Appendix 3C

BRIGHTON & HOVE CITY COUNCIL

SCRUTINY PANEL ON DUAL DIAGNOSIS

10AM 28 MARCH 2008

HOVE TOWN HALL

MINUTES

Present: Councillor Watkins (Chairman); Councillors Hawkes, Taylor and Young.

Witnesses: Andy Winter (Brighton Housing Trust), Dr Tim Ojo (Sussex Partnership NHS Trust), Khrys Kyriacou (Brighton Women's Refuge Project), Jo-Anne Welsh (The Oasis Project), Mike Pattinson (CRI – Crime Reduction Initiative).

PART ONE

ACTION

16 PROCEDURAL BUSINESS

16A. Declarations of Substitutes

16.1 Substitutes are not permitted on ad-hoc Scrutiny Panels.

16B. Declarations of Interest

16.2 There were none.

16C. Exclusion of Press and Public

16.3 The Committee considered whether the press and public should be excluded from the meeting during the consideration of any items contained in the agenda, having regard to the nature of the business to be transacted and the nature of the proceedings and the likelihood as to whether, if members of the press and public were present, there would be disclosure to them of confidential or exempt information as defined in Schedule 12A, Part 5A, Section 100A(4) or 100 1 of the Local Government Act 1972 (as amended).

16.4 **RESOLVED** - That the press and public be not excluded from the

meeting.

17. MINUTES

17.1 That the minutes of the meeting held on 07.03.08 be approved.

18. CHAIRMAN'S COMMUNICATIONS

18.1 The Chairman welcomed the witnesses giving evidence at the meeting and reminded all present of the Panel's Terms of Reference.

EVIDENCE FROM WITNESSES

Witnesses at this session were: **Andy Winter**, Chief Executive of Brighton Housing Trust; **Dr Tim Ojo**, Consultant Psychiatrist at Sussex Partnership NHS Trust; **Khrys Kyriacou**, Brighton Women's Refuge Project; J**o-Anne Welsh**, Director of the Oasis Project; **Mike Pattinson**, Chief Executive of CRI.

19. Evidence from Andy Winter.

19.1 Mr Winter told the Panel that he was Chief Executive of Brighton Housing Trust, and had spent his career working with people with substance misuse and mental health problems.

19.2 Brighton Housing Trust provides a range of services for people with mental health/substance misuse problems, including the "First Base" Day Centre (for homeless/insecurely housed people with mental health and substance misuse problems); "Phase 1" (52 bed spaces for homeless people, many of whom will have mental health and substance misuse problems); the "Route 1 Project" (63 bed spaces with varying levels of support for people with mental health problems – many of whom may also have substance misuse issues); a three-person flat providing accommodation for (abstinent) clients with a Dual Diagnosis); Addiction Services – a variety of detox and recovery services.

19.3 Mr Winter noted that he considered the term "Dual Diagnosis" unsatisfactory as it effectively sought to impose a single definition on a broad continuum of problems which might in actuality be very disparate. (Thus someone with a severe mental health problem who self-medicated with cannabis, and someone with substance misuse issues who developed mild symptoms of anxiety/depression as a result of their drugs use would both potentially be classified as having a Dual Diagnosis, even though the nature of and treatment of their problems might be radically

different.) Mr Winter prefers to use the term "complex needs".

19.4 Asked to explain his position on the use of methadone in treating people with a problematic history of opiate use, Mr Winter told the Panel that methadone can be very useful in the short term. However, many people who are prescribed methadone either "top-up" with street-acquired opiates, or associate with people who are still using heroin, thus compromising methadone's long-term effectiveness as an addiction resource.

19.5 The majority of the supported places which are provided by Brighton Housing Trust accept people with a methadone prescription, but a minority do not, as methadone users do tend to socialise with heroin users and/or continue to use heroin with a likely negative impact upon their own recovery and on those with whom they are housed.

Mr Winter stated that he does not believe that there are too many "abstinent" supported housing places in Brighton & Hove, but rather that there are too few.

19.6 Mr Winter explained that all Brighton Housing Trust's supported housing clients were referred via one of the established pathways (e.g. mental health; homelessness). Most clients' needs had been competently assessed, although it was often the case that other needs became apparent only once clients had been in settled accommodation for some time.

19.7 In response to a question regarding the integration of Needs Assessments for clients with complex needs, the Panel was told that there was much better co-working currently than had formerly been the case. However, the much improved resources for assessment very often came with specific targets attached to them. This could make co-working problematic, as different agencies often operated to their own Performance Indicators which were not necessarily compatible with those of partner agencies. Since these different Performance Indicators were often effectively immutable (at any rate at a local level), 100% effective co-working was not always a practical possibility.

19.8 In answer to a query regarding client motivation to achieving a goal of abstinence, the Panel was told that clients varied greatly in the degree of motivation they demonstrated: some clients evinced no desire to be abstinent, and in such instances, help needed to be focused upon harm minimisation (maintaining the client's health and minimising the impact of their behaviour on the wider community). However, most people presenting for treatment did have a long term aim of being abstinent. Services need to be flexible in order to deliver a rapid response to people who wanted immediate help with their substances misuse problems, but who might not be willing or able to wait any length of time for treatment to commence.

19.9 In response to a question regarding the origins of Brighton Housing Trust's interest in abstinence-based treatment programmes, the Panel was told that this arose internally, after staff expressed an interest in this approach. Mr Winter stressed that Brighton Housing Trust was also involved in a number of treatments which featured minimisation of substance use: the organisation by no means followed a rigid "abstinence only" policy.

19.10 In answer to a question concerning the percentage of people successfully treated/supported by Housing Brighton Trust who had presented with a Dual Diagnosis, Mr Winter told the Panel that it was impossible to give an accurate estimate of this figure without a stable definition of Dual Diagnosis.

Nearly everyone with severe substance misuse issues that Brighton Housing Trust supported would, at one time or another, have been prescribed therapeutic drugs for some form of mental health problem (although not everyone prescribed such drugs would actually take them: prescription drugs were often sold on to other drugs users). Thus, in theory, almost every person with a long-term substance misuse problem might be categorised as also having a mental health problem. However, the great majority of this group have relatively minor mental health problems (such as mild anxiety and/or depression) caused or greatly exacerbated by their drugs or alcohol use. The percentage of people with substance misuse and unrelated mental health problems is far smaller.

19.11 In answer to a question concerning the desirability of a central co-ordinating agency to deal with Dual Diagnosis, the Panel was told that the present system of co-working with the Sussex Partnership NHS Trust as the lead body was an effective one.

19.12 In response to a question about what could be done to improve Dual Diagnosis services, Mr Winter told the Panel that a residential assessment centre for people with a possible Dual Diagnosis (with assessment taking 2-4 weeks) would be a valuable asset. This would have to provide very high levels of support.

19.13 Mr Winter also argued in favour of more flexibility in terms of referral processes into existing support services, with a particular aim of avoiding the inappropriate use of general B&B accommodation.

19.14 In addition, there is currently no provision in the city of long-stay accommodation for people with a Dual Diagnosis who decline to engage with services. This was formerly available, but is no longer supported via Supported People grants (in accordance with recent Government Guidance which discourages its use). However, such a service would be useful and would mean that clients who declined to engage with services could, if necessary, be housed separately from other people with a Dual Diagnosis.

19.15 Mr Winter also suggested that Panel members might want to speak directly with service users and offered to arrange a visit to a Brighton Housing Trust recovery project. **GR**

20. Evidence from Dr Tim Ojo

20.1 Dr Ojo introduced himself to the Panel. He is a consultant psychologist working for the Sussex Partnership NHS Trust and an Associate Medical Director for the Trust's Brighton & Hove locality.

20.2 Dr Ojo noted that Dual Diagnosis could be an inaccurate term, as many of the people presenting to mental health services with co-existing mental health and substance misuse problems would not be "classic" Dual Diagnosis cases, being as likely to have a serious mental health problem and a relatively minor substance misuse issue (for instance problematic use of cannabis or "dance drugs"), as to have a serious mental illness coupled with major substance misuse issues such as an addiction to opiates.

20.3 In response to a question as to how the treatment of people with a Dual Diagnosis might be improved, Dr Ojo told the Panel that treatment should be as individualised as possible: best results would only be achieved by being responsive to each individual patient's particular problems rather than by offering a generic Dual Diagnosis treatment.

20.4 Whilst people with a severe mental health problem could, under certain circumstances, be detained for treatment under a section of the Mental Health Act, there was no such provision to require people with severe substance misuse problems to undergo treatment. Thus people with a Dual Diagnosis would often only receive treatment if the mental health aspect of their co-morbidity had become so disruptive as to necessitate placing them under a Section.

20.5 City mental health services have a limited number of detox facilities, meaning that patients who do present with a Dual Diagnosis cannot always be treated as swiftly as would be wished.

20.6 In answer to a question regarding the therapeutic value of methadone, the Panel was told that methadone could be of considerable value in treating opiate-dependant patients as it might significantly reduce the problems associated with using "street" drugs, such as varying levels of drug purity, the health risks associated with injecting drugs, and acquisitive crime undertaken to feed a drug habit. However, some other countries do not consider methadone to be useful; preferring, for instance, to prescribe heroin.

If methadone is to be prescribed it is important to ensure that the dosage is appropriate and that a gradual reduction of dosage is encouraged.

20.7 In response to a question about how quickly mental health services could be accessed following a GP referral, Panel members were told that assessment (by the Community Mental Health Team) should take place within 72 hours of referral in urgent cases. However, there might be a much longer wait before the actual commencement of treatment.

Sussex Partnership Trust is working to ensure that equally rapid assessment is available for all patients who present with a Dual Diagnosis, even if people do not enter the system via the normal GP-referral pathway. However, this is work in progress.

20.8 In response to questions regarding the integration of mental health and substance misuse services, Dr Ojo told the Panel that treating a Dual Diagnosis was, in some respects, equivalent to treating a co-morbidity of two physical ailments in that one would expect to have treatment from two distinct teams working in close liaison rather than from a single formally integrated team. This was generally the most logical way to work in treating Dual Diagnosis, as many patients with a mental illness would

have relatively minor substance misuse issues, and would consequently be best dealt with by a specialist mental health team (and vice versa for people with a Dual Diagnosis in which substance use problems predominated).

To treat and support Dual Diagnosis patients via an integrated mental health and substance misuse team might improve services for some patients, but for many others it would likely entail generalist treatment when expert specialist intervention would have been a better option.

20.9 In answer to a query as to whether Dual Diagnosis was most prevalent in certain social classes or income groups, the Panel was told that, although the problem was traditionally associated with low incomes, there was an increasing problem amongst "middle-class" people, particularly in terms of the problematic use of cannabis and of "dance drugs" such as ketamine and methamphetamine ("crystal meth").

21 Evidence from Khrys Kyriacou

21.1 Ms Kyriacou introduced herself as representing the Brighton Women's Refuge Project.

21.2 Ms Kyriacou told the Panel that many victims of domestic violence also had problems which amounted to a Dual Diagnosis. There was strong evidence to demonstrate that exposure to domestic violence (either directly as the victim of assaults, or indirectly as a child witnessing their mother being assaulted) was very likely to lead to either or both problematic substance misuse and to mental health problems, either concurrent with the abuse or in later life.

21.3 Ms Kyriacou stressed that, whilst there was a significant level of female abuse of male partners, and indeed of same-sex abuse, the bulk of domestic violence and certainly the bulk of the most serious cases involved men abusing women. The ways in which statistics were recorded and published did not always make this as clear as it should have been.

21.4 The Women's Refuge has a very limited capacity to accept clients with a Dual Diagnosis, and is only equipped to deal with fairly low levels of Dual Diagnosis.

21.5 In response to a question concerning the best way to improve services for Dual Diagnosis, Ms Kyriacou told the Panel that the current difficulty of accessing funds to pay for a deposit on private rented accommodation negatively impacted upon

many people being helped by the Women's Refuge, including women with a Dual Diagnosis. Access to deposit money would not only enable women to establish a more settled existence, but it would very likely end up saving money, as many women were entitled to and claimed dual Housing Benefit (for Women's Refuge accommodation and for the tenancies they had been forced to flee due to domestic violence), and had little to choice other than to continue claiming if it was, in practical terms, impossible for them to access private rented housing.

21.6 Ms Kyriacou also told Panel members that the Women's Refuge is wholly funded by Supporting People grants. This funding is targeted at particular services, and financial support is not given to important areas that fall outside of the Supporting People Key Performance Indicators (KPIs) such as providing emotional support to clients or directly supporting clients' dependant children. Given the restricted nature of Supporting People's KPIs, and hence of the Women's Refuge funding, Ms Kyriacou felt that it was not always currently possible to provide the best possible treatment for women with a Dual Diagnosis.

Councillor Pat Hawkes noted that this was a very serious problem, particularly with reference to the Council's duties to children and families as set out in "Every Child Matters."

21.7 Ms Kyriacou told the Panel that particular problems for women with a Dual Diagnosis included possible involvement in prostitution in order to fund a drugs habit (often involving a degree of coercion) and a reluctance to present for treatment, particularly for women with dependant children who feared their children might consequently be taken into care.

21.8 Ms Kyriacou noted that legislative restrictions made helping certain groups of people particularly problematic. For instance, the Women's Refuge is unable to house women who require prescribed medications to manage substance misuse issues. The Women's Refuge may, after conducting a risk assessment, house women who refuse prescribed medication for mental health problems.

22 Evidence from Jo-Anne Welsh

22.1 Ms Welsh introduced herself as the Director of the Oasis Project. The Oasis Project provides support services for women with drugs misuse problems and their children. The Oasis Project works closely with Sussex Partnership trust and with CRI (which provides a similar range of support services for men).

22.2 The Oasis Project offers a number of services, including open-access support for women with drugs problems (and for their relatives and/or carers); support for people serving Community Sentences; and support for women designated as Parents Of Children At Risk (POCAR) and therefore obliged to seek support.

The Oasis Project also funds outreach workers to engage with sex-workers and a part-time outreach officer to work with drugs users.

22.3 Ms Welsh noted that many of the Oasis Project's clients would have some form of Dual Diagnosis as very many long term problematic drugs users/victims of abuse would inevitably have some kind of mental health problem such as mild depression or anxiety. However, these mental health problems, whilst evident to support workers, were often undiagnosed and untreated.

However, relatively few of the Oasis Project's clients could be characterised as having a severe Dual Diagnosis (serious mental health problems and major substance misuse issues).

22.4 Councillor Jan Young noted that the Panel should seek to avoid defining Dual Diagnosis so broadly that it would include a diagnosis of relatively mild depression coupled with relatively minor substance use problems, since people with such a diagnosis did not necessarily have a great deal in common with people with more severe Dual Diagnoses.

22.5 In answer to a question about the POCAR programme, Ms Welsh told the Panel that the programme was for parents who were problematic drugs users at risk of having their children taken into care.

The support programme included an element of coercion, in that parents who refused to engage were potentially at greater risk of having their children removed.

More women had presented for support via POCAR than had men (men are supported by CRI rather than by the Oasis Project), although the reasons for this imbalance were not clear. The programme seems to have had some success in educating parents and allowing them to remain as families without further endangering their children.

22.6 Ms Welsh noted that the Oasis Project is currently reviewing the services it provides in light of the recent publication of National Institute of Clinical Excellence (NICE) and National Treatment Agency (NTA) guidance.

23 Evidence from Mike Pattinson

23.1 Mr Pattinson introduced himself as the Chief executive of CRI (Crime Reduction Initiative). CRI provides non-clinical substance misuse services; interventions for clients within the Criminal Justice system; a Priority Offender programme; and a Rough Sleepers programme.

23.2 Mr Pattinson noted that a key factor in successfully supporting people with a Dual Diagnosis was ensuring that the right pathways are in place. Current treatment is effective, providing people present with "mainstream" problems; but treatment, and the co-ordination of services, for people with more uncommon problems is often not as good as it might be.

23.3 Mr Pattinson also noted that, although there were some very good examples of the increasing co-ordination of city services, more work still needed to be done in this area. In order to effectively support people with a Dual Diagnosis, it was necessary to co-ordinate substance misuse services, mental health services, housing support and criminal justice services.

23.4 Mr Pattinson told Panel members that, in his experience, people who presented with a Dual Diagnosis were often problematic users of opiates. However, whilst opiate users can access a prescribed alternative to heroin (methadone) by presenting for treatment, there is no such prescribed substitute for other drugs or for alcohol. This may mean that heroin users tend to present in greater numbers than users of other substances, and thus effectively skew the statistics.

23.5 In response to a question regarding the integration of treatment services for substance misuse/mental health issues between prison and the community, Panel members were told that there should be continuity of care for both drugs and mental health programmes. People who did not actively present for (non-mandatory) treatment did risk "falling between the gaps", although outreach teams would generally attempt to engage with them.

There are fewer facilities, both in prison and in the community, for treating alcohol problems than there are for drugs problems.

23.6 In answer to a query concerning how effectively people were assessed as having a Dual Diagnosis, Mr Pattinson told the Panel that the Sussex Partnership Trust had recently employed two specialist nurses to assess and treat Dual Diagnosis clients (Dual

Diagnosis of mental health and *drugs* misuse problems). Assertive Outreach Team clients were currently being assessed to see if they might have previously unidentified Dual Diagnoses. (The Assertive Outreach Team is part of the Sussex Partnership Trust Community Mental Health Team.)

23.7 In response to questions regarding the assessment of clients, Mr Pattinson told the Panel that assessment is comprehensive and relatively well integrated; Care Plans are constantly re-assessed to ensure that they remain relevant.

Clients may be provided with a "key worker," although this system does not work as effectively as it might, particularly when a client's changing needs necessitate the appointment of a new key worker (for instance, if a client's problems change from being substantially those of mental illness to being substantially those of substance misuse). Agencies are currently moving towards a system whereby a single key worker is retained even if a client's needs significantly change.

23.8 In response to a query regarding the involvement of carers and families in supporting people with a Dual Diagnosis, the Panel was told that Brighton & Hove had a relatively good record in this respect, but that more could and should be done, although it was important to ensure that facilitating more family involvement was balanced by a patient's right to confidentiality.

23.9 In answer to questions regarding patients' Care Plans, Panel members were told that a Sussex Partnership Trust officer would take the lead on each individual Care Plan. However, it had been mooted that officers of other bodies, including non-statutory agencies, might sometimes be asked to assume this co-ordinating role if doing so would improve the services offered to individual clients.

23.10 Asked to identify an aspect of Dual Diagnosis support/treatment which might be improved, Mr Pattinson told the Panel that the treatment pathways for Dual Diagnosis should be as clearly and flexibly defined as possible so as to ensure that people obtained the most appropriate service.

23.11 Suggestions from members of the public

23.12 A member of the public attending the meeting, Mr Richard Scott, asked to address the Panel and suggested some topics which he felt might merit further attention. These included: the impact of poverty upon people with a Dual Diagnosis; what affect the split of mental health provision between services for

people of working age and services for older people had on the effectiveness of Dual Diagnosis services; what kind of provision there was to monitor people being treated for a Dual Diagnosis who "fell off the radar" (e.g. people who were presumed to have moved away from the area; were these people recorded as presenting for services in other areas?); whether there would be value in compiling a Directory of city-wide Mental Health services (to mirror or perhaps to be merged with the existing Directory of Substance Misuse services).

24 Future Meetings

24.1 Panel members agreed to hold further meetings on **April 25 2008** and **May 02 2008**.

25 Any Other Business

25.1 There was none.

The meeting concluded at 12:30pm.

Signed Chairman

Dated this day of 2008