substance misuse issues. It is vital that appropriate support services are available for families and that every effort is taken to identify those in need of such support. Therefore, a protocol

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[58] Evidence from Simon Scott: 07.03.08 (point 9.4).

[59] Evidence from 29.02.08 (point 5.4).

should be developed whereby a formal assessment of the support needs of families is undertaken whenever someone is diagnosed with a Dual Diagnosis.

10. Integrated Working and Care Plans

10.1 One of the problems posed by Dual Diagnosis is that its treatment involves two historically distinct disciplines: psychiatric care and substance misuse services. Successful outcomes for patients will rely, to a large extent, on the effective integration of these services.

10.2 There are three basic approaches to co-ordinating treatments for Dual Diagnosis: ***sequential***, ***parallel*** and ***integrated*** care models.

- ***Sequential*** care involves the treatment of one aspect of the Dual Diagnosis before the other. Thus, treatment of a substance misuse problem might be attempted before engaging with a client's mental health problems. However, people with a Dual Diagnosis are likely to suffer from mutually interactive conditions, meaning that it may not be practically possible to separate the problems and treat each in isolation.

- ***Parallel*** care involves the concurrent, but separate treatment of both conditions (i.e. distinct teams delivering a co-ordinated treatment of both mental health and substance misuse problems). There are obvious potential pitfalls here, as patients may be required to engage with contrasting therapeutic approaches and present for treatment to different agencies: the risk is that treatments are mutually contradictory or that patients 'fall between the gaps' of services. However, there is a broad range of possible parallel configurations, and some may be considerably more effective than others; thus, whilst wholly separate teams working in parallel might struggle to deliver good services; formally discrete, but effectively integrated teams based together on a single site might be able to deliver excellent results.

- ***Integrated*** care involves the concurrent treatment of both conditions delivered by a single team. Integration is a popular technique in American healthcare, and US evaluations of this model have tended to show it to be more effective than either sequential or parallel treatment. However, it may be the case that an integrated system of mental health and substance misuse care fits comfortably with American training and working practices, but much less so with UK practices, where a move to formal integration might require considerable changes to the way in which services are organised and training is conducted. Some experts suggest that comprehensively integrated parallel care may produce

similar results to formal integration, without requiring structural changes which might resonate far beyond services for Dual Diagnosis.[60]

10.3 Panel members were told that co-working between mental health and substance misuse services in Brighton & Hove was generally very effective. Several witnesses believed that this kind of co-ordinated parallel working was preferable to the formation of a single, multi-disciplinary Dual Diagnosis team.[61] It was pointed out to the Panel that treatment via an integrated mental health and substance misuse team might improve services for some patients, but for many others it would entail receiving a generalist treatment when expert specialist intervention by distinct teams might have provided a better option.[62]

10.4 While integrated treatment for Dual Diagnosis might not be the best way forward, some witnesses did feel that integrated assessment may be desirable. Thus, the Panel was told that an integrated assessment team would allow all agencies to contribute to the assessment process in accordance with their expertise, improving services for clients.[63] Brighton & Hove City Teaching Primary Care Trust (PCT) is ultimately responsible for commissioning these services, and so it would be the PCT's decision whether to move to an integrated system of assessment.

10.5 City GPs have recently commissioned (working together as 'Practice Based Commissioners') a service from the Sussex Partnership Foundation Trust which will provide a single referral point for people suspected of having Dual Diagnosis problems. Three teams situated within the Community Mental Health Team will be responsible for assessing patients in the East, the West and the Centre of Brighton & Hove. It is hoped that these teams will speed up the assessment process as well as mitigating the danger of people with a Dual Diagnosis being referred to inappropriate services or being 'bounced around' agencies.[64]

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[60] Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide, Department of Health, 2002 (pp22, 23).

[61] See: evidence from Richard Ford: 29.02.08 (9.3); evidence from Andy Winter 28.03.08 (19.11; 19.7). [Mr Winter argued that full integration of the assessment of patients' needs is practically unattainable because different agencies work to differing Performance Indicators (PIs)/targets. Since these PIs are generally nationally established and therefore immutable at a local level, it is very unlikely that a fully integrated local assessment system could ever be established, since it seems unlikely that a single joint assessment could ever satisfy the various requirements of all the agencies involved.]

[62] Evidence from Dr Tim Ojo: 28.03.08 (point 20.8).

[63] Evidence from Joy Hollister, Director of Adult Social Care and Housing, Brighton & Hove City Council (point 1.6 in the evidence notes).

[64] Evidence from Simon Scott: 29.02.08 (points 4.12; 4.13).

10.6 Integration between NHS services and those dealing with employment and housing has historically been much more problematic, with poor communication often leading to a lack of co-ordination. Current Government initiatives to increase the availability of 'talking therapies' may strengthen links between mental health and employment services.[65] The roll-out of improved access to these therapies is intended, at least in part, to enable people with mental health problems to access appropriate support and therapy in order to remain in employment rather than claiming Incapacity Benefits. (This may not, however, have much of a direct impact upon Dual Diagnosis, as the target group for intervention via talking therapies is likely to feature people with much less severe conditions.)

Integration with housing services is an issue that has been partly addressed at a local level, with the co-location of Sussex Partnership Trust's Mental Health Placement Officer alongside Brighton & Hove City Council's Housing Options Team.[66] However, it is apparent that there is much still to do in terms of the effective integration of mental health, substance misuse and housing services, particularly in terms of relationships between the statutory services and the Registered Social Landlords who provide city-wide supported housing.[67]

10.7 An important aspect of co-ordinated working between agencies involves the creation, maintenance and use of 'Care Plans' – regularly updated documents which determine the types of treatment and support an individual client is to receive. There are clear advantages to co-ordinating work in regard to the creation of Care Plans. However, it may not be possible to formally integrate Care Plans as different organisations have differing requirements which could not be easily met by a single joint Care Plan: for such a document to meet all the various requirements of the agencies involved might mean that it was too unwieldy to be of much practical use. Effective co-working may therefore be a better option here than formal integration.[68] Witnesses were generally positive about Care Plans currently in use within the city.[69]

10.8 Although Care Plans are regularly shared between the statutory agencies, they are not necessarily readily available to other services which might benefit from access to them. For instance, housing support services might usefully refer to Care Plans when determining where a

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[65] See evidence from 29.02.08 (point 8.1).

[66] Evidence from David Allerton: 07.03.08 (point 11.1).

[67] See evidence from 29.02.08 (point 7.8).

[68] Evidence from David Allerton: 07.03.08 (point 11.11).

[69] Evidence from Mike Byrne: 07.03.08 (point 12.9).

client with Dual Diagnosis should be housed. There is some ongoing work in this area, although progress has been slow.[70]

10.9 Recommendations

That Panel recommends that:

a) Consideration should be given to adopting an integrated approach to the assessment of people with Dual Diagnosis problems. Such assessments must be outcome focused. If the commissioners are unable/unwilling to move towards such a system, they should indicate why the current assessment regime is considered preferable.

b) A single integrated Care Plan may be neither possible nor desirable, but co-working in devising, maintaining and using Care Plans is essential. Whilst good work has clearly been done in this area, the development of a Care Plan, including clearly expressed 'move-on' plans, which can be accessed by housing support services (and other providers) is a necessary next step in the integration of support services for Dual Diagnosis.

11. Funding

11.1 The adequacy of funding is obviously a relevant concern for any study of the effectiveness of aspects of health or social care. In terms of Dual Diagnosis, a number of witnesses commented on the funding situation.

11.2 To a degree, the question of the adequacy of funding for these services hinges on one's definition of Dual Diagnosis. It is, for instance, widely recognised that funding for relatively low level substance misuse problems is rarely wholly adequate, and this is equally so in terms of the treatment of relatively mild mental health problems. (In both instances, treatments or interventions may be available, but with very lengthy waiting lists.) Therefore, it might be argued that people with a fairly low level co-morbidity of mental health and substance misuse problems may not be receiving the best possible services, and almost certainly not services delivered as soon as they are required.

However, as has been noted above, Dual Diagnosis is more typically defined as the co-existence of *severe* mental health and substance misuse problems. People with conditions such as schizophrenia or bi-polar disorders can usually anticipate relatively quick access to therapies and a very high level of treatment, largely because these conditions may be extremely serious in terms of health risks to the

[70] Evidence from 29.02.08 (point 9.6).

individual, but also because of the impact these illnesses can cause on families, carers and the wider community. A similar point may be made about very severe manifestations of substance misuse problems: their impact is likely to be such that they will be treated as priority issues and accorded appropriate funding.[71]

Therefore, whilst general funding for both substance misuse and mental health services may not be wholly adequate, it seems reasonable to assume that funding for Dual Diagnosis (as defined above) is not a very major issue.

11.3 Witnesses identified the funding for services relating to the problematic use of alcohol as being worryingly low, both in national and in local terms. Given the major and growing problems associated with alcohol use in Brighton & Hove this is an obvious worry. Although there are proposals to increase the funding of these services, the planned increases may not be adequate to address this problem.[72] (See also ***point 9.11*** above regarding funding for young people's alcohol services.)

11.4 While a number of witnesses expressed concerns regarding the provision of Supported Housing for people with a dual Diagnosis, there seemed to be general agreement that this was not, fundamentally, an issue of funding of supported housing places: adequate supported housing is available, but there may not be enough of it which is appropriate for the particular needs of this client group.

However, additional funding may be needed to commission particular types of supported housing, such as a residential assessment centre, temporary accommodation for people discharged from residential healthcare or housing for people who refuse treatment (see ***points 7.6, 7.7*** and ***7.8*** above).

Clearly, funding is not wholly an irrelevance here: providing support services for clients with very complex needs is obviously expensive, and the seeming reluctance of some housing providers to accommodate (non-abstinent) Dual Diagnosis clients may reflect a belief that the available funding does not always cover the levels of support required. There may therefore be a need for some fine-tuning of the allocation of funds for housing support to encourage and enable providers to offer a greater variety of services for people with a Dual Diagnosis.

11.5 All of the above assumes that general funding in this area will remain relatively static. However, this may not be the case, as planned cuts to the Supporting People budget may impact widely upon city services.

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[71] Evidence from 29.02.08 meeting (point 6.1).

[72] Evidence from 29.02.08 meeting (point 6.1).

Whilst there is a general aspiration to protect services for working age adults with mental health problems, the city-wide effects of the cuts, including their impact upon supporting housing providers who offer a variety of other services in addition to Dual Diagnosis services (including services which will see funding reduced), is not yet known.[73]

While the general climate may be one in which there is little prospect of getting increased funds for health and social care provision, the Panel was informed that it might be possible to re-profile parts of the budget for mental health and substance abuse in order to provide additional funding for supported housing services for Dual Diagnosis if clear benefits could be shown.[74]

11.6 Recommendations

The Panel recommends that:

a) Better provision for alcohol related problems, both in terms of treatment and Public Health, is a priority and urgent consideration should be given by the commissioners of health and social care to developing these services so that they meet local need.

b) The commissioners of Dual Diagnosis services must agree on a level (or levels) of housing support appropriate for people with a Dual Diagnosis and ensure that there is sufficient funding available for city supported housing providers to deliver this level of care.

12. Treatment and Support

12.1 The Panel heard evidence from a number of witnesses concerning ways in which people with a Dual Diagnosis were or should be treated and supported.

12.2 One point made was that effective treatment of Dual Diagnosis should aim to be as personalised as possible; ‘Dual Diagnosis’ is a blanket term encompassing a very wide range of conditions and a generic treatment is highly unlikely to fit well with the needs of all individuals.[75]

12.3 Since treatment and support services for Dual Diagnosis are often very specialised, it is important that the right services are in place as and when they are needed, including services providing supported housing, ‘talking therapies’, suicide prevention and professional carers. Ensuring that the correct services are in place can be a considerable challenge,

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[73] See Evidence from Steve Bulbeck: 07.03.08 (13.8).

[74] Evidence from Simon Scott: 29.02.08 (point 7.9).

[75] Evidence from Dr Tim Ojo: 28.03.08 (point 20.3).

and the local implementation of the national Self-Directed Support initiative (giving individuals much more say in aspects of their own care and support) is bound to make this process more complex. Currently, Sussex Partnership Trust takes the lead on this 'micro-commissioning' process, and the Trust's ability to continue to deliver effectively in this area will be key to maintaining and improving Dual Diagnosis services.[76]

12.4 The Panel also heard evidence that 'support' services for people with Dual Diagnosis needed to be broadly interpreted, as some services which might be of great value to this client group were not commonly thought of as support services. For instance, the Panel was informed that pharmacists could provide a key resource in helping people with a Dual Diagnosis, building up good relationships with people receiving methadone prescriptions etc. (particularly since pharmacists tend to be seen as independent of the statutory agencies – a potentially important factor for people with a distrust of such agencies).[77] Similarly, third sector organisations may find that they are able to interact with Dual Diagnosis clients in way which the statutory agencies cannot. It is therefore important for the commissioners of Dual Diagnosis services to ensure that thought is given to which providers are most capable of winning clients' trust, rather than the providers who offer the most obvious value for money.

12.5 Brighton & Hove has a limited number of detoxification facilities available, both in terms of adult and children's services.[78] This means that people presenting with a Dual Diagnosis may not always be offered timely and appropriate treatment.[79] Relatively rapid access to detoxification facilities is particularly important as people with substance misuse issues (including people with a Dual Diagnosis) may vacillate between being committed to abstinence and having no immediate interest in it. Thus, in some instances there may be a limited window of opportunity to offer detoxification services.

12.6 The point on detoxification (***12.5 above***) is almost equally applicable to other therapies. People with a Dual Diagnosis typically live very chaotic lives; someone who is willing to submit to a therapeutic intervention now may not be willing to do so at a later date, or may have ceased presenting to services altogether. Although it seems that assessment of people with a suspected Dual Diagnosis is now very rapid (within 72 hours in urgent cases), there may be a much longer wait before

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[76] Evidence from Joy Hollister (1.3-1.5).

[77] Evidence from Joy Hollister (1.11).

[78] Evidence from Sally Wadsworth, Commissioning Manager, Child and Adolescent Mental Health Services (CAMHS), Children & Young People's Trust: 25.04.08 (point 29.5).

[79] Evidence from Dr Tim Ojo: 28.03.08 (point 20.5).

treatment actually commences[80]. Too long a wait may have an impact upon the efficacy of the services delivered.

12.7 People with a Dual Diagnosis, along with other people with severe mental health problems, may potentially need to be temporarily detained in a secure mental health facility 'under a section' of the Mental Health Act. The Panel heard evidence from the parent of someone with Dual Diagnosis concerning aspects of the 'sectioning' process and of the treatment and support locally available to people under a section. Problems identified included:

- An apparent reluctance on the part of NHS Mental Health staff to respond quickly to calls concerning the fragile mental state of a person with a Dual Diagnosis. The witness told the Panel that Trust staff would advise the person's family/carers to call the police should the carers consider that the situation required an urgent response. In the view of the witness, this was inappropriate advice which might have placed families and carers at risk of violence should police officers have interviewed an individual with a Dual Diagnosis at the behest of family members but subsequently decided not to arrest or detain them (police officers may detain someone for assessment under section 136 of the Mental Health Act even though that person has committed no crime).

- Poor detoxification facilities at Mill View Hospital (*see* ***point 12.3*** *above*).

- Poor security at Mill View Hospital, which meant that the witnesses' son was able to obtain alcohol from local shops whilst supposedly being detained in a secure environment.

- Poor access to therapeutic activities at Mill View Hospital (including Occupational Therapy and Cognitive Behavioural Therapies), and inadequate encouragement of patients to engage with therapies, to take exercise, or to maintain levels of personal hygiene etc.

- Inadequate attempts to persuade people detained under a section to take their prescribed medication.

- Inadequate support following discharge (from the local NHS Assertive Outreach Team)[81].

- 'Leave' inappropriately granted to patients detained under a section of the Mental Health Act.

[80] Evidence from Dr Tim Ojo: 28.03.08 (point 20.7).

[81] This was not a complaint about the performance of the Assertive Outreach Team as such, but rather a view taken that the team's remit was too narrow to enable it to provide truly effective support services for vulnerable people leaving residential psychiatric services.

- The provision of inappropriate accommodation following discharge (Bed & Breakfast accommodation with no cooking facilities).[82]

12.8 The Panel has not sought to elicit detailed responses to these points from the NHS Trusts involved, as it was not considered directly within the Panel's remit to do so, particularly in instances where some other recourse, such as appeal to official NHS complaints procedures, might be more appropriate. The Panel is therefore not in a position to judge whether all of these comments are valid, or whether they refer to historic levels of service or the current levels. The Panel does consider that all of these points should be addressed by the appropriate NHS Trusts. (In some instances, such as the question of the provision of therapeutic activities at Mill View Hospital, it is members' understanding that recent and ongoing initiatives, such as the reconfiguration of the Mill View site, may have effectively ameliorated many of the problems identified.)

12.9 Historically, the NHS has a very mixed record of involving families and carers in developing and adapting services for people with a Dual Diagnosis. Although there are legitimate concerns of patient confidentiality to be considered, it is clear that much more should be done in this area. The Panel was assured that Brighton & Hove NHS Trusts, led by Brighton & Hove City teaching Primary Care Trust, were engaged with ongoing work to better involve families and carers in the design, provision and commissioning of Dual Diagnosis services.[83]

12.10 The Panel also received written evidence from someone with a Dual Diagnosis.[84] This evidence highlighted the gap between presenting for treatment and assessment/treatment commencing as a major problem.

The witness also felt that a support group for people with a Dual Diagnosis would be a valuable addition to city services, enabling people to better understand and cope with their conditions and lessen the inevitable isolation that a Dual Diagnosis can cause.

It was also suggested that there should be greater user involvement in designing city services for Dual Diagnosis. Involving service users in designing systems, recruiting and training staff and so on, may not always be an easy process, but it can have considerable benefits in terms of creating a service that is genuinely responsive to actual client needs.

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[82] Evidence from Sue Baumgardt, parent of someone with a Dual Diagnosis: 28.04.08 (points 30.4; 30.5; 30.6; 30.8).

[83] Evidence from Simon Scott: 29.02.08 (point 9.5)

[84] Evidence from Mr D Curtis (see **Appendix 6** to this report).

12.11 Recommendations

The Panel recommends that:

a) The provision of detoxification facilities for city residents be reconsidered, with a view to providing more timely access to these services, particularly in light of growing alcohol and drug dependency problems in Brighton & Hove.

b) Treatments commissioned for people with a Dual Diagnosis need to be readily available at short notice, so that the chance for effective intervention is not lost with clients who may not be consistently willing to present for treatment. Any future city Strategic needs Assessment for Dual Diagnosis should focus on the accessibility as well as the provision of services.

c) The Sussex Partnership Foundation Trust examines its policies relating to detaining people under a section of the Mental Health Act, in order to ensure that the inevitably distressing process of 'sectioning' is as risk free as possible (for patients and also for their families and carers), and that maximum possible therapeutic benefit is extracted from the process. If the trust has recently undertaken such work/carries out this work on an ongoing basis, it should ensure that it has relevant information on this process available to be accessed on request by patients and their families.

d) Service users should be central to the development of Dual Diagnosis services. When they commission services, the commissioners should ensure that potential service providers take account of the views of service users when designing services and training staff, and should be able to demonstrate how these views have been incorporated into strategies, protocols etc.

13. Data Collection and Systems

13.1 The last comprehensive Needs Assessment in relation to Dual Diagnosis in Brighton & Hove was undertaken in 2002. Since then much may have changed, but without accurate data it is very hard to be sure what the situation is. The Panel heard from witnesses who recommended that an updated Needs Assessment was urgently required, since without a relatively accurate assessment of demand it was difficult to plan and budget effectively for services.[85] There are major opportunities here, particularly in terms of the council potentially purchasing properties to be used for the provision of supported housing. Such an initiative might significantly reduce the cost to the local authority of this provision and improve the quality of some

[85] Evidence from Jugal Sharma: 25.07.08 (36.21, 36.22).

supported accommodation (if, for instance, this housing were to be used instead of privately provided B&B accommodation, which can be expensive and of poor quality).[86]

13.2 Recommendations

The Panel recommends that:

a) A new Strategic Needs Assessment for Dual Diagnosis services in Brighton & Hove is undertaken as a matter of urgency.

C Conclusions

13. Concluding Remarks

13.1 Dual Diagnosis presents very serious problems. Some aspects of these problems receive a great deal of publicity: the difficulties caused by people with severe substance misuse and mental health problems in terms of crime, anti-social and chaotic behaviour and pressures upon health, social care and housing services are well known.

13.2 The personal impact of Dual Diagnosis is not as well publicised as its public impact, but its effect upon people with a co-morbidity of mental health and substance misuse problems and on their families and carers can be devastating. The Panel heard evidence from Sue Baumgardt, whose son Yannick had a Dual Diagnosis. Yannick died several years ago as a result of heroin poisoning after having lived with a Dual Diagnosis for a number of years. It was clear from Ms Baumgardt's evidence how extraordinarily difficult it can be to live with or to support someone who has a Dual Diagnosis.[87]

13.3 It may not be possible to 'cure' people with a Dual Diagnosis: mental health problems are, in general, managed rather than cured; problematic patterns of drug or alcohol use can be replaced with abstinence, but the possibility of relapse is always present. However, this does not necessarily mean that the prognosis is gloomy: very severe mental health problems can be managed with a combination of medicines and psychiatric therapies so as to allow sufferers to live relatively normal lives in the community. Many people with severe substance misuse problems do eventually achieve a goal of abstinence. The process of 'recovery' and effective management of co-existing mental health and substance misuse problems may be a long one, with many false starts, but it is, in many instances, an achievable goal.

[86] Evidence from Jugal Sharma: 25.07.08 (36.11-36.13).

[87] Evidence from Sue Baumgardt: 28.04.08 (point 30.).

13.4 However, for treatments of Dual Diagnosis to work, they have to be as good as possible. The Panel learnt that city services are often excellent, with highly committed staff and generally very good patterns of co-working. However, it is clear that much more can and must be done in terms of further integrating city services; of ensuring that funding is properly directed; of ensuring that services address the real needs of the local population, including currently unmet need; and of providing enough appropriate supported housing.

13.5 The Panel hopes that this report and the recommendations it contains will contribute to improving city services for people with a Dual Diagnosis. However, this is clearly an enormous issue and one which will necessitate a good deal of ongoing work from the City Council, from the local NHS and from other agencies and individuals in Brighton & Hove.