



THE ROYAL BOROUGH OF
KENSINGTON
AND CHELSEA

Report of the
Overview and Scrutiny Committees on Health
and on Housing, Environmental Health and
Adult Social Care

Review of Services for Adults at the Interface
of Mental Health and Drugs

September 2006

Chairman's Foreword

The review has examined a range of activities falling within its scope. Defining the scope of the review has been challenging, because Mental Health and Substance Use Services are multi-faceted. Six meetings of the Sub-Group were held during 2005/06 to monitor progress and discuss findings.

It was against this background that the Sub-Group agreed the review should focus on the following areas:

1. Defining Dual Diagnosis
2. Mapping current provision and identify gaps
3. Best practice audit and service review
4. International and local Prevalence
5. Funding arrangements and future investment plans

During the review the extent of the Primary Care Trust's (PCT) financial difficulties became evident. However savings made against Substance Misuse budgets were significantly less than had been anticipated.

The services were benchmarked against other areas and revealed that the Council's model is delivering high quality interventions within effective systems. Central and North West London Mental Health Trust work across eight London boroughs and recognise Kensington and Chelsea as having the most effective system to respond to the needs of this complex service user group.



*Cllr David Lindsay
Review Group Chairman*

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1 INTRODUCTION

1.1 Membership of the Sub-Group

Councillor David Lindsay (Chairman)
Councillor Dr Hanham
Councillor Bridget Hoier
Councillor Robert Freeman

1.2 The Terms of Reference of the Review was to:

'Carry out a review of dual diagnosis service provision within the Royal Borough of Kensington and Chelsea'.

2 BACKGROUND

2.1 The review of dual diagnosis service provision within RBKC was initiated in September 2005 through the Adult Care Health and Environmental Health Overview and Scrutiny Committee. The scope of the review is attached in Appendix 1. It was agreed that the review would be completed by July 2006 and would report back to the OSC for Housing, Environmental Health and Adult Social Care and the OSC for Health.

2.2 Contributions to the review have been made by staff from: Adult Social Care; Housing; Kensington and Chelsea Primary Care Trust (PCT); Central and North West London Mental Health Trust (CNWL MHT) and CNWL Substance Misuse Directorate (CNWL SMS). The Dual Diagnosis Steering Group have been kept informed of the review throughout and made comments as it has progressed. Other boroughs have also provided information to compare different treatment approaches and resource commitments.

2.3 The review focused on the following areas:

- Definitions of dual diagnosis
- Best Practice
- Models of Service/Treatment Approach
- The role of the Steering Group
- Current services available
- User involvement
- Finance
- Gaps in provision

Additionally some limited attention was given to the international and UK prevalence research.

2.4 The following report provides an overview of the development of the Kensington and Chelsea dual diagnosis service in the context of

government guidance, research and evidence based treatment interventions. The report also highlights gaps in provision and makes a number of recommendations for further development.

- 2.5 The Department of Health produced a good practice guide in 2002. This guidance has been implemented differently dependent on resources and assessed prevalence. RBKC and its health partners recognised that there is a high proportion of people with a dual diagnosis within local mental health and substance use services.
- 2.6 The DOH guidance (2002) identified the challenge of supporting someone with a dual diagnosis within mental health services stating that *"The complexity of issues makes diagnosis, care and treatment more difficult, with service users being at higher risk of relapse, readmission to hospital and suicide"*.
- 2.7 The guidance goes on to report, *"Substance misuse is usual rather than exceptional amongst people with severe mental health problems and the relationship between the two is complex. Individuals with these dual diagnosis problems deserve high quality, patient focussed and integrated care. This should be delivered within mental health services. This policy is referred to as "mainstreaming". Patients should not be shunted between different sets of services or put at risk of dropping out of care completely... Unless people with a dual diagnosis are dealt with effectively by mental health and substance use services these services as a whole will fail to work effectively."*(DOH, 2002).

Following a commitment to invest resources in dual diagnosis interventions a model of service was developed as shown in **Appendix 2**.

3 DEFINING DUAL DIAGNOSIS

- 3.1 The Department of health issued the following definition of dual diagnosis:

'The term 'dual diagnosis' covers a broad spectrum of mental health and substance use problems that an individual may experience concurrently. The nature of the relationship between these two conditions is complex. Possible mechanisms include:

- *Substance use worsening or altering the course of a psychiatric illness;*
- *intoxication and/or substance dependence leading to psychological symptoms;*
- *substance use and/or withdrawal leading to psychiatric symptoms or illnesses.'*

3.2 A number of other definitions are also prevalent in a range of documents. As a consequence there has been no clear definition adopted across London or elsewhere resulting in exclusive policies being developed. From the outset of this review it was evident that a simple definition needed to be developed. To achieve this the Minkoff model was considered along side a range of published and suggestions were used to create our definition. It was agreed that the definition needed to be inclusive, concise and simple to understand.

3.3 The following represents a distillation of a number of these definitions:

Dual diagnosis refers to the negative impact of drug or alcohol use on individuals who experience mental health difficulties. This falls into three categories:

- *those individuals who self medicate to control their mental illness through the use of non prescribed drugs or alcohol*
- *those individuals who have experienced significant deterioration in their mental health having used drugs or alcohol for enjoyment;*
- *those individuals at high risk of developing mental health problems as a consequence of significant use of or addiction to drugs or alcohol.*

3.4 This definition accommodates the DOH version and allows for the identification of lead services. The first grouping would require mental health services to lead, the second group would be led through dual diagnosis services with the involvement of mental health services and the third group would be led by substance use services. Through this process of defining the categories it allows for the development of improved pathways into and between services. It also allows for further development of the model of service we currently offer through the dual diagnosis team.

4. INTERNATIONAL PREVALENCE

4.1 Literature from Australia, New Zealand and the USA demonstrates high prevalence rates of dual diagnosis. The American National Mental Health Association (NMHA) reported that in 1999, 52% of people with alcohol problems and 59% of those with drug problems also had a mental health disorder (Watkins, et al). Other American researchers estimated in 2001 that 3% of the adult population of America suffered from a dual diagnosis condition. The Health Department of New South Wales published a report in 2000, which estimated between 30% and 80% of people with mental health problems also had substance misuse problems. This broad estimate demonstrates the difficulties faced in diagnosing co-morbidity

without a shared definition. This report concurs with research carried out in New Zealand in 1989 (Selman et al).

4.2 The message from the international research is that:

- Prevalence rates of dual diagnosis are high and continuing to increase (NMHA, 1999);
- dual diagnosis is the expectation rather than exception for service users within mental health and substance misuse services (Minkoff,2001);
- individuals with a dual diagnosis are not receiving effective treatment (Watkins, 2001);
- efforts to improve the care of individuals with a dual diagnosis need to focus on strategies that increase the delivery of effective treatment (Watkins, 2001).

4.3 The development and research into dual diagnosis in America has led to an emergence of evidence-based practice. This research has been used to inform the prevalence research and the development of the treatment of individuals with a dual diagnosis within the UK.

5. UK PREVALENCE

5.1 Dual diagnosis is a recognised problem for both mental health and drug and alcohol treatment services. It is suggested that 30-50% of people with mental health problems also have current substance use problems. One UK study carried out in a secure psychiatric unit, found a dual diagnosis rate of over 50% and another found the same was true amongst patients in acute psychiatric wards across London. These figures are backed up in a large study carried out in America. (MIND website).

5.2 It is suggested that between 50-66% of people who come in contact with substance use treatment services may also experience mental health difficulties although may never have been in contact with mental health services. (MIND website).

5.3 *'Increased rates of substance use are found in individuals with mental health problems affecting around a third to a half of people with severe mental health problems.'* (DOH, 2002)

5.4 A quick piece of research in two of the local Community Mental Health Teams (CMHT's) conducted in 2003 showed about 30% of allocated cases were reported as having a dual diagnosis. This is likely to be an under estimate of the need. Within substance use services it is reported, although not verified through research, that over 50% of drug and alcohol users have a dual diagnosis.

5.5 Exploring differences between the two service user groups shows that within drug and alcohol services a high number of individuals experience a range of neurotic disorders, whilst those within mental health services are more likely to experience psychotic disorders. Personality disorders exist in both service user groups and both service areas struggle to engage these individuals in appropriate services.

6. DUAL DIAGNOSIS SERVICE MODEL

6.1 Three broad types of service model have been described in the literature: serial, parallel and integrated. The DOH Good Practice Guide (2002) does not recommend the serial model i.e. the treatment of one condition before progressing to treatment of the other condition. It also reports that, although the integrated model has been shown to be effective in the USA, where this has been tried in the UK, in the London borough of Haringey, it has proven to be too expensive and unsustainable.

6.2 *'Where they exist, specialist teams of dual diagnosis workers should provide support to mainstream mental health service.'* (DOH,2002)

6.3 Across London there are a range of models established, the majority of boroughs have established individual dual diagnosis specialist workers located in CMHTs. These workers have expressed feelings of isolation and being viewed by their colleagues as a mental health worker rather than specialist in dual diagnosis. Some workers are employed to provide advice and guidance only.

6.4 The Kensington and Chelsea Drug and Alcohol Action Team (DAAT), agreed to support the establishment of a small team of experienced dual diagnosis workers based within Adult Social Care. The model developed was intended to outreach from one site, hold a caseload and provide training. A steering group was established to ensure the model of service could develop and progress dual diagnosis work. RBKC developed a model based on the experiences of other boroughs, locally assessed need and the available research.

6.5 The most influential model describes *"the context of Dual Diagnosis by exploring the severity of substance use and of mental health and thus plotting service provision against need"* (Minkoff) as shown below:

SEVERITY OF PROBLEMATIC SUBSTANCE USE

<p>HIGH</p> <p>e.g. a dependent drinker who experiences increasing anxiety.</p> <p>QUADRANT 3 Lead Service Substance Misuse Services</p>	<p>HIGH/HIGH</p> <p>e.g. an individual with schizophrenia who misuses cannabis on a daily basis to compensate for social isolation.</p> <p>QUADRANT 4 Lead Service Dual Diagnosis Team</p>
<p>LOW/LOW</p> <p>e.g. a recreational drug user of 'dance drugs' who has begun to struggle with low mood after weekend use.</p> <p>QUADRANT 1 Lead Service Primary Health Care e.g. GPs</p>	<p>HIGH</p> <p>e.g. an individual with bipolar disorder whose occasional binge drinking and experimental misuse of other substances destabilises their mental health.</p> <p>QUADRANT 2 Lead Service Mental Health Services</p>

SEVERITY OF MENTAL ILLNESS

- 6.6 The focus in RBKC is on the substance use needs of service users with a severe and/or enduring mental illness and substance use problems (quadrant 4). However, it is recognised that a number of service users with a diagnosis of Personality Disorder or less severe mental health difficulties have been unable to engage in substance use services or mental health services. These service users can also fall between the criteria of different services. The Dual Diagnosis Service will work with this group carrying out assessments of need with a view to engaging them in their own or other appropriate services.
- 6.7 There are three main areas of focus for the work of the dual diagnosis service:
- **Care Management** - facilitates strong working links with members of the CMHTs, the Crisis Resolution Teams, duty teams and inpatient wards. It also facilitates informal supervision, advice and learning as well as joint work with service users. The care managers also offer one-off assessments and referral into the full range of drug and alcohol services.
 - **Training** - *'one off training interventions will have a limited value.'* (DOH,2002). A lead training role has been identified to

lead the organisation and provision of training to staff in mental health services. This develops knowledge and skills in working with individuals with a dual diagnosis. Regular forums on issues relevant to dual diagnosis with input from appropriate professionals are also delivered. The knowledge gained from training is maintained through the links between the CMHTs and the dual diagnosis care manager and the monthly forums. Training has also been offered to carers and mental health supported housing staff. It is intended to extend this training to drug and alcohol services.

- **Development work**- All dual diagnosis workers have a developmental brief. This includes co-facilitating groups at day centres or day hospitals, linking with users and carers groups, involvement in research and evaluation, attendance at the London Development Centre Dual Diagnosis Forums etc.

6.8 A specialist registrar with an interest in dual diagnosis has provided sessions from within the team focused on research and evaluation. This post has recently been replaced by another specialist registrar who is responsible for a clinical caseload and who works closely with the in-patient psychiatric units. This role is reliant on the identification and recruitment of psychiatrists with a special interest during the training rotation period of 6 months.

7. TREATMENT APPROACH.

7.1 *'As with severe mental illness, substance use is often a chronic relapsing condition. It is important that staff hold a realistic and longitudinal view of treatment in which different approaches may be necessary during different stages of the process. (DOH, 2002)*

7.2 The following phases of treatment were identified through American research and have been adapted to meet local need:

- **Engagement** - assertive outreach is essential for dual diagnosis services to engage effectively with service users who are often non-compliant with both mental health and substance misuse services. There is often low motivation for change and a lack of recognition of the harmful effect of their substance use on their mental health. Therefore engagement may include working with practical or other problems before working with substance use issues.
- **Motivation for change** (persuasion)- the service uses a motivational interviewing approach to assist service users with examining their substance use and changes they wish to make. Cognitive behavioural therapy has also been found to be

effective with some people with dual diagnosis and these interventions are being developed within services.

- **Active treatment** – the service offers a range of treatments including harm minimisation, abstinence, accessing day and residential rehabilitation after care programmes dependent on assessed need and the goals of the service user. The service bridges both mental health and substance use services to obtain additional specialist services. It is recognised that abstinence is often not achievable for service users with a dual diagnosis and therefore services work to reduce harm.
- **Relapse prevention** – the service works with individuals to identify the triggers leading to their use of substances and to consider developing skills necessary to manage high-risk situations. This is a core component of relapse prevention work and enables individuals to take greater control of their risk taking behaviours. The service offers advice and support to mental health staff and relapse prevention is included as part of individual care plans.

7.3 The dual diagnosis team does not set a limit on the length of the involvement with the service user. The service focuses on the assessed needs of the service user, the length of involvement will depend on both need and progress of the individual.

8. DUAL DIAGNOSIS STEERING GROUP.

8.1 In line with DOH recommendations a steering group was established early in the development of the dual diagnosis team. The steering group consists of representatives from statutory mental health and substance use services, voluntary sector, service users and carers.

8.2 The aims of the group are to:

- consider strategic issues relating to dual diagnosis;
- deliver effective services within tight financial constraints;
- develop and implement protocols;
- develop plans for delivering dual diagnosis services over the long term;
- consider models of good practice and how to apply them locally;
- be informed by government guidance on dual diagnosis;
- advise the LIT and Primary Care Trust on dual diagnosis issues;
- commission and oversee research and evaluation projects.

8.3 It has been recognised by CNWL MH and SMS directorates that the steering group in RBKC is proactive and functions well when

compared with other boroughs within the Central North West London area.

- 8.4 The DOH Good Practice Guide recommends identifying a lead clinician for Dual Diagnosis. This has been established with a CMHT consultant psychiatrist. The lead consultant from CNWL SMS takes clinical responsibility for the senior registrar attached to the dual diagnosis service. This commitment from two consultant psychiatrists enables the ongoing improvement of pathways into and between services.

9. USER AND CARER INVOLVEMENT

- 9.1 Users and Carers are active members of the dual diagnosis steering group and take full part in the development of the dual diagnosis service. The development and progress made by the dual diagnosis service has been influenced by their input.
- 9.2 The users of mental health services have developed service user surveys, which now include questions related to drug and alcohol use. The information gained can indicate the local prevalence of dual diagnosis within the mental health service user groups.
- 9.3 Users and carers involved in the steering group have raised the profile of the issues faced by individuals with a dual diagnosis. A half-day dual diagnosis event will take place later in the year to raise awareness further, in response to the input from users and carers.
- 9.4 Dual Diagnosis Anonymous (DDA), pioneered by a service user of the RBKC dual diagnosis team, is a self-help group run by those managing their illness to support those in need of peer support. This group now takes place in North Kensington and at one other location out of the borough. Carers are intending to establish a similar group as they feel other carer support groups do not meet their needs. DDA members have agreed to assist them in developing this initiative.

10. SERVICES AVAILABLE

- 10.1 The services most closely linked with service users who have a dual diagnosis or at significant risk of developing a dual diagnosis are outlined in appendix 3. The remainder of mental health and substance use services are provided in detail in their respective service directories. Day care centres and direct access services in RBKC are all accessible to people with dual diagnosis.

11. PATHWAYS INTO SERVICES

- 11.1 The wide range of services available in RBKC, as compared to many other areas, results in a number of entry points to specialist provision. Having clear referral pathways for service users are crucial in ensuring that they access the appropriate service.
- 11.2 Referral pathways have been developed, but are considered too complicated, therefore they are to be revised following this review

12. FINANCE

- 12.1 There are a number of funding sources currently contributing to the provision of services for individuals with mental health and drug or alcohol problems. These funding sources have varying degrees of reliability as shown in appendix 4 and below. Each year funds must be negotiated against competing priorities. All funding streams are short-term with the exception of the placements purchasing budget. Over the next year there may be additional risks to the funding due to possible PCT savings taken from the overall mental health allocation.
- 12.2 Mainstream health funding enables CNWL Mental Health Trust to deliver accessible services to this service user group. This funding has been seen cuts during 2006/07, which are likely to result in increased demands on high cost acute health services due to the increased risk of relapse.
- 12.3 The RBKC Adult Social Care budget is allocated each year subject to negotiation with the usual finance constraints. The adult social care allocation is for the provision of purchased care packages.
- 12.4 A government ring-fenced substance misuse grant, the Pooled Treatment Budget, is available until 2008. This grant allocation for 2006/07 funds the dual diagnosis care management team and contributes to community mental health team staffing.
- 12.5 The Mental Health grant contributes to the funding of the team coordinator. This is an annual grant, which due to freedom and flexibilities has been absorbed into adult social care funding. This allocation contributes to funding the team coordinator.
- 12.6 The Supporting People Grant contributes to the housing initiatives targeted at mental health service users and substance users. There is no specific allocation to dual diagnosis housing initiatives.

13. GAPS IN PROVISION

- 13.1 RBKC is limited in what can be achieved locally to improve the position. It is well documented that within the UK there is a lack of specialist dual diagnosis service provision. RBKC will continue to lobby for developments within the relevant forums.
- 13.2 **Limited Specialist Resources** - Within London there is only one Day Programme. Nationally there are only two residential services targeted at the treatment of dual diagnosis. Mental In areas of need where gaps in provision exist nationally health resources are already in high demand and substance use residential treatment capacity is limited. Individuals with a dual diagnosis are often excluded from these services due to their challenging behaviour. The programmes that accept people with a dual diagnosis are very expensive. There is little one borough can do to influence the development of new treatment resources.
- 13.3 **Primary care** - There are no standardised systems for quantifying numbers of DD patients not in need of referrals into specialist services locally nor nationally. There is a list of options for referral held on the clinical systems that GPs are able to access readily. Dual diagnosis patients may be treated at their GP surgery when the patient is stable. However, without a standardised system for collecting data on those patients with both mental illness and substance misuse we are unable to gather accurate prevalence data from primary care services. GPs have not necessarily received dual diagnosis training, this may lead to individuals who require specialist interventions remaining unidentified.
- 13.4 **Older People** – The dual diagnosis service includes those over 65. Referrals from this group are sparse with only one referral during 2005/06. CMHT’s work with 18-64year olds, while specialist mental health services work with our older population. We need to assess local need working closely with these specialists to identify whether the dual diagnosis service needs to improve the pathways into the service for older people.
- 13.5 **Access Issues** - In respect of access to services for individuals from BME communities both substance use and mental health services have developed targeted services to meet the cultural needs of these groups. However difficulties are beginning to arise in providing appropriate services to our eastern European communities. There is an increase in the number of homeless individuals, who are from the accession states, who have mental health difficulties and alcohol problems but no recourse to public funds. This issue is being raised in a number of forums, including the London Development Centre and the National Treatment Agency, by a number of boroughs and will require central government guidance to assist in developing a coordinated response across borough boundaries.

13.6 Young People – Although young people were not part of the scope of the review some issues were discussed. The use of cannabis leading to psychotic episodes and increased presentations of young people in mental health services has been identified as a concern. A cannabis action group, a multi agency partnership, has been established with responsibility to develop an action plan to identify the extent of the problem with RBKC and develop those services best able to meet the needs of this group of young people. An information gathering exercise has been carried out in August 2006 to assess the local need and the outcome of this will form the basis of the action plan.

14. RECOMMENDATIONS

14.1 The following recommendations have been identified:

- to adopt the definition of dual diagnosis agreed during the review;
- to work with CNWL and the London Development Centre to promote the definition proposed across other boroughs;
- to further develop and support the current service model;
- to work with older people's services to assess the prevalence of dual diagnosis and need of specialist interventions amongst the over 65 age group;
- to simplify the pathways between non-specialist services and dual diagnosis service;
- to produce information leaflets for referral agencies;
- to extend the dual diagnosis training programme to include mental health day centres, GPs, specialist housing providers and substance misuse services;
- to host a dual diagnosis event to inform key stakeholders of the work of the service;
- to progress research into the effectiveness of the interventions of the dual diagnosis team;
- to identify funding opportunities or reconfigure resources to meet the growing demand and secure longer term funding for dual diagnosis services.

15. CONCLUSION AND FINDINGS

- 15.1 The review has shown that RBKC has adopted evidenced based practice from the national and international perspectives. The DOH guidance has been included within the treatment approach.
- 15.2 care needs to exist for individuals with a dual diagnosis across mental health and substance use services.
- 15.3 Nationally there are greater numbers of people requiring help with a dual diagnosis problem. The current provision will need to be secured through longer term funding agreement. There is a recognised limit to what the dual diagnosis team can achieve due to the resource limitations. To ensure people have access to the appropriate levels of treatment and care new resources will need to be identified to meet the increased demand. This will not be possible within the current financial constraints.
- 15.4 The involvement of users and carers in developing the service together with the commitment from members of the dual diagnosis steering group has enabled the dual diagnosis service to deliver quality services.
- 15.5 The review has shown that the dual diagnosis care system within Kensington and Chelsea does demonstrate current best practice. The steering group is a model of excellence and the team has an excellent reputation. The next phase of development will be to implement the recommendations outlined in the report and service improvement plan.

FOR INFORMATION

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