FIGURE 8
CONSULTANCY SERVICES LTD

2014

DUAL DIAGNOSIS NEEDS ASSESSMENT

Report prepared for West Sussex County Council

EVIDENCE INTO PRACTICE

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CHAPTER 1: STUDY BACKGROUND

1.1 Introduction

The study is entitled, Dual Diagnosis Needs Assessment for West Sussex. The study was undertaken by Figure 8 Consultancy Services Ltd (hereinafter refered to as Figure 8) on behalf of West Sussex County Council. The dual diagnosis study builds upon the recent West Sussex Drug and Alcohol Misuse Strategic Needs Assessment study[1] which was also conducted by Figure 8 from late 2013 to early 2014. The dual diagnosis study explored and scrutinised prevalence rates, needs, gaps and issues in the current treatment system for those experiencing co-occurring substance misuse and mental health disorders in West Sussex.

1.2 Purpose of the study

The purpose of the study is to help West Sussex County Council and its partners to develop strategies to manage dual diagnosis effectively and efficiently by looking at how well mental health combined with alcohol and drug services serve people; as well as assessing local needs, gaps, innovations and aspirations.

1.3 Objectives

The specific objectives of this study are:

- to assess current and estimate future health and social care needs of adults and young people with dual diagnosis;
- to summarise existing policy, strategy and treatment provision and resources for adults and young people presenting with dual diagnosis;
- to understand how mental health and alcohol and drug treatment services are working with each other, as well as other health and social care services;
- to understand where relevant local services are working well and where improvements are needed;
- to understand the gaps, issues and other important matters which are important to service users, their families and the wider population; and
- to provide recommendations based upon evidence about how the local dual diagnosis service model could be developed.

[1] Perkins, A. et al. (2014). *West Sussex Alcohol and Drugs Needs Assessment*. Figure 8: Dundee. Available at: http://jsna.westsussex.gov.uk/domains/westsussex.nhs.uk/local/media/publications/west_sussex_alcohol_and_drugs_needs_assessment__final_report.pdf. Accessed on 21/09/14.

1.4 Stakeholders

It is essential to engage as broad a range of interests as possible in the assessment process. To this end, the research team sought the views of a range of different mental health and alcohol and drug services, people who use services, families and carers; and other stakeholders. The qualitative element of the study in particular aimed to consult with staff from specialist mental health and alcohol and drug services, together with a sample of the following groups which support people affected by dual diagnosis:

- Service users;
- Carers and families;
- Treatment and care providers (statutory, third, private);
- Strategic planners;
- Criminal Justice including Police, Prison Service and Probation Service;
- Homelessness services including hostels; and
- Specific services; e.g. to support people with a learning disability, domestic/sexual abuse/women's aid, LGBT and other minority groups, military veterans.

1.5 Methods

The study used a range of quantitative and qualitative methods. Quantitative methods centred on a range of surveys (n=6) plus data analysis (local and national). Qualitative methods included regional seminars (n=4), working groups (n=2), interviews (n=11) and meetings with key commissioners/policy advisers (n=2), service users (n=2) and a recovery champion (n=1). Thematic papers (n=2) were provided by specific dual diagnosis linked services; namely homelessness and employability due to their emergence as key wraparound services during the fieldwork. A service user focus group (n=1) was also held.

Seminars were held on two occasions in the north (Crawley) and south (Chichester) of the region to promote inclusion and accessibility. Participants were targeted via a contact list provided to the research team by the study commissioner; a previous database of West Sussex contacts held by Figure 8[2]; or further investigation by the research team. Each workshop was co-facilitated by an experienced researcher and lasted 3 hours. Notes were taken to ensure accurate recall of information afterwards.

Two discrete working groups were then set up. Members mostly originated from their participation in the opening north or south regional seminars; supplemented through 'word of mouth' referral from initial seminar participants; through the original mail shot by Figure 8 inviting engagement in the study; or through further investigations carried out by Figure 8. Each working group met on two

[2] Op. cit. Perkins et al (2014).

occasions. Each meeting was chaired by an experienced researcher and lasted 2 hours. Each meeting was audio recorded and transcripts later produced to ensure accurate recall of the information.

Nine interviews were conducted by an experienced researcher on a face to face basis. Each interview lasted approximately 50 minutes. A bespoke designed, semi structured questionnaire was used to capture views based on the study's objectives. Two further professional stakeholders completed the questionnaire online, following telephone discussions.

A focus group was also held with seven people with a dual diagnosis who were residing in a specialist residential recovery service for people with substance misuse and homelessness problems. A bespoke designed prompt sheet was used to aid evidence gathering. The focus group was audio recorded and a transcript later produced to ensure accurate recall of the information.

Fundamentally, face to face meetings were held with three individuals engaged in different stages of recovery from dual diagnosis; a method that provided compelling, personal accounts of their lived experience.

All informants were provided with a study information sheet which explained the study in detail. All participants completed and signed a study consent form. There were no complaints or adverse incidents or accidents throughout the study fieldwork.

In total, 112 people took part in the quantitative element of the study; whilst 54 participated in the study's qualitative elements. Specific activities held; and attendance and participation levels are outlined in the tables below:

Table 1.1 Type of quantitative activity and number of participants

Type of quantitative activity	No. of discrete participants
Service Users Survey	17
Management Survey	18
Family and Carers Survey	3
Mental Health Services Staff Survey	36
Alcohol and Drug Services Staff Survey	26
Generic Services Staff Survey	12
	Total no. participants: 112

Table 1.2 Type of qualitative activity, number of activities held, number of attendances and number of participants

Type of qualitative activity	No. of activities held	No. of attendances	No. of discrete participants
Regional workshops	4	33	25
Working groups	4	37	25
Meetings with commissioners/policy advisers	2	2	2
Meetings with service users/recovery champions	3	3	3
Service user focus group	1	6	6
Mental health Providers Forum	1	[27*]	[27*]
Interviews (face to face)	9	9	9
Self completed questionnaires (preceded by telephone discussion)	2	2	2
	26	**92**	**54**

*27 delegates attended the West Sussex Mental health Providers Forum; at which a member of the Figure 8 research team was a guest of the study commissioner – this figure is excluded from the total number of informants who participated in the dual diagnosis study.

The full interview schedule is outlined at **Appendix 1** of the Final Report.

1.6 Key findings from the Figure 8 West Sussex Alcohol and Drugs Needs Assessment study

Section 8.2.4 of the West Sussex Alcohol and Drugs Needs Assessment Final Report (April 2014) by Figure 8[3] outlines the following recommendations concerning the assessment of health and social care needs of adults and young people with dual diagnosis in West Sussex:

- Recommendation 11 - Annual Partnership returns suggest that in 2012/13, 14% of new clients accessing specialist alcohol and drug misuse services in West Sussex had a dual diagnosis. This is significantly lower than rates suggested by research and indications provided in the Management Survey conducted as part of this study. Therefore, given the apparent discrepancy between perceptions of prevalence, consideration should be given to evaluating and developing staff skills and confidence in identifying mental health issues and recording details.
- Recommendation 12 - Co-occurring mental health problems and substance misuse problems are typically managed in a way which addresses the primary problem, followed by the secondary problem; regardless of equity of condition – co-occurring problems are not effectively managed simultaneously. This requires further detailed analysis.
- Recommendation 13 - Our findings highlight the absence of a specific dual diagnosis service and this is regarded as a significant gap by key stakeholders in West Sussex. Joined up working

[3] Op. cit. Perkins et al (2014).

between specialist mental health services and specialist alcohol and drug services for adults also appears sporadic. These merit further detailed analysis, including exploring options to strengthen and improve delivery, particularly treatment pathways and better inter-agency working.

1.7 Policy context

It is not straightforward to set out the policy context in respect of dual diagnosis as no national policy actually exists. The most relevant dual diagnosis policy driver may well date back to 2002 in the form of the Department of Health's *Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide* (May 2002) which states:

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

- a primary psychiatric illness precipitating or leading to substance misuse;
- substance misuse worsening or altering the course of a psychiatric illness;
- intoxication and/or substance dependence leading to psychological symptoms;
- substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses."

In practice, there is generally no commonly accepted definition of dual diagnosis. Within the practice context of West Sussex, the main formal definition of dual diagnosis is outlined in Sussex Partnership NHS Foundation Trust's *Dual Diagnosis Strategy 2011 – 2016* (September 2011) which originally derives from the Department of Health Guide definition, as outlined above.

There are of course a number of other policy and practice drivers in the shape of central Government white papers. These include The Government's alcohol strategy, Home Office (March 2012) which sets out proposals to crackdown on the country's 'binge drinking' culture, cut the alcohol fuelled violence and disorder that blights too many communities, and slash the number of people drinking to damaging levels. The strategy includes commitments to:

- consult on a minimum unit price;
- consult on a ban on the sale of multi-buy alcohol discounting;
- introduce stronger powers for local areas to control the density of licensed premises including making the health impact a consideration for this; and
- pilot innovative sobriety schemes to challenge alcohol-related offending.

Relevant policy documents also include the Government's drug strategy - *Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life*, Home Office (December 2010). This strategy sets out plans for:

- helping people to live a drug free life.

Another relevant policy document is The Government's mental health strategy for England: *Making mental health services more effective and accessible*, Department of Health, (February 2011). This

strategy sets out how the Government, working with all sectors of the community and taking a life course approach, will:

- improve the mental health and wellbeing of the population and keep people well; and
- provide high-quality services that are equally accessible to all.

1.8 Literature review

The content of Section 1.8 was published in June 2014 by Clare Toon, Clinical Effectiveness Officer, at West Sussex County Council; and relates to Treatment approaches to patients with mental illness and co-morbid substance abuse (dual diagnosis).

Dual diagnosis refers to the co-existence of mental health and substance misuse problems. Problematic substance use is one of the most common co-morbid conditions among people with a major mental illness, with prevalence of mental health of around 75% in users of drug services; and 85% among users of alcohol services (Weaver, 2002). The level of drug and alcohol use reported by users of mental health services is around 44%. Despite this high prevalence of dual diagnosis, detection of the problem remains low; and historically, individuals with a dual diagnosis have experienced difficulties in accessing services which meet all their needs. This leads to disengagement and poorer patient outcomes.

It is not clear which of the two issues is the causal factor and it is as equally likely that the drug misuse causes the mental illness, as the other way around. However, both drug misuse and mental disorders may be caused by other common risk factors. Many ideas have been put forward to explain the reason for drug use among mental health service users; including self-medication, coping and simple availability.

A variety of treatment approaches are available, including pharmacological, residential and psychological. There is little consistent evidence regarding the best method, form or location of delivery. However, the complex nature of dually diagnosed patients seems to suggest need for an integrated approach, which addresses both issues. There is little formal guidance relating to this matter, although the Department of Health has suggested that the primary responsibility for the treatment of dually diagnosed individuals should lie within mental health services. With this in mind, they go on to suggest that substance misuse agencies should provide specialist support, consultancy and training to mental health teams. One thing which is evident is the need to develop coherent pathways of joint working and treatment.

It is not clear whether the best way forward is to embed mental health professionals within substance misuse services, or substance misuse professionals within mental health services. The evidence base relating to this question is significantly lacking. Furthermore, available evidence has failed to find any treatment which shows promise of long-term efficacy. There is also little evidence to support the efficacy of an integrated approach, although there are clearly different types and levels of integration models available for consideration.

CHAPTER 2: HEALTH & SOCIAL CARE NEEDS OF THOSE WITH DUAL DIAGNOSIS

2.1 Introduction and Aims

The term dual diagnosis is a general designation used to describe those individuals who suffer from co-morbid substance misuse/dependence as well as a psychotic, affective, behavioural, or severe personality disorder.[4] This client group are very vulnerable and have complex needs relating to health, social, economic, and emotional stressors or circumstances which can often be exacerbated by their substance misuse.[5] People with a dual diagnosis are more likely to have experienced difficulties with education, employment, housing, personal relationships and their physical health. They are also more likely to have suffered trauma or abuse.[6]

Research has shown that service users with a dual diagnosis typically use NHS services more and cost more. A study of services in South London found a greater proportion of the patients with dual diagnosis used the support of community psychiatric nurses, inpatient care and emergency clinics. Their analysis found that dual diagnosis patients had significantly higher 'core' psychiatric service costs (a difference of £1,362) and non-accommodation service costs (£1,360) than patients without a dual diagnosis.[7] Moreover, service users with a dual diagnosis are more likely to be non-compliant and fail to respond to treatment than either people with substance misuse issues or a mental illness, and in their National audit of violence, the Healthcare Commission and the Royal College of Psychiatrists identified drug and alcohol use as a major trigger for violence in mental health services.[8]

In his 2004 report to the Secretary of State for Health on the implementation of the National Service Framework for Mental Health, Professor Louis Appleby stated that "services for people with dual diagnosis - mental illness and substance misuse - are the most challenging clinical problem that we face."[9]

The aim of this element of the project was to review existing datasets to identify the prevalence and trends of dual diagnosis in West Sussex and to identify the health and social care needs of this demographic within the county.

[4] Lehman (1996), cited Evans, K., & Sullivan, J. M., *Dual Diagnosis: Counselling the Mentally Ill Substance Abuser,* Guilford Press, 2001 p. 1.

[5] Afuwape S. A., 'Where are we with dual diagnosis (substance misuse and mental illness)?: A review of the literature', November, 2003.

[6] Banerjee, S., Clancy, C., Crome, I., *Co-existing problems of mental health and substance misuse (dual diagnosis): An Information Manual*, Royal College of Psychiatrists, 2002. Available at http://www.rcpsych.ac.uk/pdf/ddipPracManual.pdf. Accessed 04/12/2013.

[7] National Mental Health Development Unit, Briefing 189, *Meeting the challenge of dual diagnosis*, September 2009. Available at http://nmhdu.org.uk/silo/files/seeing-double-meeting-the-challenge-of-dual-diagnosis.pdf. Accessed 09/12/2013.

[8] Ibid.

[9] The National Service Framework for Mental Health - Five Years On, Appleby L., Dept of Health, Dec 2004.

2.2 Method of Data Collection

There are no routinely available national or local data on the prevalence of dual diagnosis, and because the definition of the term varies widely, so do prevalence estimates. Information was identified and drawn together from a range of local and national sources which indicate prevalence of mental health issues and substance abuse problems. Other sources (e.g. suicide and self-harm data), speak of the vulnerabilities that those with dual diagnosis are subject to. This is supplemented with information drawn from the management surveys and qualitative stakeholder interviews undertaken in the course of the preceeding Alcohol and Drugs Needs Assessment research project conducted by Figure 8.[10] This should help provide initial indications as to the level of need in West Sussex, and to identify any gaps in existing provision for this client group. In order to provide comparative analysis on a range of health and social indicators two local authority areas were identified from the same socioeconomic deprivation background as West Sussex.[11] Essex and Dorset were chosen as comparators since both are located in the south of England; the former has both a coastal and a commuting population akin to that in West Sussex, and the latter has similar rural populations.

2.3 Key Findings

2.3.1 Background/Context

- The term dual diagnosis is a general designation used to describe those individuals who suffer from co-morbid substance misuse/dependence as well as a psychotic, affective, behavioural, or severe personality disorder.
- This client group are very vulnerable and have complex needs relating to health, social, economic, and emotional stressors or circumstances which can often be exacerbated by their substance misuse.
- Research has shown that service users with a dual diagnosis typically use NHS services more, cost more and are less likely to comply with treatment than those with single mental health or substance misuse issues.
- There are no routinely available national or local data on the prevalence of dual diagnosis, and because the definition of the term varies widely, so too do prevalence estimates.
- The Department of Health 'Good Practice Guide' (2002) remains the most specific national policy document pertaining to dual diagnosis, the central tenet of which is a policy referred to as 'mainstreaming'.

[10] Op. cit. Perkins et al (2014).

[11] West Sussex is in socioeconomic decile 9 along with Bromley, Cambridgeshire, Cheshire East, Dorset, East Riding of Yorkshire, Essex, Gloucestershire, Merton, North Somerset, North Yorkshire, Oxfordshire, Warwickshire, Wiltshire, and York.

- In 2011, the Sussex Partnership NHS Foundation Trust (SPFT) developed a dual diagnosis strategy and formulated seven key themes into objectives to be reached within the five year implementation period.

2.3.2 Epidemiology of dual diagnosis

- The nature of the relationship between mental health and substance misuse problems is complex and co-morbidity can occur at any level of severity.
- Frisher et al (2005) concluded that, only a comparatively small proportion of psychiatric illness could be attributed to substance use (0.2%), whereas a more substantial proportion of substance use seems possibly attributable to psychiatric illness (14.2%).
- The estimated risk of suicide in the presence of current alcohol misuse or dependence is eight times greater than in the absence of such misuse/dependence and as many as 65% of suicides have been linked to excessive drinking. According to np-SAD data, of the 131 cases noted as diagnosed with mental health issues, 51.9% (68/131) were listed as suffering from depression, with 25.0% of these (17/68) deaths being attributed to suicide.
- At least two thirds of alcohol-dependent individuals entering treatment show evidence of anxiety, sadness, depression and/or manic-like symptoms and a higher incidence of alcohol use disorders (AUDs) is reported for patients in treatment for depression.
- A higher incidence of alcohol use disorders (AUDs) is reported for patients in treatment for depression, and a recent study found that a diagnosis of affective disorder was associated with a five-fold increased risk of developing alcohol dependence within five years of onset.
- Amongst the general population, alcohol dependence and major depression co-occur at higher levels than would be expected by chance.
- Using alcohol or drugs to reduce emotional distress (self-medication) has been proposed as an explanation for the high co-morbidity rates between non-clinical anxiety, depression and substance use disorders.
- Up to 50% of problem drinkers have a personality disorder, up to 80% have neurotic disorders[12] and people with anti-social disorders have 21 times the average population risk of experiencing alcohol abuse or dependence[13]. Personality disorder is also strongly associated with an increased risk of substance misuse issues[14,15]. Estimates suggest that over half the patient population of

[12] Cited in *Dual Diagnosis Needs Assessment: Brighton & Hove*, December 2012, p29. See also Preuss, U., Johann, M., Fehr, C., Koller, G., Wodarz, N., Hesselbrock, V., Wong, W., Soyka, M., ' Personality Disorders in Alcohol-Dependent Individuals: Relationship with Alcohol Dependence Severity', *European Addiction Research*, 2009; 15(4): 188-95.

[13] Cited in *Dual Diagnosis Needs Assessment: Brighton & Hove*, December 2012, p29. See also Preuss, U., Johann, M., Fehr, C., Koller, G., Wodarz, N., Hesselbrock, V., Wong, W., Soyka, M., ' Personality Disorders in Alcohol-Dependent Individuals: Relationship with Alcohol Dependence Severity', *European Addiction Research*, 2009; 15(4): 188-95.

[14] Welch, S., 'Substance use and personality disorders', *Psychiatry*, 2007; 6(1):27-9.

[15] Pennay, A., Cameron, J., Reichart, T., Strickland, H., Lee, N., Hall, K., Lubman, D., 'A systematic review of interventions for co-occurring substance use disorder and borderline personality disorder', *Journal of Substance Abuse Treatment*, 2011; 41(4):363-73.

drug and alcohol services will meet the criteria for one or more personality disorders. Personality disorders can influence: the clinical course of alcohol/substance-dependence; their response to treatment; and their risk of relapse.

- Individuals with severe and enduring mental illnesses, such as schizophrenia and bipolar disorder, are at least three times as likely to be alcohol dependent as the general population[16,17], and an estimated 40% of people diagnosed with psychosis have also misused a substance at some point in their lifetime[18].

2.3.3 Prevalence of dual diagnosis across the UK

- In the UK, 'Rethink Mental Illness' estimated that a third of patients in mental health services have a substance misuse problem, and around half of patients in drug and alcohol services have a mental health problem. There is however widespread social and regional variation.
- The COSMIC Study (2002) estimated that 74.5% of drug service users and 85.5% of alcohol service users experienced co-occurring mental health problems and 44% of the community mental health team (CMHT) patients reported problem drug use and harmful alcohol use in the preceding year.
- In 2011 the MEAM coalition estimated that around 60,000 people living in the UK were experiencing multiple needs relating to mental health, substance misuse, homelessness and offending.
- An estimated 18% of rough sleepers have a mental health issue combined with a substance misuse issue.
- The prevalence of dual diagnosis among the prison population has been estimated at 75%[19]. This has ramifications for local areas when prisoners are released [see section 2.6.2 Criminal Justice / Prison Population].
- Estimates of prevalence of mental health problems amongst those with learning disabilities vary from 25-40% and there is a small but growing trend for people with learning disabilities to misuse substances (prevalence rates for alcohol misuse somewhere between 0.5% - 2%; similar low prevalence rates for drug misuse). Service providers have reported a number of difficulties in recognizing and meeting the complex needs of this population.

[16] Institute of Alcohol Studies, *Alcohol and Mental Health*, 2004, Cambridge cited op. cite. Mental Health Foundation (2006).

[17] Phillips, P., Johnson, S., 'How does drug and alcohol misuse develop among people with psychotic illness? A literature review,' *Soc Psychiatry Psychiatry Epidemiology* 2001; 36(6):269-76.

[18] National Institute for Clinical Excellence, *Clinical Guideline (CG120) Psychosis with co-existing substance misuse*, March 2011, p 4. Available at http://guidance.nice.org.uk/CG120/NICEGuidance/pdf/English. Accessed 04/12/2013.

[19] Prison Reform Trust. Prison Fact File December 2011. Available at http://www.prisonreformtrust.org.uk/Portals/0/Documents/Bromley%20Briefing%20December%202011.pdf. Accessed 06/12/2013.

- There is very limited data available to assess the trend in prevalence rates of dual diagnosis either nationally or locally, but there are suggestions that co-morbidity is being increasingly recognised over time.

2.3.4 Prevalence of Dual Diagnosis in West Sussex

- Residents of West Sussex experience better than average personal wellbeing, although there is variation across the county with the Worthing sample consistently reporting poorer wellbeing than the West Sussex average.
- Compared to the national average West Sussex had:
  - Significantly more adults on the GP register for depression (18+ yrs) in 2011/12 than the national average[20,21].
  - A higher prevalence of panic disorders and hospital admissions for unipolar depressive disorders 2009/10 to 2011/12.
  - Significantly better (lower) rates of neurotic disorders, mixed anxiety & depression and generalised anxiety disorders (in those aged 16-74) than the national average.
  - Low rates of general hospital admissions for mental health problems.
  - A slightly higher than average rate of general hospital admissions for self-harm 2009/10 to 2011/12.
- In any one night in West Sussex 85 individuals sleep rough (see Table 2.5).[22] Based on a dual diagnosis prevalence rate of 18% this implies around 15 of these people both misuse substances and have a mental health issue. A snapshot of clients undertaken by Stonepillow at their homeless shelter one night in November 2013 revealed 55.6% had both mental health and substance abuse issues.
- It is likely that around 3,500 people in West Sussex have both a learning disability and a mental health issue. Of these, a small proportion will also misuse substances. [See section 2.7.4 below].
- Figures from specialist substance misuse services across West Sussex suggest 14% of those presenting with drug and/or alcohol problems also had a diagnosed mental health condition. This is significantly below national estimates, but information provided through a Management Survey sent to all specialist substance misuse services in West Sussex as part of the West Sussex

[20] Source: Quality and Outcomes Framework - 2011-12, PCT level: Prevalence Table. Available at http://www.hscic.gov.uk/article/2021/Website-Search?productid=9592&q=. Accessed 06/12/2013.

[21] Community Mental Health Profiles 2013: West Sussex, North East Public Health Observatory. Accessed December 2013. Available at http://www.nepho.org.uk.

[22] Source: *Rough Sleeping Statistics England:2012*, Dept for Communities and Local Government, available at http://data.gov.uk/dataset/rough_sleeping_statistics_england. Accessed 06/12/2013.

Alcohol and Drugs Needs Assessment[23] points to a much higher prevalence of dual-diagnosis amongst this client group.

- Based on analysis of provider services, coupled with a combination of qualitative and quantitative feedback through interviews and provider workshops, the authors found that the treatments and interventions provided across West Sussex are generally in line with national policy, guidance and standards. However, currently there is no West Sussex based dual diagnosis service for adults with co-occurring mental health problems and substance misuse problems. Some stakeholders wish to see such a service reinstated.
- Joined up working between specialist mental health services and specialist alcohol and drug services for adults is sporadic.
- Co-occurring mental health problems and substance misuse problems are generally managed in a way which addresses the primary problem, followed by the secondary problem; regardless of equity of condition – co-occurring problems are not effectively managed simultaneously.

2.4 Legislation and Policy Context

Dual diagnosis has been a priority area since 1999 when the Department of Health commissioned a review of psychiatric disorder and substance misuse.[24] Since then, several projects and literature reviews have been conducted and training/information manuals have been issued. A very brief review of the most recent relevant policies and strategies is undertaken below to provide context for this chapter.

2.4.1 National Policy Context

In 2002, the Department of Health produced a framework for practice around dual diagnosis and this 'Good Practice Guide' remains the most specific national policy document pertaining to dual diagnosis.[25] The central tenet of this guide is that individuals with both substance misuse and mental health problems deserve integrated care delivered either by mental health services (in the case of those with severe mental health problems) or specialist substance misuse services (for those with mild to moderate mental health conditions), but with appropriate support from the other agency – a policy referred to as 'mainstreaming'.

Specific guidance has subsequently been issued on the assessment and management of those in mental health inpatient and day-hospital settings who have co-morbid conditions (2006),[26] and for the management of dual diagnosis in prisons (2009).[27]

[23] Op. cit. Perkins et al (2014).

[24] Crome, I. B. (1999) Overview: Psychiatric Comorbidity and Substance Misuse: What Are the Issues? Drugs: Education, Prevention and Policy, 6 (2), pp.149–150.

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

[26] Department of Health, *Dual Diagnosis in mental health inpatient and day hospital settings*, October 2006.

[27] Department of Health & Ministry of Justice, *A Guide for the Management of Dual Diagnosis for Prisons*, 2009.

Whilst not examined in depth, dual diagnosis is referenced in the most recent mental health strategy 'No Health Without Mental Health' (2011),[28] which focuses on mainstreaming mental health and emphasises the symbiotic relationship between inequality and mental health. The approach taken within the strategy is to "promote mental wellbeing, preventing mental illness and early intervention as soon as the problem arises [to]...help to reduce the risk of substance misuse across the population."[29] This approach is referenced in the Government's latest alcohol strategy (2012), which also notes the "clear association between having a mental illness and increasing risk of alcohol dependence."[30] The 2010 drugs strategy[31] does not specifically refer to dual diagnosis, but it too recognises preventing mental illness will reduce the risk of substance misuse, and reiterates the need for services to work together to enable recovery.

2.4.2 Local Policy Context

In 2011, the Sussex Partnership NHS Foundation Trust (SPFT) developed a dual diagnosis strategy[32] with reference to national policy, research and evidence – including the aforementioned 'Good Practice Guide'. The strategy adopted a broad definition of dual diagnosis adapted from the 2002 guide[33] and formulated seven key themes into objectives to be reached within the five year implementation period. Objectives included:

- An emphasis on harm reduction strategies, Motivational Interviewing, relapse prevention and recovery principles;
- Developing links with and support to, housing and supported accommodation agencies;
- Ensuring service users and (with the service user's permission) their family/carers, are included in care planning/decision making;
- Providing dedicated dual diagnosis champions in each team across the care groups;
- Ensuring mental health and substance misuse workers have the knowledge, skills and confidence to provide assessment, care and treatment for people with a dual diagnosis;
- Reporting and analysing dual diagnosis activity data to inform current and future dual diagnosis health and social care provision, training and education.

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[28] Department of Health, *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages*, February 2011. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf. Accessed 02/12/2013.

[29] Ibid. p. 41.

[30] HM Government, *The Government's Alcohol Strategy*, London: The Stationary Office, 2012. Available at https://www.gov.uk/government/publications/alcohol-strategy. Accessed 02/12/2013. p. 26.

[31] HM Government, *Drug Strategy 2010 Reducing Demand, Restricting Supply, Building Recovery: Support People to Live a Drug Free Life*. Available at https://www.gov.uk/government/publications/drug-strategy-2010--2. Accessed 02/12/2013.

[32] Sussex Partnership NHS Foundation Trust, *The Dual Diagnosis Strategy 2011-2016*. Available at http://www.sussexpartnership.nhs.uk/gps/dual. Accessed 02/12/2013.

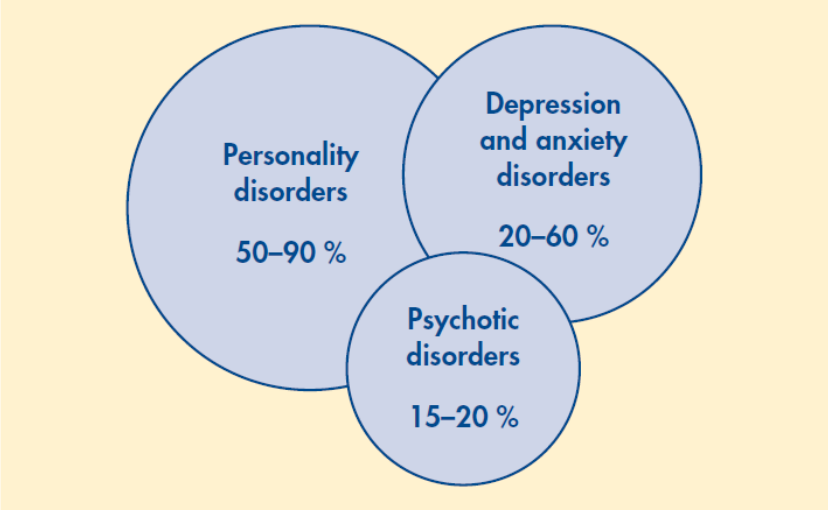
[33] "A primary psychiatric illness precipitating or leading to substance misuse, substance misuse worsening or altering the course of a psychiatric illness, intoxication and/or substance dependence leading to psychological symptoms or, substance misuse and/or withdrawal leading to psychiatric symptoms or illness" (p. 5 of the SPFT strategy).

The authors are unaware of any evaluation concerning the progress or impact of SPFT's dual diagnosis strategy. Future council and wider system dual diagnosis strategy and policy should be cognisant of the aforementioned legislation and strategy.

2.5 Epidemiology of Dual Diagnosis

Dual diagnosis or co-morbidity is often underestimated and under-diagnosed. Between 30 and 50% of psychiatric patients in Europe today have a mental illness as well as a substance use disorder, mainly with alcohol, sedatives or cannabis. In clinical prevalence samples of drug dependent patients, personality disorders (50–90%) are the most prevalent form of co-morbidity, followed by affective disorders (20–60%) and psychotic disorders (15–20%), although these syndromes interact and overlap which means a person might have more than one of these disorders in addition to drug-related disorders.[34]

Figure 2.1: Overlap of the three dominating diagnostic syndromes in patients with co-morbid drug-use disorders[35]



Furthermore, estimates of substance use of more than 50% are not uncommon in mental health services embedded in urban psychiatric facilities, although estimates in ruralities have been shown to be three to four times lower.[36]

The prevalence of co-occurring disorders has also been studied in community/general population samples[37] and particular links have been found between high alcohol consumption and depression

[34] Fridell, M. And Nilson, M., *Drugs in Focus: Briefing of the European Monitoring Centre for Drugs and Drug Addiction*, 2004. Office for Official Publications of the European Communities. Available at http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Good%20Practice/dual.pdf Accessed 04/12/2013.

[35] Op. cit. Fridell & Nilson (2004).

[36] Rush, B, and Koegl, C., 'Prevalence and Profile of People with Co-occurring Mental and Substance Use Disorders Within a Comprehensive Mental Health System', *La Revue Canadienne de Psychiatrie*, 2008; 53(12):810-22.

[37] For example: Reiger DA, Farmer ME, Rae DS. 'Co-morbidity of mental disorders with alcohol and other drug abuse. Results from the Epidemiological Catchment Area (ECA) study,' *JAMA*, 1990;264;2511–2518; Kessler, R., Nelson, C., McGonagle, K., Swartz, M., Blazer, D., 'Co-morbidity of DSM-III-R major depressive disorder in the general population: results from the US National Co-morbidity Survey',

The nature of the relationship between mental health and substance misuse problems is complex, but possible mechanisms recognised by Crome et al (2009)[38] include:

- A primary psychiatric illness may precipitate or lead to substance use, misuse, harmful use, and dependent use, which may also be associated with physical illness and affect social ability.
- Substance use, misuse, harmful use and dependent use may exacerbate a mental health problem and physical health problem, e.g. painful conditions, and any associated social functioning.
- Substance use e.g. intoxication, misuse, harmful use and dependent use may lead to psychological symptomatology not amounting to a diagnosis, and to social problems.
- Substance use, misuse, harmful use and dependent use may lead to psychiatric illnesses, physical illness, and social dysfunction.

Establishing which problem came first is often complicated and some authors warn that focussing on this issue can result in vulnerable individuals with co-morbidity being excluded from services whilst a decision about ultimate attribution is made.[39]

Co-morbidity can occur at any level of severity, and it is important to note that whilst in the UK there has been both an increased prevalence of substance misuse (particularly alcohol)[40] and an increased prevalence of dual diagnosis,[41] there is not necessarily a causal relationship between substance misuse and mental illness. Frisher et al (2005) concluded that, based on their sample of 3,969 patients with both substance misuse and psychiatric diagnosis, only a comparatively small proportion of psychiatric illness could be attributed to substance use (0.2%), whereas a more substantial proportion of substance use seems possibly attributable to psychiatric illness (14.2%).[42]

British Journal of Psychiatry Supplement, 1996; (30):17-30; Kessler R., Chiu W., Demler O, et al., 'Prevalence, severity, and co-morbidity of 12-month DSM-IV disorders in the National Co-morbidity Survey Replication.,' *Archive of General Psychiatry,* 2005;62(6):617–627; Grant B., Stinson F., Dawson D., et al. 'Co-occurrence of 12-month alcohol and drug use disorders and personality disorders in the United States,' *Archive of General Psychiatry,* 2004;61:361–368.

[38] Crome, I., Chambers, P., Frisher, M., Bloor, R. & Roberts, D., *The relationship between dual diagnosis: substance misuse and dealing with mental health issues*, Research Briefing 30, January 2009. Available at http://www.scie.org.uk/publications/briefings/files/briefing30.pdf. Accessed 02/12/2013. p. 4.

[39] Op cit. Crome et al (2009), p.3.

[40] British Medical Association Science and Education Department and BMA Board of Science (2008) Alcohol Misuse: Tackling the UK Epidemic. London, British Medical Association; NHS Information Centre (2008) Statistics on Alcohol: England 2008, London, NHS Information Centre; Murphy, R. and Roe, S. (2007) Drug Misuse Declared: Findings from the 2006/07 British Crime Survey – England and Wales, London, Home Office.

[41] Frisher, M., Crome, I., Macleod, J., Milson, D., & Croft, P., 'Substance misuse and psychiatric illness: prospective observational study using the general practice research database', *J Epidemiology and Community Health* 2005;59:847–850; Frisher, M., Collins, J., Millson, D., Crome, I., and Croft, P. (2004) 'Prevalence of co-morbid psychiatric illness and substance misuse in primary care in England and Wales', *Journal of Epidemiology and Community Health* 2004;58:1034–1041.

[42] Frisher, M., Crome, I., Macleod, J., Milson, D., & Croft, P., 'Substance misuse and psychiatric illness: prospective observational study using the general practice research database', *Journal of Epidemiological Community Health* 2005;59:847–850.

2.5.1 Specific Associations: Substance misuse, self harm and suicidal behaviour

Alcohol can make people lose their inhibitions and behave impulsively; it can therefore lead to actions they might not otherwise have taken – including self-harm and suicide.[43] Furthermore, according to the National Mental Health Development Unit (2009)[44] people who have – or are recovering from – both alcohol and drug alcohol problems are at a significantly greater risk of self-harm and suicide than the general population.

Data gathered by the NHS in Scotland, reveal that more than half of those who presented to hospital with self-inflicted injuries reported to have consumed alcohol before or during the act of self-harm, and 27% of men and 19% of women gave alcohol as the reason for self-harming.[45] More recently, in a study involving 1108 people presenting at general hospitals in Manchester with self-inflicted injuries (a third of whom were assessed by mental health specialists), probable depression was identified in 29%; alcohol or drug misuse in 32% (a further 9% were alcohol dependent); anxiety/stress-related disorders in 13%; a severe mental illness in 7%; and a further 4% were diagnosed with personality disorders (Dickson *et al*, 2009).[46]

The estimated risk of suicide in the presence of current alcohol misuse or dependence is eight times greater than in the absence of such misuse/dependence[47,48] and as many as 65% of suicides have been linked to excessive drinking.[49] The risk is especially great for men.[50] Up to 40% of men who try to kill themselves have an enduring problem with alcohol, and as many as 70% of those who succeed are intoxicated at the time,[51] this may be explained in part by the fact that people who are intoxicated by alcohol tend to use more lethal methods of suicide or attempt suicide using means that have a very low probability of survival.[52]

The authors' West Sussex Alcohol and Drugs Needs Assessment report[53] discussed the link between substance misuse and early death, and according to np-SAD data, overall 18.1% of drug-related deaths in 2011 were ruled suicide. There was however more deaths attributed to suicide in females

[43] Singleton N, Bumpstead R, O'Brien M, Lee A, Meltzer H (2001) Psychiatric morbidity among adults living in private households, 2000. Her Majesty's Stationery Office (HMSO): London.

[44] Royal College of Psychiatrists: College Report CR158, Self-harm, suicide and risk: helping people who self-harm: Final report of a working group, June 2010, Royal College of Psychiatrists, London.

[45] NHS Quality improvement Scotland, *Understanding alcohol misuse in Scotland: Harmful drinking three –alcohol and self-harm'*, 2007. Accessed 02/12/2013. Available at http://healthcareimprovementscotland.org/programmes/mental_health/programme_resources/harmful_drinking_3.aspx.

[46] Dickson, S., Steeg, S., Donaldson, I., *et al*. (2009) *Self-Harm in Manchester*. 1st September 2005 to 31st August 2007. The University of Manchester.

[47] World Health Organisation, *Global Status Report on Alcohol 2004*, 2004, Geneva, WHO.

[48] Flensborg-Madsen, T., Knop, J., Mortensen, E., Becker, U., Sher, L., Grønbæk, M., 'Alcohol use disorders increase the risk of completed suicide — Irrespective of other psychiatric disorders. A longitudinal cohort study', *Psychiatry Research*, 2009; 167(1-2):123-30.

[49] Department of Health, *Health of the Nation key area handbook: mental health*, 1993, London: HMSO.

[50] Lucas Ginera, L., Blasco-Fontecillab, H., Perez-Rodriguezc, M., Garcia-Nietod, R., Ginera, J., Guijaa, J., Barreroe, A., Lunaf, M., de Leong, J., Oquendoh, M., Baca-Garciad, E., 'Personality disorders and health problems distinguish suicide attempters from completers in a direct comparison', *Journal of Affective Disorders*, 2013; 151(2):474-83.

[51] The Royal College of Psychiatrists, *Alcohol and Depression: Help is at Hand*, 2004, London: The Royal College of Psychiatrists.

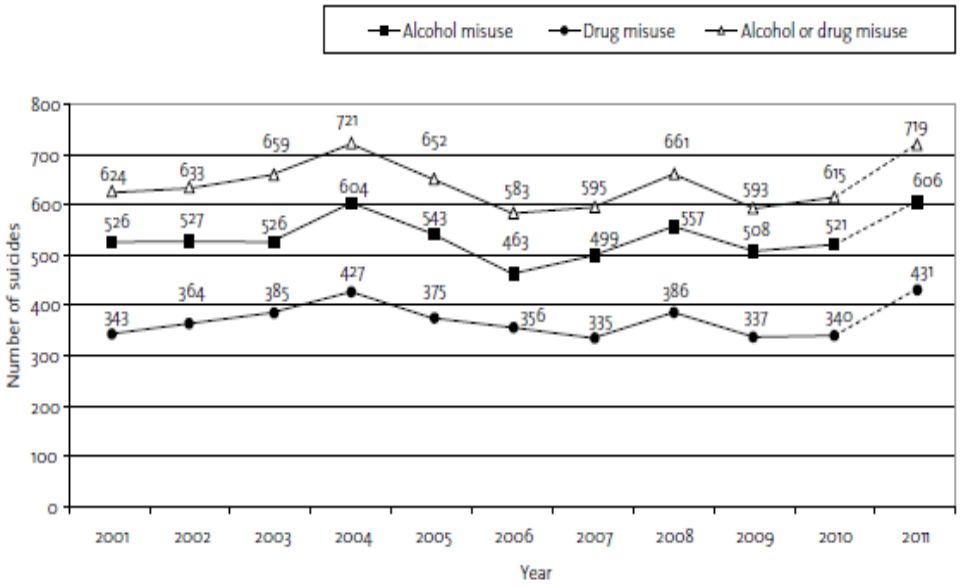
[52] Sher L. 'Alcohol consumption and suicide', *Quarterly Journal of Medicine*, 2006; 99:57–61.

[53] Op. cit. Perkins et al (2014), chapter 2.

than in males (23.1% vs. 16.1%).[54] Moreover, of the 131 cases noted as diagnosed with mental health issues, 51.9% (68/131) were listed as suffering from depression, with 25.0% of these (17/68) having deaths attributed to suicide.[55]

According to the *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report July 2013,*[56] in 2011 there were 5,880 suicides in England in patients[57] with a history of alcohol misuse (45% of the total sample) and 4,079 patient suicides had a history of drug misuse (31% of the total sample). Between 2001-2010, the number of patient suicides with a history of alcohol or drug misuse did not change, although the report projects a rise in 2011 (see figure below).

Figure 2.2: Patient suicide: number with a history of alcohol or drug misuse (England)[58]



Further, 1,970 (15%) patient suicides had severe mental illness and co-morbid alcohol drug dependence/misuse (dual diagnosis) – an average of 179 deaths per year. There was no trend during the report period overall (see figure below) but numbers have fallen since a peak in 2004.

[54] Op. cit. Ghodse et al (2012) p.7.

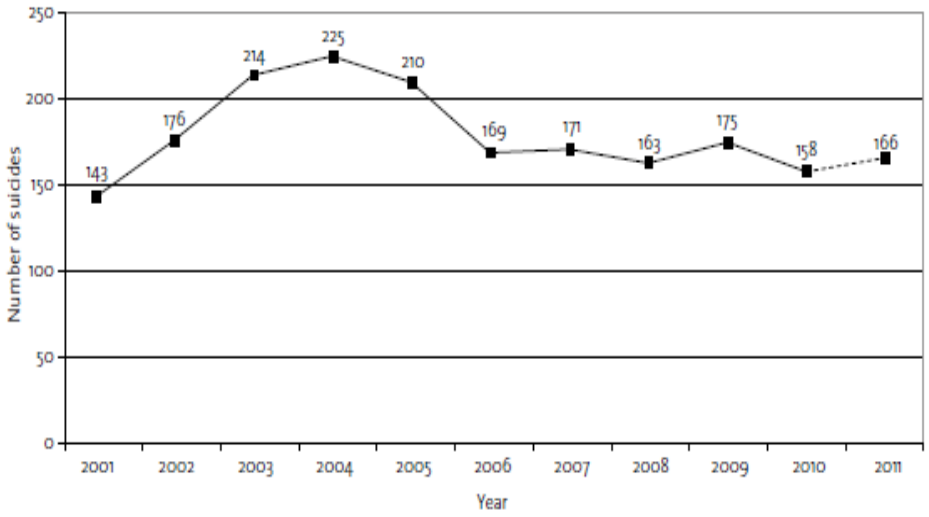
[55] Op. cit. Ghodse et al (2012) p.43.

[56] The University of Manchester, *The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Annual Report England, Northern Ireland, Scotland and Wale*s, July 2013. Available at http://www.bbmh.manchester.ac.uk/cmhr/centreforsuicideprevention/nci/reports/NCIAnnualReport2013V2.pdf. Accessed 11/12/2013.

[57] i.e. the person had been in contact with mental health services in the 12 months prior to death.

[58] Figure 19, *The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Annual Report*

Figure 2.3: Patient suicide: number with dual diagnosis (England)[59]



2.5.2 Specific Associations: Substance misuse, depression & anxiety

Evidence suggests that at least two thirds of alcohol-dependent individuals entering treatment show evidence of anxiety, sadness, depression and/or manic-like symptoms.[60] Likewise, a higher incidence of alcohol use disorders (AUDs) is reported for patients in treatment for depression,[61] and a recent Australian study found that a diagnosis of affective disorder was associated with a five-fold increased risk of developing alcohol dependence within five years of onset and for generalised anxiety the risk was three-fold.[62]

A 2011 literature review and analysis by Boden and Fergusson confirmed that the presence of either an AUD or major depression (MD) doubled the risks of the second disorder. They surmise that the epidemiological data suggests the linkages between disorders cannot be fully accounted for by common factors that influence both AUD and MD, and that the disorders appear to be linked in a causal manner. They go on to note that evidence suggests the most plausible causal association between AUD and MD is one in which AUD increases the risk of MD, rather than vice versa, although they acknowledge that further research is needed to clarify the nature of this causal link.[63]

[59] Figure 20, *The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Annual Report.*

[60] Crawford, V., *Co-existing problems of mental health and substance misuse ('Dual Diagnosis'): A Review of Relevant Literature*, London: RCP College Research Unit, 2001.

[61] Alpert J., Fava, M., Uebelacker, L., Nierenberg, A., Pava, J., Worthington, J., et al, 'Patterns of Axis I co-morbidity in early-onset versus late-onset major depressive disorder', *Biological Psychiatry*, 1999; 46(2):202-11; Blixen, C., McDougall, G., Suen, L., 'Dual Diagnosis in elders discharged from a psychiatric hospital', *International Journal of Geriatric Psychiatry*, 1997; 12(3):307-313.

[62] Liang, W., Chlkritzhs, T., 'Affective disorders, anxiety disorders and the risk of alcohol dependence and misuse', *British Journal of Psychiatry*, 2011;199:219-24.

[63] Boden, J., & Fergusson, D., 'Alcohol and depression', *Addiction Review*, 2011; 106(5):906-14.

Amongst the general population, alcohol dependence and major depression co-occur at higher levels than would be expected by chance,[64] and there is evidence to suggest that whilst light to moderate alcohol consumption may be associated with a lower prevalence of depression and generalised anxiety disorder compared to abstinence, higher volume consumption is associated with more severe symptoms of depression.[65,66,67] The primary source of information on the prevalence of both treated and untreated psychiatric disorders and their associations in England is the Adult Psychiatric Morbidity Survey (APMC). Data from the most recent survey (2007) suggests that among the 'cluster' with cothymia (co-occurring anxiety and depression) 39.7% were also dependent on alcohol, and 19.9% were dependent on drugs.[68]

Collectively the evidence seems to suggest that AUDs often co-occur with depressive symptoms, although there is less evidence to indicate whether, in the individual case, the depression causes the alcohol problems, the alcohol problems cause the depression, or whether a third factor causes both. That withstanding, according to the World Health Organisation "the evidence indicates that a clear and consistent association exists between alcohol dependence and depressive disorders and that chance, confounding variables and other bias can be ruled out with reasonable confidence as factors in this association."[69]

Using alcohol or drugs to reduce emotional distress (self-medication) has been proposed as an explanation for the high co-morbidity rates between non-clinical anxiety, depression and substance use disorders. Bolton et al (2009) analysed data from the National Epidemiologic Survey on Alcohol and Related Conditions (a large (n=43,093) nationally representative survey of mental illness in community-dwelling adults in Canada) and found that almost one-quarter of individuals with mood disorders (24.1%) used alcohol or drugs to relieve symptoms, with men more than twice as likely as women to engage in self-medication.[70] The risk of such self-medication has been examined in a recent study which concluded that drinking to alleviate mood symptoms is associated with the development of alcohol dependence and its persistence once dependence develops.[71] Similarly,

[64] Op. cit. Kessler et al (1996); Lynskey, M., 'The co-morbidity of alcohol dependence and affective disorders: treatment implications', *Drug and Alcohol Dependence*, 1998; 52(3):201-9; Mehrabian, A., 'General relations among drug use, alcohol use, and major indexes of psychopathology,' *Journal of Psychology*, 2001; 135(1): 71-86.

[65] Op. cit. Mehrabian (2001); Alcohol Concern, *Factsheet 17: Alcohol & Mental Health*, 2004, London.

[66] Bellos, S., Skapinakis, P., Rai, D., Zitko, P., Araya, R., Lewis, G., Lionis, C., Mavreas, V., 'Cross-cultural patterns of the association between varying levels of alcohol consumption and the common mental disorders of depression and anxiety: Secondary analysis of the WHO Collaborative Study on Psychological Problem in General Health Care', *Drug and Alcohol Dependence*, 2013; 133(3): 825-31.

[67] Flensborg-Madsen, T., Becker, U., Grønbæk, M., Knop, J., Mortensen, E., 'Alcohol consumption and later risk of hospitalisation with psychiatric disorders: prospective cohort study', *Psychiatric Research*, 2011; 187(1-2):214-9.

[68] National Centre for Social Research & Department of Health Sciences, University of Leicester, *Adult psychiatric morbidity in England, 2007: Results of a household survey*. Available at http://www.hscic.gov.uk/catalogue/PUB02931 Accessed 03/12/13. p227-8.

[69] WHO (2004).

[70] Bolton, J., Robinson, J., Sareen, J., 'Self-medication of mood disorders with alcohol and drugs in the National Epidemiologic Survey on Alcohol and Related Conditions', *Journal of Affective Disorders*, 2009; 115(3):367-375.

[71] Crum, R., Mojtabai, R., Lazareck, S., et al. A Prospective Assessment of Reports of Drinking to Self-medicate Mood Symptoms With the Incidence and Persistence of Alcohol Dependence. *JAMA Psychiatry*.2013;70(7):718-726. This supports the estimations made by Robinson et al (2011) that, based on the evidence, 10% of new cases of alcohol dependence and 28% of new drug dependence cases were attributable to self-medication of anxiety (see Robinson, J., Sareen, J., Cox, B., Bolton, J., 'Role of self-medication in the development of co-morbid anxiety and substance use disorders: a longitudinal investigation', *Archives of General Psychiatry*, 2011; 68(8):800-7).

Lazareck et al (2012) concluded that self-medication with drugs among individuals with mood disorders confers substantial risk of developing incident drug dependence and is associated with the persistence of co-morbid mood and drug use disorders.[72] Conversely, other studies have suggested that substance use can lead to the development of anxiety disorders, that substance misuse worsens psychiatric symptoms and the biological effects of withdrawal from substances can mimic anxiety disorders.[73]

Whilst the direction of causality has yet to be proved conclusively, there is a wealth of evidence demonstrating the co-occurrence of anxiety disorders and substance issues.

2.5.3 Specific Associations: Substance misuse and personality disorders

As noted by the Mental Health Foundation, individuals receiving treatment for alcohol dependence are often diagnosed with a personality disorder.[74] Up to 50% of problem drinkers have a personality disorder, up to 80% have neurotic disorders[75] and people with anti-social disorders have 21 times the average population risk of experiencing alcohol abuse or dependence.[76] There are differences between genders, with a recent study confirming that borderline personality disorder is more prevalent among females than males accessing alcohol detoxification treatment.[77]

In their review of the evidence,[78] the Mental Health Foundation noted that as well as possibly being a pre-disposing factor to alcohol-dependence, a personality disorder can affect the individual's use of alcohol in other ways. It may, for example, influence: the clinical course of alcohol-dependence; their response to treatment;[79] and their risk of relapse.

[72] Lazareck, S., Robinson, J., Crum, R., Mojtabai, R., Sareen, J., Bolton, J., 'A longitudinal investigation of the role of self-medication in the development of co-morbid mood and drug use disorders: findings from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC)', *Journal of Clinical Psychiatry*, 2012; 73(5):588-93.

[73] Tomlinson, K., Tate, S., Anderson, K., McCarthy, D., Brown, S., 'An examination of self-medication and rebound effects: psychiatric symptomatology before and after drug relapse', *Addictive Behaviour*, 2006;31(3):461-74; Schuckit, M., 'Co-morbidity between substance use disorders and psychiatric conditions', *Addiction*, 2006;101(Supplement 1):76-88. Both cited in *Dual Diagnosis Needs Assessment: Brighton & Hove*, December 2012, p30.

[74] Mental Health Foundation, *Cheers? Understanding the relationship between alcohol and mental health*, 2006. Available at http://www.mentalhealth.org.uk/publications/.

[75] Cited in *Dual Diagnosis Needs Assessment: Brighton & Hove*, December 2012, p29. See also Preuss, U., Johann, M., Fehr, C., Koller, G., Wodarz, N., Hesselbrock, V., Wong, W., Soyka, M., ' Personality Disorders in Alcohol-Dependent Individuals: Relationship with Alcohol Dependence Severity', *European Addiction Research*, 2009; 15(4): 188-95.

[76] Institute of Alcohol Studies, *Alcohol and Mental Health*, 2004, Cambridge cited op. cite. Mental Health Foundation (2006).

[77] Picci, R., Vigna-Taglianti, F., Oliva, F., Mathis, F., Salmaso, S., Ostaoli, L., Sodano, A., Furlan, P., 'Personality disorders among patients accessing alcohol detoxification treatment: prevalence and gender differences', *Comprehensive Psychiatry*, 2012; 53(4):355-63.

[78] Op. cit. Mental Health Foundation (2006).

[79] Further supported by: Poldrugo, F. And Forti, B., 'Personality disorders and alcoholism treatment outcome', *Drug and Alcohol Dependence*, 1988; 21(3):171-6; Bottlender, M., and Soyka, M., 'Impact of different personality dimensions (NEO Five-Factor Inventory) on the outcome of alcohol-dependent patients 6 and 12 months after treatment', *Psychiatry Research*, 2005; 136(1):61-7.

Personality disorder is also strongly associated with an increased risk of substance misuse issues, indeed estimates suggest that over half the patient population of drug and alcohol services will meet criteria for one or more personality disorders. [80,81]

As with alcohol, a personality disorder can affect the individual's substance misuse. A recent study concluded that the presence of co-occurring Borderline Personality Disorder (BPD) among male substance misuse patients may increase the risk for dropout from residential substance abuse treatment, necessitating targeted interventions focused on decreasing dropout within this patient subgroup.[82] Furthermore, poorer outcomes have been associated with (i) those who both misuse substances and have a mental health disorder compared to those with just a single disorder, with a recent US study among those with cannabis or alcohol dependence finding that those with personality disorders had an increased risk of the disorder persisting for at least three years[83] and (ii) dual diagnosis patients with prior mental disorder compared to dual diagnosis patients with prior substance use disorders.[84]

2.5.4 Specific Associations: Substance misuse and severe and enduring mental illness

Individuals with severe and enduring mental illnesses, such as schizophrenia and bipolar disorder, are at least three times as likely to be alcohol dependent as the general population,[85,86] and an estimated 40% of people diagnosed with psychosis have also misused a substance at some point in their lifetime.[87]

The incidence of dual diagnosis amongst those with a severe and enduring mental illness may be higher in the UK than elsewhere. A recent pan-European study into the lifetime prevalence of substance dependence among those with schizophrenia found that rates of co-morbidity were highest in this country; 35% reported dependence on a substance – 26% alcohol dependence and 18% drug dependence.[88] Despite this relatively high rate of co-presentation there is still no consensus on the aetiology of increased rates of substance use in people with psychosis. As noted by Gregg et

[80] Welch, S., 'Substance use and personality disorders', *Psychiatry*, 2007; 6(1):27-9.

[81] Pennay, A., Cameron, J., Reichart, T., Strickland, H., Lee, N., Hall, K., Lubman, D., 'A systematic review of interventions for co-occurring substance use disorder and borderline personality disorder', *Journal of Substance Abuse Treatment*, 2011; 41(4):363-73.

[82] Tull, M., Gratz, K., 'The impact of borderline personality disorder on residential substance abuse treatment dropout among men', *Drug and Alcohol Dependence*, 2012; 121(1-2):97-102.

[83] Hasin, D., Fenton, M., Skodol, A., Krueger, R., Keyes, K. Geier, T., et al, 'Personality disorders and the three year course of alcohol, drug and nicotine use disorders', *Archive of General Psychiatry*, 2011; 68(11):1158-67. Cited in *Dual Diagnosis Needs Assessment: Brighton & Hove*, December 2012, p30.

[84] Najt, P., Fusar-Poli, P., & Brambilla, P., 'Co-occurring mental and substance abuse disorders: A review on the potential predictors and clinical outcomes', *Psychiatry Research*, 2011; 186(2-3):159-64.

[85] Institute of Alcohol Studies, *Alcohol and Mental Health*, 2004, Cambridge cited op. cite. Mental Health Foundation (2006).

[86] Phillips, P., Johnson, S., 'How does drug and alcohol misuse develop among people with psychotic illness? A literature review,' *Soc Psychiatry Psychiatry Epidemiology* 2001; 36(6):269-76.

[87] National Institute for Clinical Excellence, *Clinical Guideline (CG120) Psychosis with co-existing substance misuse*, March 2011, p 4. Available at http://guidance.nice.org.uk/CG120/NICEGuidance/pdf/English. Accessed 04/12/2013.

[88] Carra, G., Johnson, S., Bebbington, P., Angermeyer, M., Heider, D., Brugha, T., et al, 'The lifetime and past-year prevalence of dual diagnosis in people with schizophrenia across Europe: findings from the European Schizophrenia Cohort (Euro SC), *European Archive of Psychiatry and Clinical Neuroscience*, 2012. Cited in *Dual Diagnosis Needs Assessment: Brighton & Hove*, December 2012, p30.

al (2007), there is therefore a clear need to understand the reasons for such high rates of substance use if treatments designed to help patients abstain from substance use are to be successful.[89]

2.6 Prevalence of Dual Diagnosis across the UK

As noted above, there are no routinely collected datasets on dual diagnosis; it is therefore difficult to estimate the prevalence of such co-morbidity. This difficulty is further compounded by an inconsistency in definition. Moreover, most studies are based on data collected from those already known to specialist services (mental health or substance misuse) and do not therefore tell us about the prevalence of dual diagnosis amongst the general population.

In line with European estimates, the charity 'Rethink Mental Illness' estimate that in the UK, a third of patients in mental health services have a substance misuse problem, and around half of patients in drug and alcohol services have a mental health problem.[90] Studies have however shown widespread social and regional variation in the prevalence of dual diagnosis, with higher rates recorded in deprived areas than in affluent areas. That withstanding, it has been suggested that the rate is increasing more rapidly in affluent areas.[91]

2.6.1 The 'COSMIC' Study

In 2002, the Co-Morbidity of Substance Misuse and Mental Illness Collaborative Study (COSMIC) estimated the prevalence of dual diagnosis in four inner-city areas in England (two in London, Sheffield and Nottingham). They reported that 74.5% of drug service users and 85.5% of alcohol service users experienced co-occurring mental health problems.[92] The prevalence of particular mental health problems amongst the subject group are shown in the table below:

[89] Gregg, L., Barrowclough, C., Haddock, G., 'Reasons for increased substance use in psychosis', *Clinical Psychology Review*, 2007; 27(4):494-510.

[90] Cited in *Dual Diagnosis Needs Assessment: Brighton & Hove*, December 2012, p.32.

[91] Op. cit., Frischer et al (2005).

[92] Weaver, T., Charles, V., Madden, P., & Renton, A., 'A study of the Prevalence and Management of Co-Morbidity amongst Adult Substance Misuse & Mental Health Treatment Populations', Drug Misuse Research Initiative/Dept of Health, 2002. Available at http://dmri.lshtm.ac.uk/docs/weaver_es.pdf. Accessed 06/12/2013.

Table 2.4: COSMIC study: Estimated prevalence of mental health problems among substance misuse patients[93]

Condition	% of drug treatment population	% alcohol treatment population
Psychiatric disorder	75	85
Non-substance induced psychosis disorders	8	19
Personality disorder	37	53
Depression &/or anxiety disorder	68	81
Severe depression	27	34
Mild depression	40	47
Severe anxiety	19	32

Similar rates of dual diagnosis were also reported in a study undertaken at the same in time the London borough of Bromley. Strathdee et al (2002) estimated that 83% of substance misuse clients had a dual diagnosis.[94]

The COSMIC study also found that 44% of the community mental health team (CMHT) patients reported problem drug use and harmful alcohol use in the preceding twelve months – the most commonly used substances being alcohol and cannabis:

Table 2.5: COSMIC study: Use of substances by CMHT patients[95]

Substance	Use in the past 12m by CMHT patients (%)
Harmful alcohol or drug use	44
Any drug use	31
Harmful alcohol use (AUDIT $\geq$8)	26
Cannabis	25
Dependent cannabis use	12.8
Sedatives/tranquilisers	7
Crack cocaine	6
Heroin	4
Ecstasy	4
Amphetamines	3
Cocaine	3
Opiate substitutes	1.4

[93] Source: Table 2 *Dual Diagnosis Needs Assessment: Brighton & Hove*, December 2012, p.33.

[94] Strathdee et al (2002), 'Dual diagnosis in a primary care group (PCG) – a step by step epidemiological needs assessment and design of a training and service response model', Department of Health/National Treatment Agency.

[95] Source: Table 3 *Dual Diagnosis Needs Assessment: Brighton & Hove*, December 2012, p.34.

The study in Bromley suggested lower levels of dual diagnosis within community mental health clients (20%), but recorded a prevalence rate of 43% for psychiatric in-patients and 56% in forensic patients.[96]

Other key findings of the COSMIC report were that around 30% of drug service users and 50% of alcohol service users had 'multiple morbidity' (i.e. complex needs); and some 38.5% of drug users with a psychiatric disorder were receiving no treatment for their mental health problem. Also important is the conclusion drawn that the treatment population is heterogeneous, and that responding to the range and level of need is challenging.

It should be noted that both of the aforementioned studies were conducted in city locations, care should therefore be used when applying the findings to more rurual locations.

2.6.2 Making Every Adult Matter coalition

In their 2011 vision paper *Turning the Tide*, the Making Every Adult Matter (MEAM) coalition of voluntary sector organisations Clinks, DrugScope, Homeless Link and MIND, estimated that around 60,000 people living in the UK were experiencing multiple needs relating to mental health, substance misuse, homelessness and offending.[97] The report paid particular attention to those who are excluded from services either because they do not meet their criteria or because they have complex needs and are seen as 'hard to reach' or 'not my problem'. It recommended a cross-agency approach and suggested that local leaders should make tackling multiple needs and exclusions a priority.

Homelessness

It is estimated that 18% of rough sleepers have a mental health issue combined with a substance misuse issue[98] and according to rough sleeping statistics published for Autumn 2012, an estimated 2,309 people are sleeping rough in England on any one night.[99]

Criminal Justice/Prison Population

Those with a dual diagnosis are at higher risk of contact with the criminal justice system, both compared to the general population and to others with just mental health issues.[100] Consequently, the prevalence of dual diagnosis among the prison population has been estimated at 75%[101]. This

[96] Op. cit. Strathdee et al (2002).

[97] MEAM and Revolving Doors, *Turning the Tide: A vision paper for multiple needs and exclusions,* MEAM/RDA,2011. Available at http://meam.org.uk/wp-content/uploads/2011/09/turning-the-tide.pdf. Accessed 06/12/2013.

[98] *Preventing suicide in England: A cross-government outcomes strategy to save lives,* Department of Health, Sept 2012, p.29. Available at https://www.gov.uk/government/publications/suicide-prevention-strategy-launched. Accessed 06/12/2013.

[99] *Rough Sleeping Statistics England:2012*, Dept for Communities and Local Government, available at http://data.gov.uk/dataset/rough_sleeping_statistics_england. Accessed 06/12/2013.

[100] Cited *Dual Diagnosis Needs Assessment: Brighton & Hove*, December 2012, p.36.

[101] Prison Reform Trust. Prison Fact File December 2011. Available at http://www.prisonreformtrust.org.uk/Portals/0/Documents/Bromley%20Briefing%20December%202011.pdf. Accessed 06/12/2013.

finding has wider implications within a community setting, for example, the Bradley review into offender mental health concluded that dual diagnosis was a vital component, and that no approach to diverting offenders with mental health issues from custody would be effective unless it addressed alcohol and drug misuse.[102]

Learning Disabilities

According to the Mental Health Foundation, there are around 1 million people with learning disabilities in England and estimates of prevalence of mental health problems vary from 25-40%, depending on the population sampled and the definitions used.[103]

Due to the growth of 'substance misuse' (i.e. alcohol, illicit drugs and over use of prescribed medications) in both the general and psychiatric populations, there is also a growing trend for people with learning disabilities to misuse such substances (Degenhardt et al., 2000, Sturmey et al., 2003).[104] There is however a paucity of evidence examining the misuse of substances amongst those with learning disabilities. Sturmey et al. (2003) stated that "it is difficult to define any consensus among the studies as to the prevalence of alcohol misuse among people with learning disabilities, however, prevalence rates may vary somewhere between 0.5% - 2% of this population" (p. 44). Figures for illicit drug misuse in people with learning disabilities also indicate far lower prevalence rates (Westermeyer et al., 1988, Gress & Boss, 1996, Christian & Poling, 1997, Pack et al., 1998). Nonetheless, ARAC (2002) have reported that few learning disability, and also mainstream addiction, service providers have clear written policies and procedures for co-working with this population. Consequently, both service providers have reported a number of difficulties in recognising and meeting the complex needs of this population.[105]

2.6.3 Future

There is very limited data available to assess the trend in prevalence rates of dual diagnosis either nationally or locally. A study in primary care in England and Wales in 2004 did however estimated that the prevalence of co-morbid psychiatric illness and substance misuse was increasing by 10% each year, but it is not clear this has occurred.[106]

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[102] The Bradley Report Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system, April 2009. Available at http://www.rcpsych.ac.uk/pdf/Bradley%20Report11.pdf. Accessed 06/12/2013.

[103] Giraud-Saunders , A., *Mental health in people with learning disabilities*, Mental Health Foundation. Accessed 06/12/2013. Available at http://www.mentalhealth.org.uk/content/assets/PDF/policy-archive/Mental_health_in_people_with_learning_disabilities.pdf.

[104] Cited Taggart et al, An Exploration Of Substance Misuse In People With Learning Disabilities Living Within Northern Ireland, University of Ulster, 2004. Available at http://www.dhsspsni.gov.uk/an_exploration_of_substance_misuse_in_people_with_learning_disabilities_living_in_northern_ireland.pdf. Accessed 06/12/2013.

[105] Ibid.

[106] Frisher, M., et. al, 'Prevalence of co-morbid illness and substance misuse in primary care in England and Wales', *Journal of Epidemiology & Community Health*, 2004;58:1036-41.

National trends show that over the last 20 years there have been large increases in rates of substance dependency. This, together with the increasing prevalence of common mental health disorders such as anxiety and depression suggest that dual diagnosis could increasingly be recognised. It is however difficult to quantify any such increase with the data currently available.[107]

2.7 Prevalence of Dual Diagnosis in West Sussex

There are separate prevalence estimates available for mental health conditions, and for substance misuse in the local population of West Sussex, however these estimates do not indicate how many people have both conditions. Data from treatment services approximates how many people in the area are being treated for a dual diagnosis, but this does not give an insight into unmet need, therefore in this section such data is supplemented by information from a range of other sources (detailed below).

2.7.1 Mental Health in West Sussex

Personal Wellbeing

Since April 2011, the Office for National Statistics has measured personal wellbeing across the UK against four domains: life satisfaction, worthwhile, happiness and anxiety. According to all four measures, residents of West Sussex experience better than average personal wellbeing (similar to that reported in Essex and Dorset). There is however variation across the county, with the Worthing sample consistently reporting poorer wellbeing than the West Sussex average in all measures bar one, where the Arun sample reported the highest level of anxiety.

[107] National Mental Health Development Unit, Briefing 189, *Meeting the challenge of dual diagnosis*, September 2009. Available at http://nmhdu.org.uk/silo/files/seeing-double-meeting-the-challenge-of-dual-diagnosis.pdf. Accessed 09/12/2013.

Table 2.6: Life satisfaction, Worthwhile, Happiness and Anxiety ratings by UK, country, region, UA/ County, April 2012 to March 2013[108]

Area names	Life satisfaction rating[109]	Worthwhile rating[110]	Happiness rating[111]	Anxiety rating[112]
UNITED KINGDOM	7.45	7.69	7.29	3.03
ENGLAND	7.44	7.68	7.28	3.05
Essex	7.41	7.67	7.25	2.96
Dorset	7.65	7.93	7.39	2.91
West Sussex	7.59	7.86	7.40	2.81
Adur	7.43	7.66	7.27	2.54
Arun	7.64	7.82	7.43	3.04
Chichester	7.61	8.01	7.52	2.68
Crawley	7.53	7.82	7.26	2.83
Horsham	7.80	8.06	7.56	2.79
Mid Sussex	7.73	7.86	7.49	2.84
Worthing	7.20	7.70	7.16	2.41

Regular physical activity is also associated with improved personal wellbeing. In the period 2009/10-2011/12, the percentage of adults (16+) participating in the recommended level of physical activity in West Sussex was higher than both the England average (11.2%) and that reported in Essex (10.9%) at 13.4%, and similar to that seen in Dorset (13.8%).[113]

[108] Source: Estimates of personal well-being from the Annual Population Survey (APS) Personal Well-being dataset: by UK, country, region, UA/ County in England, LADs in England, UAs in Wales, LAs in Scotland, DCAs in Northern Ireland, April 2012 to March 2013, available at http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-327124. Last accessed 22/11/2013.

[109] Sample populations were asked 'Overall, how satisfied are you with your life nowadays?' A scaling of 0-10 was given, where 0 was 'not satisfied at all' and 10 was 'completely satisfied'.

[110] Sample populations were asked, 'Overall, to what extent do you feel the things you do in your life are worthwhile?' A scaling of 0-10 was given, where 0 was 'not at all worthwhile' and 10 was 'completely worthwhile'.

[111] Sample populations were asked, 'Overall, how happy did you feel yesterday?' A scaling of 0-10 was given, where 0 was 'not at all happy' and 10 was 'completely happy'.

[112] Sample populations were asked, 'Overall, how anxious did you feel yesterday?' A scaling of 0-10 was given, where 0 was 'not at all anxious and 10 was 'completely anxious'.

[113] Community Mental Health Profiles 2013: West Sussex/Essex/Dorset, North East Public Health Observatory. Accessed December 2013. Available at http://www.nepho.org.uk.

Mental Health Conditions

The above withstanding, West Sussex had significantly more adults on the GP register for depression (18+ yrs) in 2011/12 than the national average. There was also a higher prevalence of panic disorders and hospital admissions for unipolar depressive disorders 2009/10 to 2011/12. The Table below does however show that the rate of neurotic disorders, mixed anxiety and depression and generalised anxiety disorders (in those aged 16-74), was significantly better in West Sussex than the national average. West Sussex also has low rates of health service use for mental health problems, with significantly fewer adults receiving care under a Care Programme Approach, significantly fewer patient contacts by Outpatient & Community Psychiatric Nurses per year and significantly fewer total patient contacts by mental health staff.

Table 2.7: Mental health in West Sussex

Prevalence	West Sussex		Dorset		Essex	England
	No.	Rate per 1,000 pop	No.	Rate per 1,000 pop	Rate per 1,000 pop	Rate per 1,000 pop
Adults on GP register for depression (18+ yrs) 2011/12[114],†	83,363	124	43,313	131	96.8	116.8
Adults on Mental Health Register 2011/12[115]	6,125	7	2,906	7	As Essex comprises of four separate PCTs, data under these prevalence indicators could not be provided.	7.9
Any neurotic disorder (16-74)*	74,398.3	137.3	41,846.0	148.4		166
Mixed anxiety & depression (16-74)*	41,283.8	76.2	23,679.4	84.0		89.0
Generalised anxiety disorder (16-74)*	19,861.3	36.7	10,881.8	38.6		45.0
Panic disorder (16-74)*	3,958.8	7.3	1,546.2	5.5		6.5
Depressive episode (16-74)*	10,337.6	19.1	3,341.4	11.8		
Rate for hospital admissions for mental health 2009/10 to 2011/12†		2.34		3.28	1.97	2.43
Rate for hospital admissions for unipolar depressive disorders 2009/10 to 2011/12†		0.40		0.54	0.25	0.32
Rate for hospital admissions for schizophrenia, schizotypal & delusional disorders 2009/10 to 2011/12†		0.54		0.60	0.28	0.57
Rate for hospital admissions for self-harm 2009/10 to 2011/12†		2.12		1.98	1.41	2.07
Adults receiving care under a Care Programme Approach 2010/11 (CPA)†[116]		5.9		4.3	3.9	6.4
Number of patient contacts by Outpatient & Community Psychiatric Nurses per year 2010/11†		153		167	105	169
Total patient contacts by mental health staff 2010/11†		247		229	256	313

[114] Source: Quality and Outcomes Framework - 2011-12, PCT level: Prevalence Table. Available at http://www.hscic.gov.uk/article/2021/Website-Search?productid=9592&q=. Accessed 06/12/2013.

[115] Total number of people with schizophrenia, bipolar disorder and other psychoses. Source: Quality and Outcomes Framework - 2011-12, PCT level: Prevalence Table. Available at http://www.hscic.gov.uk/article/2021/Website-Search?productid=9592&q=. Accessed 06/12/2013.

[116] The Care Programme Approach is a way of co-ordinating community mental health services for people with severe and enduring mental health problems. It involves carrying out a comprehensive assessment and producing a care plan for each patient.

* Source: National Psychiatric Morbidity Survey 2006. Accessed 06/12/2013. Available at: http://www.nepho.org.uk/publications.php5?rid=628.

†Source: Community Mental Health Profiles 2013: West Sussex/Essex/Dorset, North East Public Health Observatory. Accessed December 2013. Available at http://www.nepho.org.uk.

Significantly lower than England average

Significantly worse than England average

Significantly better than England average

Not significantly different to England average

High prescribing of psychotropic drugs, particularly benzodiazepines and anxiolytics, is associated with higher than average levels of deprivation and with a high prevalence of substance misuse. In West Sussex, in 2004/5, benzodiazepine prescribing was highest in the Adur, Arun and Worthing areas. However, more recently this is likely to have reduced in all areas as reduced prescribing of benzodiazepines became a Department of Health performance indicator.[117]

2.7.2 Self-harm and suicide

West Sussex had a slightly higher than average rate of hospital admissions for self-harm 2009/10 to 2011/12, which is an indicator of emotional and mental distress. Those who self-harm have a one in six chance of repeat attendance at A&E within a year, and there is a significant and persistent risk of future suicide following an episode of self-harm.[118]

In 2011 there were 62 deaths registered in West Sussex with an underlying cause of suicide[119] (68 in 2012)[120]. According to data held by the Reducing Drug Related Deaths Steering Group, of the 12 np-SAD deaths recorded in West Sussex in 2011, three recorded a verdict of suicide/taking of one's own life.[121]

2.7.3 Homelessness

According to the street counts and estimates published for Autumn 2012, in any one night in West Sussex 85 individuals sleep rough. Based on a dual diagnosis prevalence rate of 18% this implies around 15 of these people both misuse substances and have a mental health issue.

[117] Mental Health Needs Assessment For Adults Aged 16-64 In East And West Sussex: Executive Summary, accessed 09/12/2013, available at http://www.eastsussexjsna.org.uk/JsnaSiteAspx/media/jsna-media/documents/comprehensiveneedsassessment/16b-Adult_mental_health_Excec_Summary.pdf.

[118] Department of Health (2012), *Improving outcomes and supporting transparency: Part 2 – Summary technical specifications of public health indicators*, Available at http://www.vision2020uk.org.uk/core_files/dh_Summary_technical_specifications_of_public_health_indicators_Jan_2012.pdf, p.35. Accessed 09/12/2013.

[119] Office for National Statistics, Number of deaths where the underlying cause of death was suicide, by sex and local authority in England and Wales, deaths registered in 2012, available at http://www.ons.gov.uk. Accessed 09/12/2013.

[120] Office for National Statistics, Suicides in the United Kingdom, 2011, available at http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-288089. Accessed 09/12/2013.

[121] Data received from Vicky Fenwick, Harm Reduction Programme Manager, 12/11/2013.

Table 2.8: Rough sleeping estimates West Sussex Autumn 2012

Area	Estimate of rough sleeping[122]	Estimated prevalence of dual diagnosis (n)
Adur	0	-
Arun	26	5
Chichester	26	5
Crawley	17	3
Horsham	2	-
Mid Sussex	6	1
Worthing	8	1
TOTAL WEST SUSSEX	**85**	**15**

More specifically, a snapshot of clients undertaken by Stonepillow at their homeless shelter one night in November 2013 revealed that of the 18 people who presented 10 (55.6%) had both mental health and substance misuse issues.[123] Of the substances misused:

- All 10 were either binge drinkers or alcohol dependent;
- Three used cannabis;
- Three used crack/cocaine;
- Three were on a methadone programme (one of whom also used heroin).

Of the mental health issues reported:

- Seven had depression (two were suicidal/ had suicidal thoughts);
- Two had anxiety related conditions/panic attacks;
- One had paranoia;
- One had schizophrenia.

Further, when the managers of specialist substance misuse services were asked what particular needs the homeless/street drinkers present with, one comment provided specifically mentioned multiple/complex needs and mental health issues: *"Often dependent on alcohol and also poly drug use and addiction to opiates which is difficult to manage in terms of risk with prescribing. Often severe mental health difficulties that don't get picked up because of alcohol use."*

[122] Source: *Rough Sleeping Statistics England:2012*, Dept for Communities and Local Government, available at http://data.gov.uk/dataset/rough_sleeping_statistics_england. Accessed 06/12/2013.

[123] Source: information received from Helen Keats, Rough Sleeping Advisor, 26/11/2013.

2.7.4 Learning Disabilities

Overall, applying national prevalence assumptions to local population figures, it is estimated that there are over 14,000 adults with some form of learning disability living in West Sussex, 3,000 of whom are estimated to have a 'moderate or severe' learning disability.[124] Using the lowest prevalence estimate of 25%, (and with all the attendant caveats noted in Chapter 2), it is possible that around 3,500 people in West Sussex have both a learning disability and a mental health issue. Of these, at least 18 are likely to also have a substance misuse issue.

2.7.5 Specialist alcohol and drug service – quantitative data

National prevalence statistics indicate that at least 50% of clients attending specialist drug and alcohol services will also have mental health issues.[125]

Adult Partnership Performance Reports provide information on the number of those attending specialist services and 2012 data is thus:

- Number of clients with a new presentation to alcohol treatment financial year 2012/13 = 593
- Number of clients with a new presentation to drug treatment calendar year 2012 = 537

However, only 81 of the alcohol treatment clients were recorded as presenting with dual diagnosis; and only 78 of the drug treatment clients had dual diagnosis noted. These figures suggest a dual diagnosis prevalence rate of 14%, which is significantly below national estimates. There are a number of potential reasons for this. There may be differences in recording practices and the figures reported may be an underestimate, depending on how different professionals define dual diagnosis. It could also indicate a degree of unmet need amongst this group.

It is interesting to note that information provided in the Management Survey (conducted in the West Sussex Alcohol and Drugs Needs Assessment project[126]) which was sent to all specialist substance misuse services in West Sussex, points to a much higher prevalence of dual-diagnosis amongst this client group. When asked 'In 2012/13, what percentage of your service users had already been diagnosed with the following mental health problems at first contact?' the results from the six services who responded were thus:

[124] West Sussex Joint Strategic Needs Assessment: Update of local data – March 2013, West Sussex Public Health Research Unit. Available at http://jsna.westsussex.gov.uk. Accessed 09/12/2013.

[125] Op.cit. Dual Diagnosis Needs Assessment: Brighton and Hove, 2012,p.32.

[126] Op. cit. Perkins et al (2014).

Table 2.9: Mental health status of specialist substance misuse clients – Management Survey results

	No Mental Health Diagnosis (%)	Depression (%)	Anxiety (%)	OCD (%)	PTSD (%)	Bipolar Disorder (%)	Schizophrenia (%)	Personality Disorder (%)	ARBD (%)
Addaction Mid-Sussex*	20	70	80	10	20	<5	<5	30	20
Stonepillow	60	70	70	0	5	10	0	5	0
Recovery Project*	5	50	50	10	5	20	10	10	5
Alcohol Specialist Nurse*	50	20	20	Nil response	Nil response	Nil response	Nil response	Nil response	10
CRI Crawley*	60	70	50	Nil response	10	Nil response	Nil response	20	20
CRI Clock Walk*	65	15	5	<5	<5	<5	Nil response	5	Nil response

* Estimated figures

2.7.6 Specialist alcohol and drug service – qualitative data

The information in this section derives from a combination of methods including interviews with young people and professional stakeholders; and focus groups with current and former adult service users, former service users, non-service users including people in recovery as well as the lay; and family and friends affected by someone else's drinking and/or drug taking. Some findings are supported by quotes from study informants.

For the sake of brevity, the information is presented in bullet point form.

- Mental health problems often occur in tandem with not only alcohol or drug misuse but other problems such as homelessness, unemployment, destitution, crime, relationship breakdown, trauma; and negative childhood or other experiences.
- Ambiguity exists concerning whether West Sussex used to have a dual diagnosis service.
- There is a perception from identified informants that a West Sussex based dual diagnosis service would improve the scope and quality of current mental health as well as alcohol and drug misuse services. Furthermore, there is aspiration from some key stakeholders (including substance misuse service providers, GP, nurse, pharmacist, Programme Manager, homeless providers) to create a West Sussex based dual diagnosis service.
- Outlying counties such as East Sussex have a dual diagnosis service.
- There are very limited general hospital based mental health services for adults in West Sussex – the focus is on community based provision, supported by purchased out of area services.

- At the time the fieldwork was conducted for this study there was a single specialist alcohol and drug treatment and prescribing service provider in West Sussex, which contracted specialist locum doctors (n=2) and employed mental health nurses (n=8) and a general nurse (n=1) to support substitute related treatment including prescribing (partial resource provision); rather than on a mental health or dual diagnosis basis.[127]
- Co-occurring mental health problems and substance misuse problems are generally managed in a way which addresses the primary problem, followed by the secondary problem; regardless of equity of condition – co-occurring problems are not effectively managed simultaneously.
- Based on analysis of provider services, coupled with a combination of qualitative and quantitative feedback through interviews and provider workshops, the authors found that the treatments and interventions provided across West Sussex are generally in line with national policy, guidance and standards; despite the lack of a dual diagnosis service which is commonplace throughout the UK and often viewed as best practice.
- Joined up working between specialist mental health services and specialist alcohol and drug services for adults is sporadic.

Selected supporting quotes:

> *"Social workers need basic training in substance misuse. There is a huge barrier between adult social work services, substance misuse services and mental health services. By design, the West Sussex system is not integrated - the substitute treatment provider is dealing with severe mental health issues, often beyond their scope, competence and wish. Need a dual diagnosis worker."*
>
> *"The 'Options' dual diagnosis service was lost about 5 years ago. A specialist substance misuse provider employs mental health nurses but they do not do mental health work. Needs to include collaborative working, valuing each profession."*[128]
>
> *"We work jointly and well with the specialist substance misuse provider when alcohol patients are in hospital. There are no dual diagnosis services so patients are normally led down a mental health route."*
>
> *"There are good relationships and communications between the substitute treatment service and mental health services. There is no dual diagnosis service."*

[127] The service provider in question has subsequently been replaced by another provider, Central and North West London NHS Foundation Trust (CNWL) in May 2014. West Sussex Integrated Drug and Alcohol services are now delivered in partnership between CNWL and Crime Reduction Initiatives (CRI).

[128] Throughout the fieldwork of this study a number of poloarised views were expressed as to whether there had indeed been a specialist Dual Diagnosis service available in West Sussex as suggested by this quote. The authors have been unable to verify the actual position.

CHAPTER 3: PERSONAL EXPERIENCIES OF PEOPLE RECOVERING FROM DUAL DIAGNOSIS

3.1 Introduction

This chapter highlights key life experiences of three individuals who have experienced dual diagnosis. The text is a verbatim account of each person's documented journey: from early age; through to current times including their ongoing recovery from co-occurring substance misuse and mental health problems. The research team is particularly grateful to Mark, Nicola and Joe for sharing their life stories as part of this study, with aims of highlighting issues and solutions; and striving to help others suffering from, or affected by, dual diagnosis. The names of Mark, Nicola and Joe have been changed for the purpose of this report; they are real people. Despite such anonymity, it is pertinent for all readers of this report to convey respect, sensitivity and perhaps empathy for Mark, Nicola and Joe; and to wish them continued success in their recovery and happiness in life.

3.2 Mark's experience

The following case study has been adapted from a transcript of a meeting between a senior researcher and 'Mark', a service user of Worthing Churches Homeless Project who has a personal experience of dual diagnosis. The Figure 8 research team is extremely grateful to Mark for providing such a compelling insight; as well as Niall, Mark's Recovery Manager; and Tina, Mark's Dual Diagnosis Worker for facilitating the meeting.

"I am a 55 year old man called Mark. I am sharing my life experience as part of the dual diagnosis study in the hope that my story will help other people with combined psychiatric and substance misuse problems.

I have had two long term relationships. My first wife died. I have a 20-year old daughter, who attends university, from my second partner whom I separated from some time ago. I live in sheltered accommodation in Worthing but was raised in industrial Lancashire. I receive ESA (Employment Support Allowance) *and DLA* (Disability Living Allowance) *benefits.*

I am physically disabled. I also have a diagnosed psychiatric illness called schizophrenia due to hearing voices. I receive support for this from Tina, the Dual Diagnosis Worker from Worthing Churches Homeless Projects. I have been in contact with NHS mental health services since childhood but have never received adequate support, although this is down to me. I also have a problem with alcohol, dating back to when I was 13 years old.

I experienced a trauma when I was 6 years old; and consequently hear voices. My personality changed and I became disruptive, violent and introvert. I burned down a school and this act along with my general behaviour led to my expulsion from school and the scouts when I was 7. My education became home learning from my mother. I was referred to a psychiatrist. Before I went, I was warned by my mother not to disclose the nature of my trauma and hearing voices which led to my damaging

behaviour. I was a victim. I stuck with my mum's instruction and did not disclose anything to the psychiatrist about the incidents or voices.

When I was 10, I experienced another trauma in my life. My 7-year-old sister died which led to a worsening of my behaviour. I committed crimes such as arson and burglary. I continued to see the psychiatrist but disclosed no reason for my behaviour or personality.

I returned to high school when I was 12. I got involved in fights then set fire to the school which effectively led to my final expulsion and the end of my school education at the age of 13. I had been in and out of school since the age of 7 so had a very low level of academic ability.

When I was 14, I went to Canada to work on my uncle's farm. I was forced to come back when I was 16 as my mum found me an Apprentice Electrician job. I drank heavily but alcohol helped me function and focus. Despite my heavy drinking, I qualified as an electrician when I was 19 and then did a HNC (Higher National Certificate) *in electrical engineering. I set up my own electrician business when I was 22. The business expanded and 5 years later I employed 7 people.*

The pressure of work, coupled with my drinking, had become uncontrollable; and led to me having a breakdown. I saw my GP who referred me for a psychiatric assessment. I stayed in a psychiatric hospital for two weeks. When I tried to leave, I was sectioned and knew that I was detained. I was given a range of medication. For the first time, I told a psychiatrist about hearing voices but not about my personal victimisation. The doctor put the voices down to losing my sister when I was 10. The doctor explained my breakdown through a combination of my sister's death, being expelled from school, losing my father when I was 15, pressures at work and my business suffering; my heavy drinking; and the passing of my partner when I was 28. My partner died unexpectedly of a heart defect.

I got out of hospital when I was 29. I had lost my business and I had no work so I returned to Canada. I spent about a year in Canada before returning to England to attend my mother's wedding. She got divorced a short time later. I started a small business and moved to London. I got a job with the Daily Telegraph in 1987.

I then moved to the south coast where I met a new partner. We stayed together for 4 or 5 years and had a daughter. I moved my mother from the north to live beside us in Brighton. I owned and ran a shop business and owned some properties. My mother died shortly after relocating. I was still drinking very heavily and separated from my partner. My physical health was deteriorating rapidly including liver problems. I spiralled into depression and made crazy business and financial decisions which left me virtually broke, having successfully attained a healthy level of assets. I gave some assets to my ex-partner and daughter as financial security. However, I lost control and responsibility. I blew a significant sum of cash but I kept back enough money to self fund a 6-month placement in a residential rehabilitation service around 2001.

I did well when I came out of rehab. I managed my voices through medication, started yet another business venture with a partner and stayed 'dry'. I rented a flat. I refused a drink on my 50th birthday, but 4 days later, I had 4 pints. The joint business ultimately failed due to my drinking habit.

Last year, I got admitted to Worthing Hospital and was detoxed (detoxified from alcohol). *I became homeless and was referred to Worthing Churches Homeless Project and specifically, Tina; the Dual*

Diagnosis Worker. I see Tina weekly and attend weekly voice hearing support groups. I also attend voice hearing conferences.

Despite my contact with mental health services for 40 years, it is only recently that I have trusted someone like Tina to come clean; and tell my true and difficult story. As far as I know, Tina is the only specialist Dual Diagnosis worker in West Sussex who is qualified and experienced to help people like me with co-existing mental health and alcohol/drug problems. Mental health and substance misuse services need to employ more people like Tina, instead of working separately which does not meet an individual's needs. With the support of medication (Tina liaises with the Homeless GP service*), Worthing Churches continues to help me to assume control, take responsibility, help myself and lead a gratifying life; despite my losses and suffering. I hope my documented journey in your study report will help other people with dual diagnosis."*

3.3 Nicola's experience

The following case study has been adapted from a transcript of a meeting between a senior researcher and 'Nicola', a service user of Worthing Churches Homeless Project who has a personal experience of dual diagnosis. The Figure 8 research team is extremely grateful to Nicola for providing such a gripping insight; as well as Georgina, Nicola's Outreach Project Worker; and Tina, Nicola's Dual Diagnosis Worker for facilitating the meeting.

"My name is Nicola. I am 31 years old. I am single and have no children. I live alone in a studio flat in Worthing. I work as a volunteer in a local charity shop 3 or 4 times per week.

I have been in contact with Worthing Churches Homeless Projects since 2012 when I was homeless. I stayed in a friend's place for a while, then a hostel for several months before moving to a private rented flat in July '13. Since then, I continue to meet my Outreach Project Worker, Georgina once or twice a week for up to 1½ hours each time. Georgina helps me to cope with life through a range of practical and emotional support. For example, she helps me with my physical and mental health problems, drug taking, debts, shopping and relationships. A few months ago when I planned and took an overdose, I phoned Georgina who talked me into calling an ambulance so I got needed emergency help.

I have a long term history of diagnosed psychiatric illness which dates back to when I was 11, although my problems started at a much younger age. I am on anti-psychotic and anti-depressant medication. I also have a long history of drug misuse, although I am not currently on any prescribed medication for this. My former and current drug use includes illicit drugs; and abuse of over the counter and prescribed medication. I continue to misuse drugs occasionally; cannabis and illicit diazepam. I know from my other worker, Tina that my problem is sometimes called dual diagnosis. Whatever it is called, I would not say I have successfully addressed my problems; but am still working on these.

I was first sectioned when I was only 11. I was a rebellious child. I remember being troublesome and doing mad things. I was once found drinking bleach and walking on railway tracks. I spent 2 years in a mental hospital as a child. Before being sectioned, I remember my dad shooting a gun at me, my mum and my sister when we were in a car. My mum ran him over. I also remember other traumatic events like my dad keeping the family hostage and my brother dying when I was very young. My parents were both alcoholics and my dad regularly abused and beat up my mum.

My mum left my dad when I was 5. I became a victim of abuse by my mum who regularly battered me. I was a regular visitor to hospitals and the doctor with made up illnesses and injuries to mask the truth. I was also in contact with social services and mental health services; receiving child counselling from the age of 6. Until recently, I don't think I ever opened up to counsellors as I always wanted to have a good relationship with my mum and saw the telling the truth as an inhibitor to realising this.

By the time I reached 13, my mum no longer wanted me to live at home. It was probably not safe to stay at home anyway, even though I didn't want to leave. I was placed in a foster home then numerous other foster homes and children's care homes. At 15, I left my last care home and moved into supported lodgings.

I had been sexually assaulted when I was 12 and was raped when I was 15. I reported the second incident to the police. I have been in trouble myself with the police but have never been in prison, although I was arrested for being drunk and disorderly in 2008.

Throughout my entire childhood and adulthood, my life has been traumatic and dysfunctional due to events in my life and what I now see as a dual diagnosis. I have been very unwell mentally and have attempted suicide. In recent years, I once again found myself at the lowest possible ebb, living in a mental hospital and on a steep downward spiral. I was discharged homeless and went to live in a friend's house. I stopped eating and had to sell drugs to survive.

This was when I came into contact with Worthing Churches Homeless Projects. Their outreach worker treated me differently; with humanity, dignity and respect ..... and with realism. She told me it is okay and acceptable not to want to stop drug taking; but to get help through support services.

She encouraged me to see their Dual Diagnosis Worker which I did. She, in turn contacted my NHS Mental Health Worker. The Mental Health Worker also arranged for me to see a psychiatrist, whom I've met about 3 times in the past 2 years. This has helped stabilise my medication. I am not sure if my mental health medication is working, although this might be because I am topping this up with cannabis and diazepam.

For 25 years, different so called specialist doctors and nurses have diagnosed me with different mental illnesses including schizophrenia, manic depression, manipulative personality disorder, bi-polar disorder and emotional intensity disorder. The list is confusing and I cannot honestly tell you what mental illness or illnesses I currently have; only how I feel and my goals in life.

Right now, I feel quite good and happy. I have no unmet support needs, although I don't think there is as much contact as there should be between mental health services and Worthing Churches' Dual Diagnosis Worker. I am pleased with the service I get from Worthing Churches, through Georgina. I eventually want to get a paid job, get noticed and be appreciated. In the meantime, I would like the doctor to prescribe me diazepam to stop my illicit use of this drug which I need to sleep.

In finishing, thanks for giving me the opportunity to briefly share my life story with you in the hope that it will help other people like me overcome mental health and substance misuse problems and live meaningful and satisfying lives."

3.4 Joe's experience

The following case study has been adapted from a transcript of a meeting and subsequent telephone discussion between a senior researcher and 'Joe', a recovery champion, proactive in and beyond West Sussex, who has personal experience of dual diagnosis. The Figure 8 research team is extremely grateful to Joel for providing an absorbing insight.

"My name is Joe. I am 43 years old. I am single. I live in a private rented flat in Midhurst. In 2009, I set up a community interest company for people engaged in or seeking recovery from addictive behaviour such as substances or activities. I am paid for my work through a grant from a statutory body but also receive Working Tax Credit due to my modest wage. Before my severe onset of dual diagnosis problems, I worked successfully as a Sales Manager for 15 years.

I was first referred to specialist mental health services in 2010 and was diagnosed with anxiety and depression. However, I have been seeing my GP for mental health problems since my mid 20s when I was first prescribed 'Seroxat'. Seroxat is a drug which helps people with anxiety, depression, stress, panic attacks and obsessive compulsive disorders. I endured 13 years of hell with this drug before my GP switched me about 7 years ago to a different anti-depressant drug, 'sertraline' which is more commonly known as 'Lustral'. This drug is also commonly used to combat severe depression and anxiety.

I left my sales job after landing my 'dream job'. The new job proved to be a nightmare and I soon found myself out of work. I no longer had a £25K a year salary and matching lifestyle. I did not cope well with life and got extremely depressed. I was 21 stone, so grossly overweight. I was at a difficult crossroads in my life. I began self medicating to try to cope with life. I saw my GP and was put in contact with mental health services within weeks. The year was 2010 and the main service was known as Chapel Street Day Hospital.

I saw a psychiatrist but was not properly assessed. Neither did I receive a care plan. The system's solution was not based on my individual needs; but primarily upon my attendance at mood management and other types of groups. I attended 5 groups from the 6 available. I also attended 3 out of 6 available over eating groups. None of the mood or over eating groups proved effective as they were too low level and not tailored to my specific needs.

My GP was still involved in processing my ant-idepressant prescriptions. I began using opium which I sourced cheaply via the internet. Dating back to my early 20s, I have a long history of illicit drug use; mainly ecstasy and other types of amphetamine. I have also misused codeine which I was later prescribed, although this was for a physical shoulder injury. I also abused alcohol for 7 years whereby I drank about 8 cans of beer a day, topped up with wine; although drinking is no longer an issue in my life.

About 4 years ago My GP referred me to Addaction, a specialist national substance misuse provider. I used Addaction for support in respect of my drinking and drug use. Addaction carried out a comprehensive assessment and produced a personal care plan. I was prescribed 'Subutex'. Although my Addaction worker focused mostly on my drug related problems, the service also arranged counselling sessions for me which partially covered my mental health related issues.

I planned suicide in 2011 after my GP diagnosed me with Treatment Resistance Depression. Again, there was no proper assessment tool to diagnose this condition. The GP also prescribed me diazepam at that point. I was again referred to mental health services; and again, I saw a psychiatrist. I explained to the psychiatrist that I needed therapy; not more or different tablets simply being thrown at me. I was referred to 'Time to talk' for psychological support.

A few weeks later, I attended a meeting with a 'Time to talk' Key Worker. The meeting lasted less than 5 minutes as I was told the service was unsuitable for me due to my suicidal thoughts. The Worker referred me back to Chapel Street Day Hospital for help which was not forthcoming.

The whole system is in West Sussex is disjointed with regards to the management of treatment and support for people with co-existing mental health and alcohol or drug disorders. Services operate in isolation; they do not work together. I cannot recall a single example of effective integration or partnership working involving my GP, mental health services and substance misuse services. Within West Sussex, there are at least two types of mental health services which seem to work in isolation from each other. This is in direct contradiction to my own needs at the time; and I am sure, many other patients' needs.

In my case, I believe the onset of my substance misuse problems derived from my mental health problems. Whilst I know this is the case for many other dual diagnosis patients, I realise that the opposite is also commonly the case. I know that my ongoing recovery from my mental health and alcohol and drug problems is largely down to myself retaking ownership, control and responsibility for helping myself; complemented by support from peers in recovery. I am not undermining the efforts or good work of mental and substance misuse services, despite the fragmentation I have just highlighted.

In ending, I am glad to say that I am feeling upbeat and have a positive outlook to life. I still experience low moods from time to time; but helping others, helps me. Without my current job role, I would really struggle to survive and lead a purposeful life.

Finally, I hope that that this personal chronicle can go a little way to help someone with dual diagnosis to help them self. After all, there is help and hope out there for everyone."

3.5 Summary

The three case studies outlined above have been chosen by the research team to highlight the key findings and recommendations of this research.

CHAPTER 4: QUANTITATIVE ANAYLSIS OF SURVEYS

4.1 Introduction

An online survey development tool (Survey Monkey) was used to design and distribute questionnaires to managers and employees working across specialist and generic services across West Sussex. Additionally, surveys were also distributed to service users and family/carers. The purpose of the surveys was to gather local data on the prevalence of dual diagnosis and identify gaps as well as getting views on the capacity and quality of services. The surveys were disseminated in West Sussex between 2nd April 2014 and 16th April 2014. This section provides an analysis of the 6 study surveys which received a total of 112 responses.

4.2 Response rates

The response rates of the six surveys were as follows:

- Service user survey - There were just 17 responses to this survey. The low response means it is impossible to draw any reliable conclusions from the responses. The responses received are therefore presented for information purposes only.
- Management survey - There were a total of 18 responses. 2 responses were discounted as survey participants only answered questions pertaining to service and postcode. The management survey responses are outlined in the table below:

Table 4.1: Management Survey Respondents

Organisation	Questions answered
Addaction Integrated Substance Misuse	Q1-15
Addaction Integrated Substance Misuse	Q1-28
Addaction Integrated Substance Misuse	Completed Questionnaire
Addaction Integrated Substance Misuse	Completed Questionnaire
Addaction Integrated Substance Misuse	Q1-15
Addaction Integrated Substance Misuse	Q1-15
Crawley Open House	Q1-15
CRI Integrated Substance Misuse Recovery Service (CRI)	Completed Questionnaire
Lifecentre	Completed Questionnaire
MIND	Q1-15
Sussex Partnership NHS Foundation Trust (SPFT)	Q1-15
Sussex Partnership NHS Foundation Trust (SPFT)	Completed Questionnaire
Sussex Partnership NHS Foundation Trust (SPFT)	Completed Questionnaire
Sussex Partnership NHS Foundation Trust (SPFT)	Q1-13
Sussex Partnership NHS Foundation Trust (SPFT)	Q1-15
Worthing Churches Homeless Project	Completed Questionnaire

- Mental health staff survey - There was 36 responses to this survey.
- Alcohol and drug staff survey - There were 26 responses.
- Generic staff survey - There were 12 responses.
- Family and carer survey - There were 3 responses to the family and carer survey. Due to the low numbers they are not included in the evaluation.

4.3 Limitations

Care needs to be taken when interpreting the results of some of the surveys, due to:

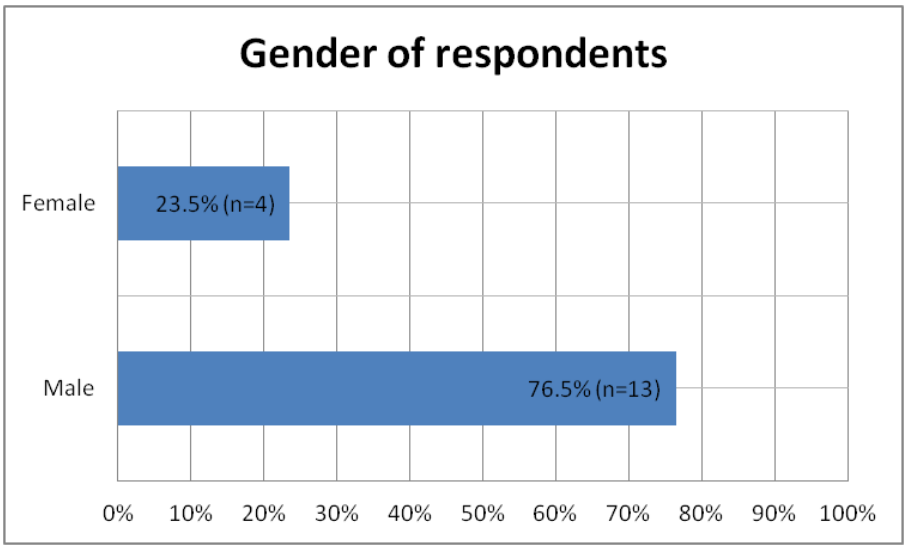
- low numbers of completed surveys;
- low numbers of completed responses to a number of questions in the survey; and
- high numbers of estimates rather than actual figures[129].

4.4 Service User Survey

4.4.1 Gender of respondents

There were a total of 17 respondents to the service user survey, with the majority of respondents being male (76.5%;n=13).

Figure 4.2: Breakdown of respondents by gender

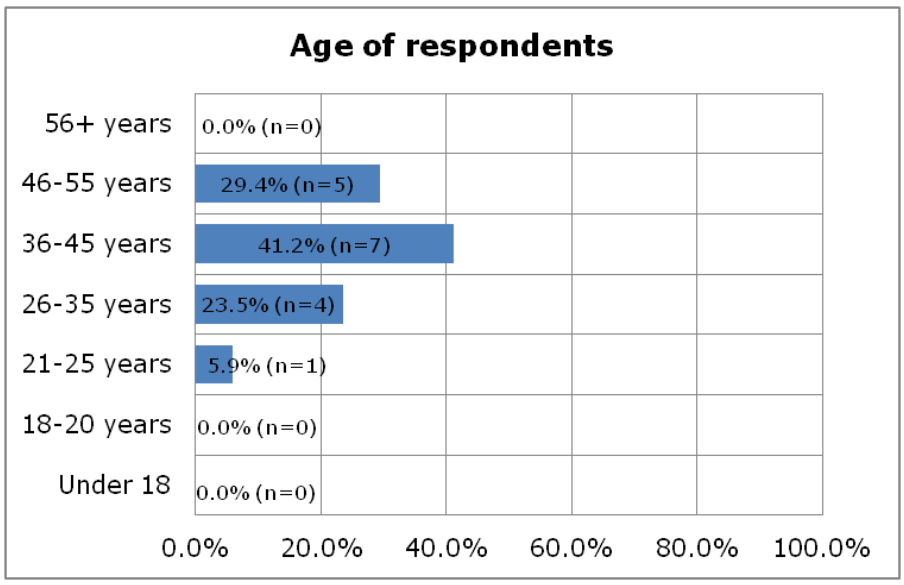


[129] This is in relation to a management survey used by Figure 8 as part of this reseach.

4.4.2 Age of respondents

The majority of respondents who complete the online survey were aged between 36-45 years of age (41.2%; n=7). There were no responses from respondents' who indicated that they were aged under 18, between 18-20 and older than 56 years.

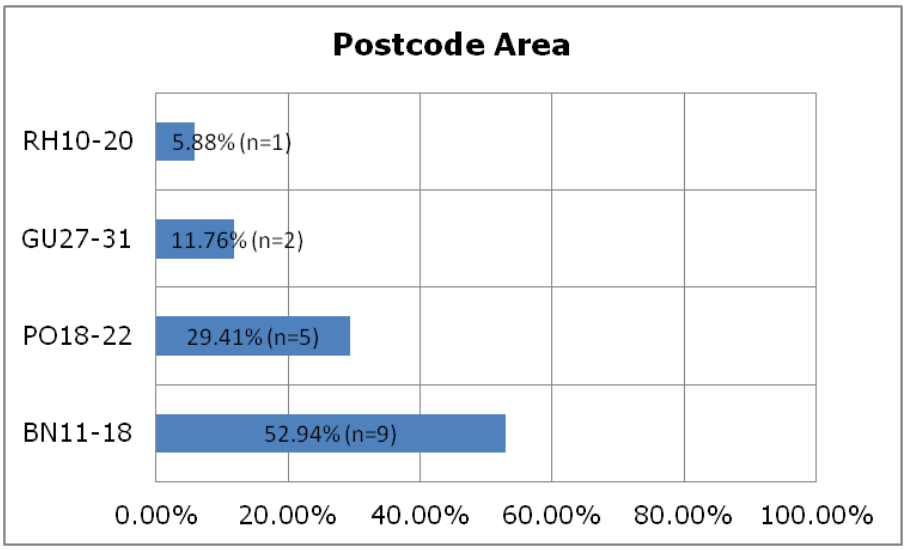
Figure 4.3: Breakdown of respondents by age



4.4.3 Locality of service users

A large proportion of respondents indicated that they were from the postcode areas named BN11-18. There were no responses from postcode areas: GU33, RH6, GU8, BN42-45, PO9-10 and BN5-6.

Figure 4.4: Breakdown of respondents by postcode area

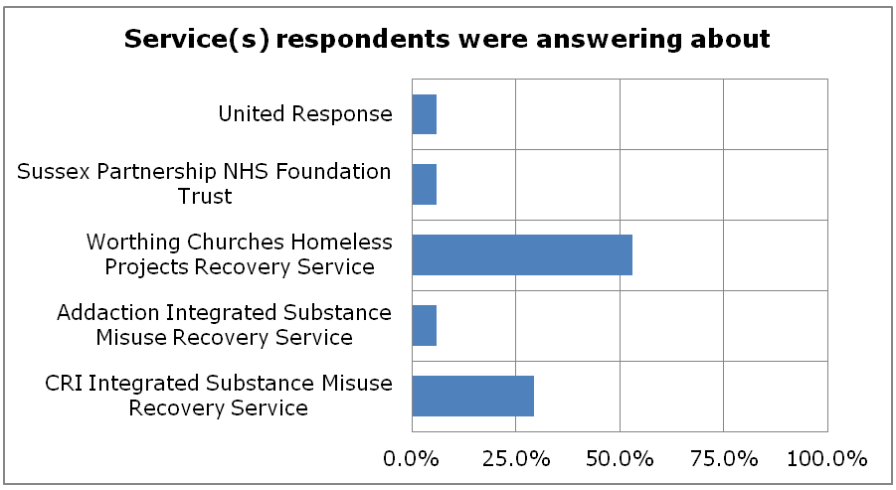


4.4.4 Service(s) that respondents were attending/engaging with

Approximately 55% (n=9) of those who responded were answering their questions after attending or engaging with Worthing Churches Homeless Projects Recovery Service. No responses were received from service users who attended / were engaged with the following services:

- CRI Counselling Service
- CRI Young Persons Substance Misuse Service
- Ravenscourt Residential Detoxification and Rehabilitation Service
- Ravenscourt Structured Day Service
- Worthing Churches Homeless Projects Other Service
- Stonepillow Sands Recovery Service
- Stonepillow Other Service
- Sussex Alcohol & Substance Misuse Service
- Mid Sussex Alcohol Project
- CARAT/ HMP Ford
- Needle Exchange (Non Integrated Substance Misuse Recovery Service
- Sussex Community NHS Trust
- Capital Project Trust
- MIND
- Re-think - Asian Mental Health Helpline
- Richmond Fellowship
- United Response
- General Practitioner (GP)

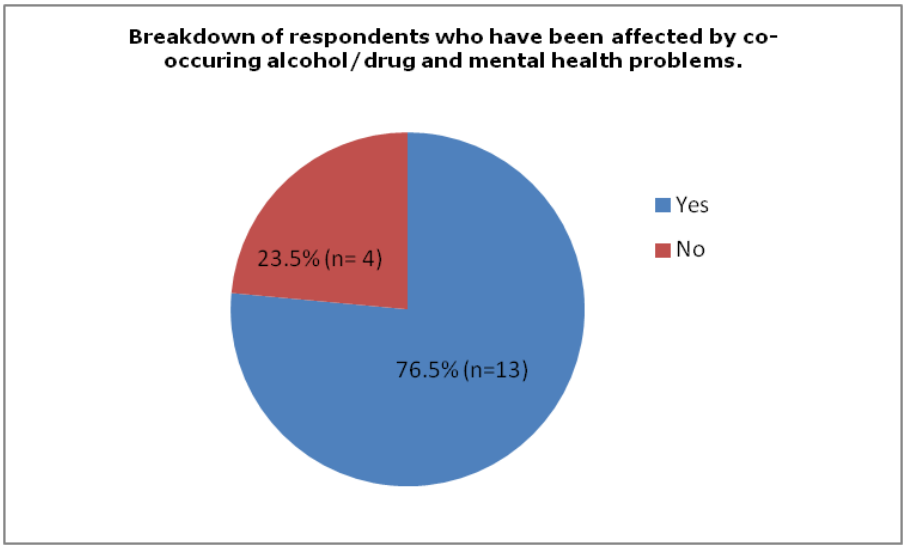
Figure 4.5: Breakdown of service(s) which respondents were answering about



4.4.5 Dual diagnosis of alcohol/drug and mental health problems

Just over three quarters (76.5%; n=13) of respondents indicated that they had been affected by an alcohol/drug and mental health problems.

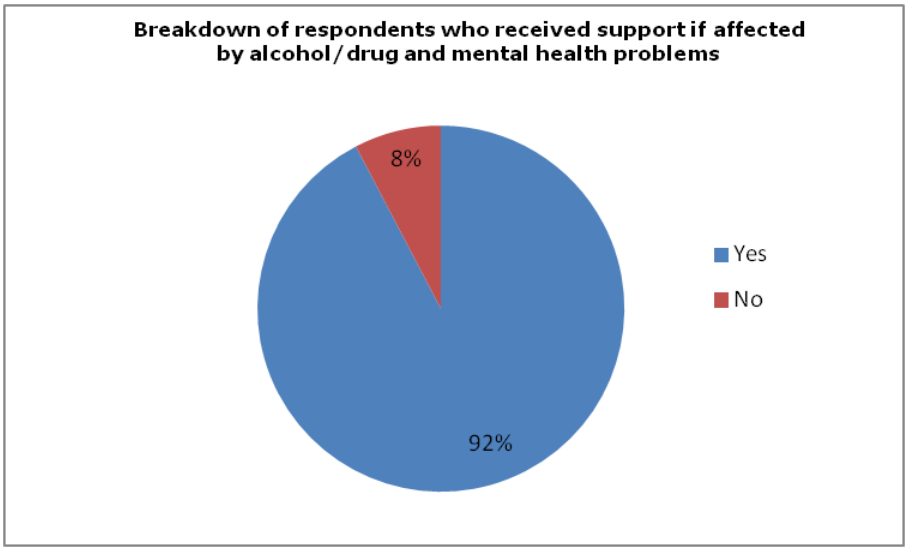
Figure 4.6: Breakdown of respondents who have been affected by co-occurring alcohol/drug and mental health problems



Of those who were affected by co-morbidly of alcohol/drug and mental health problems, over 90% of those indicated that they had received support.

4.4.6 Support for dual diagnosis

Figure 4.7: Breakdown of respondents who received support if affected by alcohol/drug and mental health problems



Respondents were asked to provide details of the support they are receiving. Their comments are below:

"I am supported by the staff at Clock Walk [CRI Project] in various ways - accessing treatments, housing and in-house courses to do with recovery and also acupuncture."

"I access Clock Walk Project, doing meetings on a Saturday, and having keyworking sessions with Mark, my keyworker. I also have meetings at the Bedale [Centre, Bognos Regis]."

"Good encouragement to keep me drug free. At Clock Walk [CRI], the drop-in is very useful for further support."

"1-2-1, groups, keyworker helps me. Dr. X is no help."

"I have always used drugs to deal with my mental health, not got mental health [problems] from the use of drugs. I get help from Addaction for my drug use. I am currently getting help from mental health but this has taken a long time."

"24/7 Residential Care Selden Road (Delaney House) [Worthing Churches Homeless Project] Worthing. Mental Health Nurse."

"Am being treated for mental health issues by GP and am addressing my alcohol issues at Delaney House"

"Very little. Refused most things like talking therapy and eventually referred to Chapel Street day surgery in Chichester to attend a 6 session day class. Total waste of time and money."

4.4.7 Referral

Respondents were asked if they had received help, if they were referred from another service. 75% (n=9) of respondents indicated that they had been referred by 'Other specialist mental health services'.

Table 4.8: Service(s) that respondents were referred by

Service(s)	Responses %	N
Other specialist mental health service	**75.0%**	9
General Practitioner (GP)	**16.7%**	2
Sussex Partnership NHS Foundation Trust (SPFT)	**8.3%**	1
Addaction Integrated Substance Misuse Recovery Service	**0.0%**	0
Carer/Family/Friend	**0.0%**	0
CRI Integrated Substance Misuse Recovery Service	**0.0%**	0
Other specialist alcohol and drug service	**0.0%**	0
Self	**0.0%**	0
Sussex Community NHS Trust	**0.0%**	0
Total	**100%**	12

4.4.8 Quality of service

People who responded to the survey were asked to rate the extent to which they agree with a set of statements relating to service(s) they attended using a 5 point Likert scale:

5 = Strongly Agree

4 = Agree

3 = Don't Know

2 = Disagree

1 = Strongly Disagree

Responses from the survey are set out in Table 4.9 below:

Table 4.9: Percentage of respondents that indicated that they agreed or disagreed with the statements relating to the service(s) they attended.

	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
The information I was given about the service helped me decide whether to access the service.	33.33% 4	41.67% 5	16.67% 2	0.00% 0	8.33% 1
The referral to the service was straightforward.	8.33% 1	8.33% 1	75.00% 9	8.33% 1	0.00% 0
When I was referred to the service, my case was dealt with quickly.	41.67% 5	33.33% 4	8.33% 1	8.33% 1	8.33% 1
I find it easy and convenient to get to the service.	50.00% 6	8.33% 1	33.33% 4	0.00% 0	8.33% 1
I feel safe and comfortable when I attend the service.	66.67% 8	16.67% 2	0.00% 0	16.67% 2	0.00% 0
When I attend appointments, I am given sufficient time to discuss my situation.	0.00% 0	0.00% 0	91.67% 11	0.00% 0	8.33% 1
The service is flexible.	0.00% 0	0.00% 0	91.67% 11	8.33% 1	0.00% 0
I can easily access the service at all times.	0.00% 0	0.00% 0	91.67% 11	0.00% 0	8.33% 1
The service explained their confidentiality policy to me.	50.00% 6	33.33% 4	8.33% 1	0.00% 0	8.33% 1
I have been told how I can make a complaint about the service if I am not happy.	33.33% 4	50.00% 6	8.33% 1	0.00% 0	8.33% 1
The assessment I was given helped me to work out my problems and needs; and how to address these.	33.33% 4	41.67% 5	8.33% 1	8.33% 1	8.33% 1
My family/partner/carer was allowed to contribute to my assessment and resulting care plan.	8.33% 1	25.00% 3	33.33% 4	16.67% 2	16.67% 2

Another helping service was allowed to contribute to my assessment and resulting care plan.	8.33% 1	33.33% 4	33.33% 4	16.67% 2	8.33% 1
I have a direct say in my care plan.	0.00% 0	8.33% 1	58.33% 7	16.67% 2	16.67% 2
I have a direct say in how the service is run.	16.67% 2	16.67% 2	33.33% 4	16.67% 2	16.67% 2
I am encouraged to talk about my alcohol/drug use in the service.	0.00% 0	8.33% 1	83.33% 10	0.00% 0	8.33% 1
I am encouraged to talk about my mental health in the service.	0.00% 0	8.33% 1	91.67% 11	0.00% 0	0.00% 0
The service gives me good information.	0.00% 0	58.33% 7	33.33% 4	8.33% 1	0.00% 0
The service lets me know about other services that might be useful to me.	33.33% 4	33.33% 4	16.67% 2	8.33% 1	8.33% 1
I know where to seek help about any mental health issues affecting me.	0.00% 0	8.33% 1	75.00% 9	8.33% 1	8.33% 1
The service helps me find other support services to help with my wider needs.	0.00% 0	8.33% 1	75.00% 9	8.33% 1	8.33% 1
The service is good at working together with another service(s) I use.	16.67% 2	33.33% 4	25.00% 3	16.67% 2	8.33% 1
The service treats me equally no matter my race, gender, disability, age or belief system.	58.33% 7	41.67% 5	0.00% 0	0.00% 0	0.00% 0
The service is good at finding ways to keep improving the service.	16.67% 2	16.67% 2	58.33% 7	0.00% 0	8.33% 1
My worker(s) is sufficiently knowledgeable to try to help me successfully tackle my problems.	0.00% 0	25.00% 3	66.67% 8	0.00% 0	8.33% 1
My worker(s) is sufficiently competent to try to help me successfully tackle my problems.	8.33% 1	16.67% 2	66.67% 8	0.00% 0	8.33% 1
My worker(s) is sufficiently confident to try to help me successfully tackle my problems.	0.00% 0	25.00% 3	66.67% 8	0.00% 0	8.33% 1
The service helps me understand my alcohol/drug problem better.	8.33% 1	16.67% 2	66.67% 8	0.00% 0	8.33% 1
The service helps me understand my mental health problem better.	8.33% 1	16.67% 2	66.67% 8	8.33% 1	0.00% 0
If applicable, I can talk safely about suicide and self harm in the service.	0.00% 0	0.00% 0	91.67% 11	0.00% 0	8.33% 1
The service is good at helping me.	16.67% 2	50.00% 6	16.67% 2	8.33% 1	8.33% 1
The service is good at helping me when my particular circumstances and needs change.	33.33% 4	25.00% 3	16.67% 2	16.67% 2	8.33% 1

The service helps to make my situation better.	66.67% 8	16.67% 2	0.00% 0	8.33% 1	8.33% 1
The service helps me get ready for education, training or work including volunteering.	25.00% 3	41.67% 5	16.67% 2	0.00% 0	16.67% 2
My co-occurring alcohol/drug misuse problem is given equal priority and managed effectively by the service and another service(s).	0.00% 0	8.33% 1	75.00% 9	8.33% 1	8.33% 1

From Table 4.9, it can be observed that there are a few statements that respondents strongly **agree** with. These are:

- *"I feel safe and comfortable when I attend the service."* (Strongly agree = 66.67%, n=8; agree=16.67%, n=2).
- *"The service explained their confidentiality policy to me."* (Strongly agree= 50%, n=6; agree=33.33%,n=4).
- *"I have been told how I can make a complaint about the service if I am not happy."* (Strongly agree= 33.33%, n=4; agree=50%, n=6).
- *"The service treats me equally no matter my race, gender, disability, age or belief system."* (Strongly agree= 58.33%, n=7; agree=41.67%, n=5).

Also worth noting are certain statements that indicate **mixed levels of agreement** amongst respondents. These are:

- *"My family/partner/carer was allowed to contribute to my assessment and resulting care plan."* (Strongly agree=8.33%,n=1; agree = 25%,n=3;Don't know= 33.33%,n=4, disagree=16.67%,n=2, strongly disagree= 16.67%, n=2).
- *"Another helping service was allowed to contribute to my assessment and resulting care plan."* (Strongly agree=8.33%,n=1; agree = 33.33%,n=4;Don't know= 33.33%,n=4, disagree=16.67%,n=2, strongly disagree= 8.33%, n=1).
- *"I have a direct say in how the service is run."* (Strongly agree=16.67%,n=2; agree = 16.67%,n=2;Don't know= 33.33%,n=4, disagree=16.67%,n=2, strongly disagree= 16.67%, n=2).
- *"The service is good at working together with another service(s) I use."* (Strongly agree=16.67%,n=2; agree = 33.33%,n=4;Don't know=25%,n=3, disagree=16.67%,n=2, strongly disagree= 8.33%, n=1).

4.4.9 Improvements to services and generally in West Sussex in relation to dual diagnosis.

Respondents were asked what improvements they would like to see in relation to the service. Their comments are presented below:

- *"I would like the services that I access to have more continuity."*

- *"An understanding that it is the substance, and not the person, that is the cause of the problem."*
- *"More support from mental health services as was shoved from pillar to post and it seemed before I could get proper help for my mental health they wanted me to address drinking issues. I believe the two go hand in hand."*
- *"Total overhaul of the system and the attitudes that prevail within it. Very few seem to actually care."*

Respondents were asked what improvements they would like to see in West Sussex more generally for supporting people with co-occurring alcohol/drug and mental health problems. Their comments are presented below:

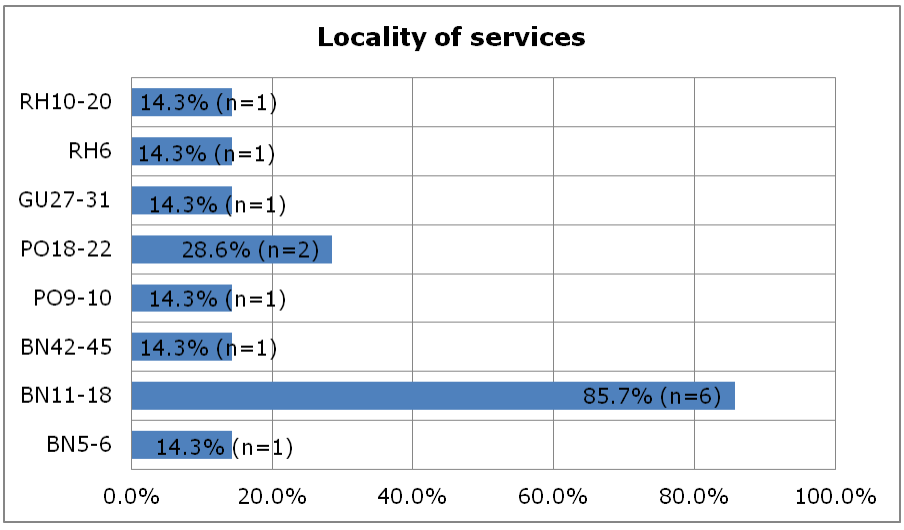
- *"More Services in Horsham to cover Drugs and alcohol mental help. Council to help more. More help from other groups."*
- *"For it to be recognised a disease because controlled drinking or using don't work for people like me."*
- *"(Service/s) Needs to be more integrated."*

4.5 Management Survey

4.5.1 Locality of services

Just over 85% of respondents indicated that their service covered the postcode area BN11- 18 in West Sussex. There were no responses for postcode area GU8 and postcode area GU33.

Figure 4.10: Locality of services – manager's survey



4.5.2 Type of service(s)

From the seven responses that were received to the question relating to the type of service the respondents worked for, 5 respondents (71.43%) indicated that their service was a 'Voluntary/Charity' organisation.

Table 4.11: Type of service

Type of service	**Responses % / N.**	
Voluntary/Charity	**71.43%**	5
Statutory (NHS/Local Authority)	**28.57%**	2
Private	**0.00%**	0
Total responses = 7		

4.5.3 Nature of service(s)

Over 70% (71.43%; n=5) of respondents indicated that their service was community based.

Table 4.12: Nature of service(s)

Nature of service(s)	**Response %/N**	
Community-based	**71.43%**	5
Out-patient	**14.29%**	1
Residential/ in-patient	**14.29%**	1
Prison	**14.29%**	1
Other	**14.29%**	1

4.5.4 Range of referral sources

Most services get referrals from any source. SPFT gets referrals from alcohol/drugs services, mental health services, general practitioners, other health professionals, social work, criminal justice, counselling services and homeless/housing services. The service also receives self-referrals.

Table 4.13 : Referral sources to mental health and alcohol/drug treatment services in West Sussex

REFERRAL SOURCE / SERVICE	CRI	Addaction	WCHP	SPFT	MIND	Crawley Open House	Lifecentre
Any Agency	✓	✓	✓		✓**	✓	✓
Self Referral	✓	✓	✓	✓	✓	✓	✓
Carer/Family/Friend	✓	✓	✓		✓	✓	✓
Alcohol/Drug Service	✓	✓	✓	✓	✓	✓	✓
Mental Health Service	✓	✓***	✓	✓	✓	✓	✓
GP	✓	✓	✓	✓	✓	✓	✓
Other Health Professional	✓	✓	✓	✓		✓	✓
Social Work	✓	✓	✓	✓	✓	✓	✓
Criminal Justice*	✓	✓	✓	✓	✓	✓	✓
Mutual Aid / Self-Help Groups	✓	✓***	✓			✓	✓
Counselling Service	✓	✓***	✓	✓		✓	✓
Homeless / Housing Service	✓	✓	✓	✓	✓	✓	✓
Employability Service	✓	✓	✓			✓	

* Court, probation, prison.

** Please note, the respondent from MIND answered that they receive referrals from any agency, although they have not mentioned receiving any from employability services, self-help groups and other health professionals (besides GPs and those in Alcohol/Drug- and Mental Health Services).

*** Only ¼ respondents from Addaction answered this way.

Respondents were asked where they referred their clients on to. Findings from the Management Survey, shown in the table below, suggest that polled services refer clients on to a wide variety of other services. SPFT and Addaction are the only services that refer clients on to the criminal justice system.

Table 4.14: Range of services clients referred to in West Sussex

REFERRED TO / SERVICE	CRI	Addaction	WCHP	SPFT***	MIND	Crawley Open House	Lifecentre
Alcohol/Drug Service	✓	✓	✓	✓	✓	✓	✓
Mental Health Service	✓	✓	✓	✓	✓	✓	✓
GP	✓	✓	✓	✓	✓	✓	✓
Other Health Professional	✓	✓	✓	✓		✓	✓
Social Work	✓	✓	✓	✓		✓	✓
Criminal Justice*		✓		✓**			
Mutual Aid / Self-Help Groups	✓	✓	✓	✓**	✓	✓	✓
Counselling Service	✓	✓	✓	✓	✓	✓	✓
Homeless / Housing Service	✓	✓	✓	✓	✓	✓	✓
Employability Service	✓	✓	✓	✓	✓	✓	

* Court, probation, prison.

** 1/5 respondents from SPFT referred service users on to Criminal Justice. The same proportion referred clients to self-help groups.

*** 1/5 respondents noted they also refer clients to 'Time to TalK.

4.5.5 Range of Clients Provided for

The table below shows the range of service users catered for (by service):

Table 4.15: Profile of service user groups in West Sussex Mental Health and Alcohol/Drug Services

SERVICE USERS	CRI	Addaction	WCHP	SPFT	MIND	Crawley Open House	Lifecentre
Under 16							✓
16-17				✓*			✓
18-19	✓	✓	✓	✓		✓	✓
19-25	✓	✓	✓	✓		✓	✓
25+	✓	✓	✓	✓	✓	✓	✓
Both Sexes	✓	✓	✓	✓	✓	✓	✓
Homeless	✓	✓	✓	✓		✓	✓
Street Drinkers	✓	✓	✓	✓		✓	✓
Offenders	✓	✓	✓	✓		✓	✓
Ex-offenders	✓	✓	✓	✓		✓	✓
DIP Clients	✓	✓	✓	✓		✓	✓
Sex offenders	✓	✓	✓	✓		✓	
Victims of domestic/sexual violence	✓	✓	✓	✓		✓	✓
A10 migrants	✓	✓	✓	✓		✓	✓
People from the Ascension States		✓	✓	✓			✓
Undocumented migrants	✓	✓**	✓	✓			✓
People who do not speak English/require translator	✓	✓	✓	✓		✓	✓
People involved in prostitution	✓	✓	✓	✓		✓	✓
People with a physical disability	✓	✓	✓	✓			✓
People with a learning disability	✓	✓	✓	✓		✓	✓
People with dual diagnosis	✓	✓	✓	✓	✓	✓	✓
People with other complex needs	✓	✓	✓	✓	✓	✓	✓
Carers/families affected by alcohol/drug problems	✓	✓	✓	✓			✓
Carers/families affected by mental health problems	✓	✓	✓	✓			✓
Carers/families affected by dual diagnosis	✓	✓	✓	✓			✓

*One individual from SPFT answering the manager's survey said their service sees clients between 16-17 years of age.

**One respondent from Addaction commented that "we have not had any undocumented migrants that I am aware of to date."

All groups of service users are catered for within the West Sussex area. However only one service has provision for the under 16 group, and only Lifecentre and SPFT* see clients aged between 16 and 17 years of age.

4.5.6 Hours of service provision

The table below details opening days/times and out of hours service provision within West Sussex.

Table 4.16: Opening hours of West Sussex Mental Health and Alcohol/Drug Services

	Opening days/times	Out of hours service (please specify)
CRI	Monday – Friday 9am – 5pm Saturday 9am – 12pm	Late clinic on a Tuesday 5pm to 8pm
Addaction	Monday – Friday 9am – 5pm	Tuesdays/Thursdays open late to 7 pm Wednesdays open late to 8 pm*
WCHP	24 hours a day (24 hr residential service)	
SPFT	Monday – Friday 9am – 5pm Some services operate from 8am - 6.30pm**	AOT (Assisted Outpatient Treatment) 7 day service
MIND	Monday – Friday 9am - 5pm/7.30 pm	Some weekend provision
Crawley Open House	Hostel is open 24 hours a day. Day Centre is open Monday – Friday 10am - 2pm Saturday – Sunday 2pm – 5pm***	
Lifecentre	Monday – Friday 9am – 3:30pm	Telephone helpline

*All individuals from Addaction stated their service operated 'out of hours' at least one day of the week.

**2/5 individuals managing SPFT services responded this way in the management survey.

***Explanation of weekend opening times at Crawley Open House Day Centre from: www.crawleyopenhouse.co.uk/Day%20Centre.htm

The residential services are available for their service users 24 hours a day, seven days a week. Most of the rest operate within normal working hours with some sort of out of hours service. However, Crawley Open House (Day Centre) has less than normal open hours on weekdays with some hours of provision on weekends. The Lifecentre also has fewer hours of service provision than normal.

4.5.7 Methods of Service Delivery

Most services have a drop-in service clients can use. SPFT and Lifecentre do not have a drop-in facility. Most services do home visits, however MIND [and Crawley Open House (a service for homeless)] do not. Over half of the services have telephone helplines, however the surveyed CRI, MIND and Crawley Open House services do not. All surveyed services have disabled access.

Table 4.10 below illustrates the means by which the services engage with service users.

Table 4.17: Profile of service access methods in West Sussex Mental Health and Alcohol/Drug services

SERVICE	Drop-In	Home visits*	Disabled access	Telephone helpline	Other (please specify)
CRI	✓	✓	✓		
Addaction	✓	✓	✓	✓**	
WCHP	✓	✓	✓	✓	
SPFT		✓	✓***	✓	
MIND	✓	✓	✓		
Crawley Open House	✓		✓		
Lifecentre			✓	✓	Appointments

* A respondent from Addaction and another from SPFT noted that the service they manage did not do home visits.

**2/6 respondents from Addaction noted that their service has a telephone helpline, 4/6 stated that it did not.

***1/5 respondents from SPFT noted that their service did not have disabled access.

4.5.8 Substances Treated

Respondents were asked to specify what substances their clients are treated for. Their responses can be seen in the table below. All services, apart from MIND, would provide help for all the substances listed.

Table 4.18: Substances clients are treated for by service

Substances Treated	CRI	Addaction	WCHP	SPFT	MIND	Crawley Open House	Lifecentre*
Alcohol					✓		
Heroin/opiates/ opioids							
Psychostimulants					✓		
Hallucinogens					✓		
Benzodiazepines					✓		
Over-the-counter medication					✓		
Prescription medication					✓		
Solvents/volatile substances							
Novel Psychoactive Substances							
All of the above	✓	✓	✓	✓		✓	✓

*"*All of the above but under control and not under the influence when coming to appointments otherwise it's a waste of time, them trying to access our service, due to the nature of what we do."*

4.5.9 Interventions, Rehabilitation and Other Services

Most of the services offer a variety of interventions and rehabilitation methods, excluding Lifecentre which offers counselling only. It appears that SPFT is the only service to offer compulsory hospital admission under the Mental Health Act. Most services offer crisis support, excluding MIND and Lifecentre. Worthing Churches Homeless Project and Crawley Open House are the only services to offer crisis support including accommodation amongst the polled services across West Sussex.

The table below illustrates that each service provides a wide range of interventions and rehabilitation services to its service users.

Table 4.19: Profile of service provision of mental health and alcohol/drug services across West Sussex

SERVICES PROVIDED	CRI	Addaction	WCHP	SPFT	MIND	Crawley Open House	Lifecentre
Compulsory Hospital Admission under the Mental Health Act		✓		✓			
Supervised Community Treatment	✓	✓		✓			
Crisis Support	✓	✓	✓	✓		✓	
Crisis Support inc. Accommodation			✓			✓	
Assessment	✓	✓	✓	✓		✓	
Care Plan	✓	✓	✓	✓		✓	
Information	✓	✓	✓	✓	✓	✓	
Advice	✓	✓	✓	✓		✓	
Education		✓	✓	✓	✓		
Training/Skills		✓	✓	✓	✓		
Counselling	✓	✓	✓	✓		✓	✓
Group work	✓	✓	✓	✓	✓		
Criminal Justice	✓	✓		✓*			
Residential/in-patient detox		✓	✓				
Community detox	✓	✓				✓	
Home detox	✓	✓					
Day programme/structured daycare	✓	✓		✓	✓		
Family Services	✓	✓	✓	✓			
BBV Services	✓	✓					
Needle Exchange	✓	✓	✓				
Drop-in	✓	✓	✓		✓	✓	
Outreach	✓	✓	✓	✓*	✓	✓	
Substitute Prescribing		✓					

Rehabilitation (Community)	✓	✓					
Rehabilitation (Residential)		✓	✓				
Peer Support/ Self-help	✓	✓	✓		✓		
Aftercare	✓	✓	✓	✓			
Supported Accommodation		✓	✓			✓	

*One respondent from Sussex Partnership NHS Foundation Trust specified these as provided methods of intervention/rehabilitation.

4.5.10 Staffing levels

The table below sets out the staff composition of specialist mental health and alcohol/drug services in West Sussex. The largest services in terms of staff is Worthing Churches Homeless Projects Recovery Service, which has 200 volunteers alone (227 staff across services), although it should be noted that it is not known whether posts are full time. The same applies to all services polled apart from SPFT, which referred to whole time equivalent of posts. SPFT had the largest number of professionals (92 across surveyed services) including roles such as consultant psychiatrists, mental health liaison practitioners and community mental health nurses.

Table 4.20: Profile of staff compostion in West Sussex Mental Health and Alcohol/Drug services

STAFF COMPOSITION IN SERVICES	Senior Manager(s)	Manager(s)	Project/Key/ Support Worker(s)	Administrator(s)	Professional(s)*	Volunteer(s)	Other (please specify)
CRI	<5	<5	5<10	<5	-	-	
Addaction	<5	5<10	20<25	5<10	5<10	5<10	
WCHP	<5	<5	20<25	-	<5	200<205	
SPFT	5<10	<5	10<15	15<20	90<95	-	[Job title and number of staff in] ATC [Assessment Treatment Centre] / Recovery & Wellbeing / AOT [Assisted Outpatient Treatment].
MIND	-	<5	5<10	-	-	10<15	Our volunteers are Peer Mentors. We also have paid peer mentor posts for some roles in the service.
Crawley Open House**	N/K	N/K	N/K	N/K	N/K	N/K	Chiropodist, Chef
Lifecentre	<5	<5	-	<5	10<15	<5	

*Social Worker, Nurse Occupational Health Therapist, Psychologist, GP, Psychiatrist etc.

**Numbers not filled in but staffing composition can be seen on updated website: http://www.crawleyopenhouse.co.uk/Contact%20Us.htm

4.5.11 Barriers to Service Access

The Management Survey asked respondents to specify barriers to accessing their service, shown in the table below. All services, except for Worthing Churches Homeless Project, perceived stigma to be a barrier to accessing their service. Most services listed cost of travel and opening hours as access barriers to their clients.

None of the services perceived fear of safety to be an issue.

Figure 4.21: Barriers to access by service

ACCESS BARRIERS	CRI	Addaction	WCHP	SPFT	MIND	Crawley Open House	Lifecentre
Open Hours	✓	✓		✓	✓		✓
Waiting Times		✓**		✓			
Referral Criteria				✓***			
Exclusion Criteria			✓	✓***	✓		✓
Funding		✓**	✓	✓			
Capacity		✓	✓	✓		✓	
Locality of Service	✓	✓			✓		
Cost of Travel	✓	✓		✓	✓		✓
Availability of Public Transport	✓	✓		✓			
Concerns about confidentiality		✓**		✓			
Environmental Factors*				✓			
Fear of safety							
Lack of childcare		✓		✓	✓		✓
Stigma	✓	✓		✓	✓	✓	✓

*including types/standards of premises/accommodation

**One respondent from Addaction specified these as perceived barriers to accessing their service.

*** One respondent from Sussex Partnership NHS Foundation Trust perceived referral- and exclusion criteria as barriers to accessing their service.

4.5.12 Percentage of users with a Dual Diagnosis at first contact

The table below outlines the percentage of service users diagnosed with co-occurring mental health and alcohol/drug problem at first contact, and the proportion already receiving mental health support at first contact in the financial year of 2012/2013. CRI, Addaction and WCHP had a significant percentage of clients with co-occurring mental health and alcohol/drug problems at first contact. All services, apart from Lifecentre, suggested that a very low proportion of those dually diagnosed at initial contact were in receipt of any mental health support at this point in time.

Table 4.22: Percentage of users with a dual diagnosis at first contact in 2012/2013

Service	Service users affected by a co-occurring mental health and alcohol/drug problem at initial contact (%)	Estimate	Dually diagnosed service users in receipt of mental health support at initial contact (%)	Estimate
CRI	70%	✓*	5%	✓**
Addaction	70%	✓	15%	✓
WCHP	70%	x***	10%	✓
SPFT	20%	✓	1%	✓
MIND	Nil response			
Crawley Open House	Nil response			
Lifecentre	10%	✓†	50%	✓†

* Self disclosure at assessment

** Experience of service and assessment

*** Our online data system

† Referral info

4.5.13 Percentage of clients with Mental Health conditions at discharge

The table below outlines the percentage of service users diagnosed with co-occurring mental health and alcohol/drug problem at discharge in the financial year of 2012/2013.

Table 4.23: Percentage of service users with co-occurring mental health and alcohol/drug problems diagnosed with the following conditions at discharge in 2012/2013

Dually diagnosed clients with listed conditions at discharge in 2012/2013 by service*							
Dually diagnosed clients with listed conditions (%)	**CRI**	**Addaction**	**WCHP**	**SPFT**	**MIND**	**Crawley Open House**	**Lifecentre**
Depression	10%	50%	40%	70%	Nil response	Nil response	40%
Anxiety	10%	20%	20%	80%			10%
Obsessive Compulsive Disorder	5%	10%	N/K	0%			5%
Post Traumatic Stress Disorder	2%	20%	10%	10%			10%
Bipolar	3%	35%	20%	0%			2%
Schizophrenia	5%	15%	10%	0%			2%
Personality Disorder	5%	50%	10%	10%			7%
Alcohol Related Brain Damage	4%	15%	5%	N/K			0%

*All figures in this table are estimates.

4.5.14 Presenting issues and needs of dually diagnosed clients

Respondents from the management survey were asked to define the main presenting issues and needs of their service users with co-occurring mental health and alcohol/drug problems. Their comments are presented below:

"*Lack of mental health support for those who fall in middle ground between CMHT and Time to Talk. Lack of joint working from mental health, substance misuse will assess every one and support everyone CMHT and time to talk strict boundaries*."

"Local community mental health teams demonstrating a reluctance to work with individuals concurrently using substances."

"Mental health won't see our clients unless they are drug or alcohol free even if they have cut down. A lot of the time they are drinking or taking drugs due to mental health issues but of course Drink and drugs can aggravate the mental health issues so it's a bit of a circle. In my experience SMS don't seem to work as well with Mental Health as it does other agencies."

"*Secure accommodation; Lack of flexibility in treatment packages; Lack of quality community housing post treatment; An uncoordinated response from mental health services; Lack of walk in direct access services for those with mental health conditions*."

"*Anxiety - often social anxiety, GAD [Generalised Anxiety Disorder], and sometimes PTSD [Post Traumatic Stress Disorder].*"

"Depression is also very common alongside the other disorders."

"Attachment disorders are very common too, so is unresolved grief."

"*Engagement, concordance, social factors including housing, levels of risk*."

"*Support and understanding and not to judge them.*"

4.5.15 User groups presenting with a higher instance of dual diagnosis

There appears to be a variety of groups perceived to present with higher than normal instance of co-occurring mental health and alcohol/drug problems.

Young people, older drug users and military veterans have each been quoted by three services as user groups presenting with a higher instance of dual diagnosis.

Table 4.24: Groups presenting with a higher instance of co-occurring mental health and alcohol/drug problems

	CRI	Addaction	WCHP	SPFT	MIND	Crawley Open House	Lifecentre
Young People		✓		✓	Nil response	Nil response	✓
Older Drug Users	✓	✓		✓			
Women		✓					
Military Veterans	✓	✓	✓				
Crack/Cocaine Users		✓					
Adults with learning disabilities		✓					
LGBT groups				✓			
Minority ethnics				✓			
Other			✓*				

*Homeless adults

The respondents were also asked to give their views on the particular needs of selected groups presenting with a higher instance of dual diagnosis. Their comments are outlined below:

"Behaviours extremely entrenched, military need specialist PTSD [Post Traumatic Stress Disorder] support."

"Specialist concurrent support from both substance misuse and mental health services working in joint partnership."

"PTSD or EDMR [Eye Movement Desensitisation and Reprocessing] counselling."

"Lack of secure housing Disabilities Disabilities Disabilities in getting assessments and engagement Being alienated and marginalised from society."

"Out of hours services - Self- referral needs to be put in place too."

4.5.16 Dually diagnosed clients presenting with issues of suicidal ideation

The table below illustrates the percentage of dually diagnosed clients who had previously attempted suicide or had instances of self harm with suicidal intent.

Table 4.25: Percentage of dually diagnosed clients with a history of attempted suicides or instances of self harm with suicidal intent

Service	Dually diagnosed clients with a history of attempted suicides or instances of self harm with suicidal intent*(%)
CRI **	30%
Addaction	40%
WCHP	50%
SPFT	30-75%***
MIND	Nil response
Crawley Open House	Nil response
Lifecentre	60%

*All figures in this table are estimates.

** Data source: self reporting.

*** One respondent stated a 30% estimate and the second respondent from SPFT stated a 75% estimate.

4.5.17 Support available for clients with issues of suicidal ideation

Respondents were asked what support their service provides to dually diagnosed clients presenting with issues of self harm and suicidal behaviour. Their comments are outlined below.

'Staff had training for ASSIST harm minimisation advice given to people who self harm. Referrals onwards to specialist support will advocate and push with CMHT if reluctant to engage an individual.'

'Emotional support and referral to mental health crisis intervention teams.'

'We offer counselling, referral to CMHT or Mental Health Hospital.'

'WRAP [Wellness Recovery Action] programme plus employ own band 7 mental health nurse who provides one to one support and runs group work programmes.'

'Referral to crisis team.'

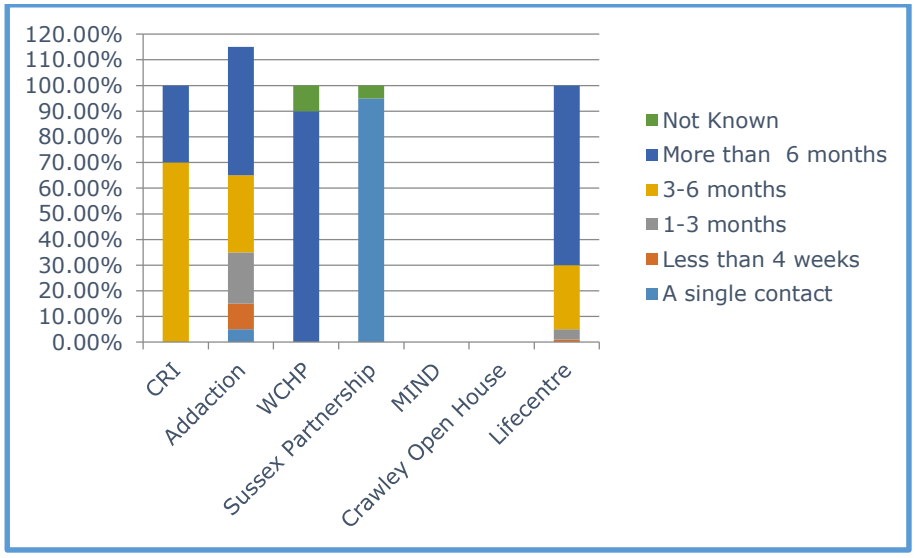
'Risk assessment, risk management, care plan including crisis and contingency plan.''

'Referral to other services that can help them whilst we see them or post or prior to us seeing them depending on circumstances.'

4.5.18 Duration of service user contact

There is a variation between services with regard to the duration of client contact, although most of the service users, apart from those at SPFT, engage with services for at least 3-6 months. This is illustrated in table below.

Figure 4.26: Profile of dually diagnosed clients by duration of service contact



4.5.19 Views on Key Priorities to Improve Current Service Provision

In the management survey conducted by Figure 8, respondents were asked to give comments on key priorities to improve upon current service provision for those with a dual diagnosis. The table below sets out their views:

Table 4.27: Key priorities to improve current service provision

Service	Key Priorities: Comments
CRI	• *Joint working between substance misuse and mental health.* • *Accountability of separate services to each other.*
Addaction	• *Drug services need to work more closely with CMHT like they do with other agencies. Issues with mental health services willing to see our clients.* • *Rapid support.* • *Specialist support from both substance misuse and mental health services.* • *Secure living accommodation.*
WCHP	• *A more flexible accommodation offer.* • *More resources to deliver a more flexible person centred approach.* • *More flexible accommodation offer for clients post treatment.*
SPFT	• *More integration of services - or at least have the possibility to work alongside existing Drug services (we would provide psychological therapies and Addaction would provide longer term support).* • *Direct referral from Drug services to talking Therapies.* • *Training of managers and staff on specific substance misuses and LGBT issues.*
MIND	Nil response
Crawley Open House	Nil response
Lifecentre	• *More information out there for them.* • *Help regardless of budgets.* • *Relaxed place for them to go to.*

Respondents were also asked to rate the following 4 statements in order of importance on a scale of 1=most important and 4=least important, depicted in the table below.

Table 4.28: Rating of four statements relating to services and dual diagnosis.

	CRI	Addaction*	WCHP	SPFT*	MIND	Crawley Open House	Lifecentre
New specialist dual diagnosis service	4	2, 4	4	4, 1	Nil response	Nil response	2
Improved integration of mental health and alcohol/drug services	1	1, 2	1	3, 3			1
Increased capacity of mental health and alcohol/drug services	3	3, 1	3	1, 4			3
Enhanced quality of alcohol/drug and mental health services	2	4, 3	2	2, 2			4

* Two respondents from Addaction and two from SPFT answered this question.

All services, apart from SPFT, rated improved integration of mental health and alcohol/drug services as most important. Other ratings varied. Many services rated enhanced quality of alcohol/drug and mental health as second most important, although both Addaction and Lifecentre rated this as least important.

The management survey asked respondents for one aspect they would change to improve how co-occurring mental health and alcohol/drug problems are managed. Respondents from CRI, Addaction, WCHP and SPFT left the following comments.

"*Joint meetings with mental health.*"

"*Specialist mental health workers based on-site.*"

"*To employ a mental health nurse directly for this service rather than having to share one across the organisation.*"

"*Accept referral from people with a substance misuse problem if they do have a mental health condition that would respond to CBT or counselling.*"

"*Dual Diagnosis Worker embedded in Recovery & Wellbeing Team.*"

4.5.20 Views on specific training needs

In the management survey conducted by Figure 8 respondents were asked to give comments on specific training needs to work more effectively with those who have a dual diagnosis. The table below sets out their views.

Table 4.29: Training needs indicated by managers of service(s)

Service	Training Needs: Comments
CRI	• *Staff need more mental health training.*
Addaction	• *Mental - health specific training would be useful for front-line key workers.*
WCHP	Nil response
SPFT	• *Motivational interviewing, solution focused training.*
MIND	Nil response
Crawley Open House	Nil response
Lifecentre	Nil response

4.5.21 Awareness of Dual Diagnosis Strategy

Respondents from the management survey were asked whether they were aware of a local dual diagnosis strategy. The following table outlines their responses.

Table 4.30: Awareness of dual diagnosis strategy

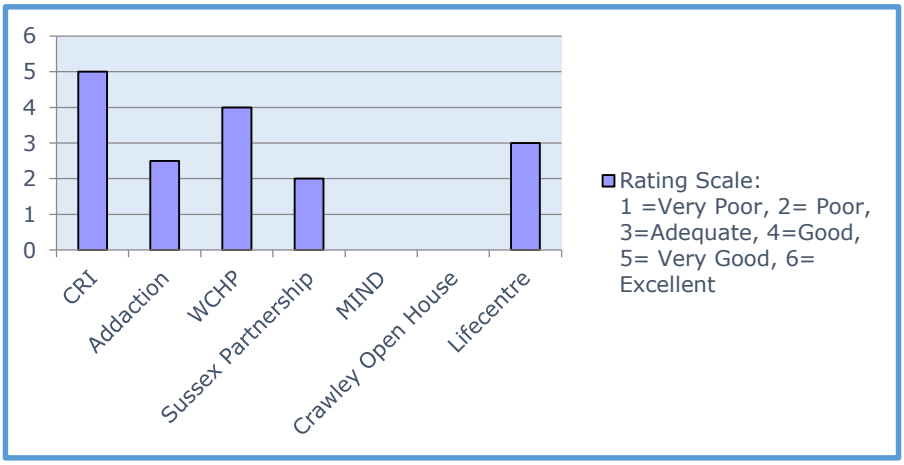
	CRI	Addaction	WCHP	SPFT	MIND	Crawley Open House	Lifecentre
Yes	Nil response	✓		✓	Nil response	Nil response	
No			✓				
Don't Know		✓		✓			✓

Only respondents from Addaction and SPFT answered that a current strategy for dual diagnosis exists.

4.5.22 Integration with other services

Respondents from the managers survey were asked to rate the level of integration between their service and other services. The range of ratings by service is displayed in the figure below.

Figure 4.31: Integration with other specialist and generic services*



*NB. The ratings from Addaction and SPFT are average scores.

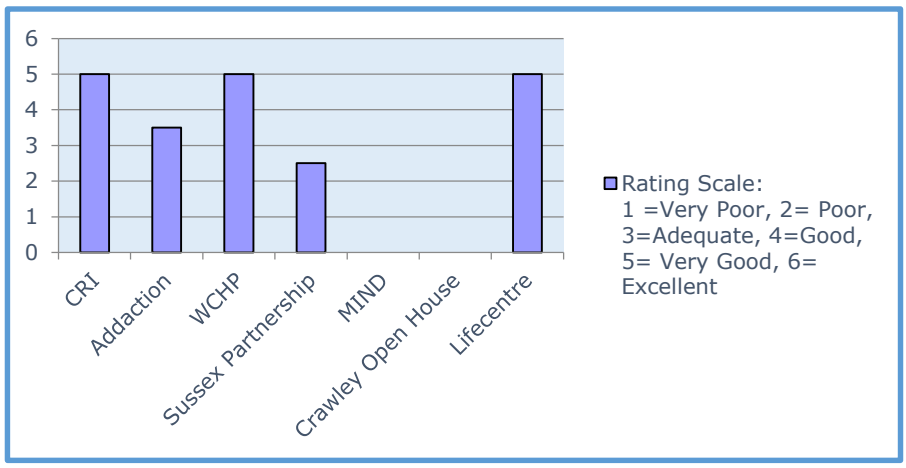
Respondents from Addaction scored 2 and 3.

Respondents from Sussex Partnership scored 1 and 3.

4.5.23 Family involvement in services

Most services rated the level at which they involved families, carers or significant others in supporting dually diagnosed clients to be above adequate, with CRI, WCHP and Lifecentre rating the family involvement as very good. The results have been laid out in the figure below.

Figure 4.32: Level of family/carer involvemement by service



* NB. The ratings from Addaction and SPFT are average scores.

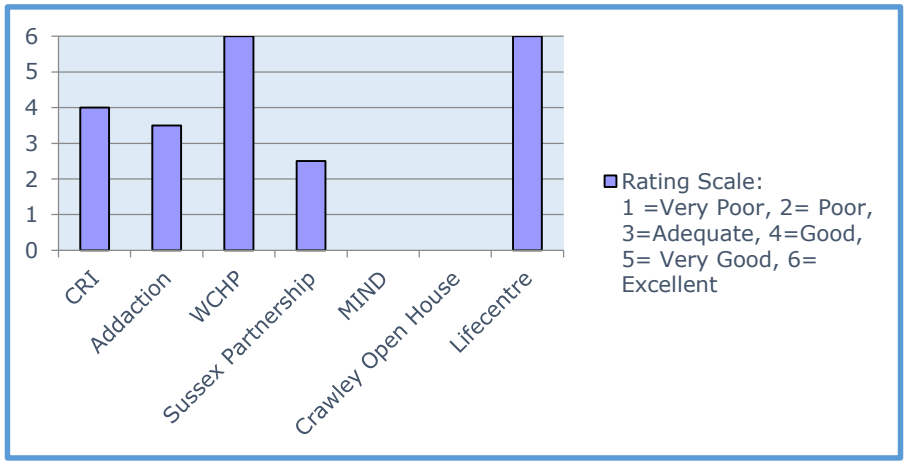
Respondents from Addaction scored 3 and 4.

Respondents from SPFT scored 1 and 4.

4.5.24 User involvement in services

Respondents from the management survey were asked to rate the level at which they involved users in their service, which is set out in the figure below. Most services rated user involvement above adequate, with Worthing Churches Homeless Projects and Lifecentre rating user involvement as excellent.

Figure 4.33: Level of user involvement by service*



* NB. The ratings from Addaction and SPFT are average scores.

Respondents from Addaction scored 3 and 4.

Respondents from SPFT scored 1 and 4.

4.5.25 Aftercare

Most surveyed services noted that they did not consider the level of aftercare for dually diagnosed clients to be sufficient, with respondents from CRI, Addaction and SPFT all being of this opinion. WCHP and Lifecentre considered the levels of aftercare to be sufficient.

4.5.26 Gaps in Services for the Dually Diagnosed

Respondents from the management survey were asked if they thought there were any gaps in services for people with co-occurring mental health and alcohol/drug use. CRI, Addaction, WCHP, SPFT and Lifecentre all answered yes. All provided comments for why they thought there where gaps in services, listed below:

"More joint working and access to mental health input."

"Clear locally-devised pathway for joint working between substance misuse and mental health services. Special roles allocated for working with dual diagnosis service users."

"Lack of interventions and resources from mental health services."

"*People with substance misuse problems who are referred to our service (Time to Talk) are systematically discharged from the service after their assessment. We signpost these patients to Addaction which is a complete disgrace. These patients do have mental health needs but our managers refused to work with them because of their substance misuse. This must change."*

"Housing options, homeless facilities, detox beds, clear pathway for Korsakoffs or alcohol related conditions."

"Sometimes when a client has finished their scheduled treatment with whatever service they still need support but we find mental health providers take them off their books unless we stress the importance that they continue to support the client. We are only a short term service and not ongoing."

4.5.27 Representation at Strategic Level

Respondents were asked whether they engaged with their local Health & Wellbeing Board and Police & Crime Commissioner in order to establish their level of representation at a strategic level. The results are shown in the table below. Only Addaction and WCHP engaged with their local HWB Board and PCC.

Table 4.34: Engagement with HWB & PCC

	CRI	Addaction	WCHP	SPFT	MIND	Crawley Open House	Lifecentre
Engagement with local Health & Wellbeing Board (HWB)							
Yes - as members of the HWB board			✓		Nil response	Nil response	
Yes - formally fed in via Joint Strategic Needs Assessment consultation			✓				
Yes - via local Healthwatch							
Yes - formally fed in via HWB members		✓					
Yes – formally fed in via other methods							
Yes – informally via HWB members							
No	✓	✓		✓			✓
Engagement with Police & Crime Commissioner (PCC)							
Yes, formally through Police and Crime Plan consultation			✓		Nil response	Nil response	
Yes, through Safer Future Communities		✓	✓				
Yes, other (specified below)							✓*
No	✓	✓		✓			

* With the police in training them with dealing with clients who have been sexually abused or raped. Working with them to help bring them intelligence on client situations without the pressure of reporting it formerly. Police feedback forms.

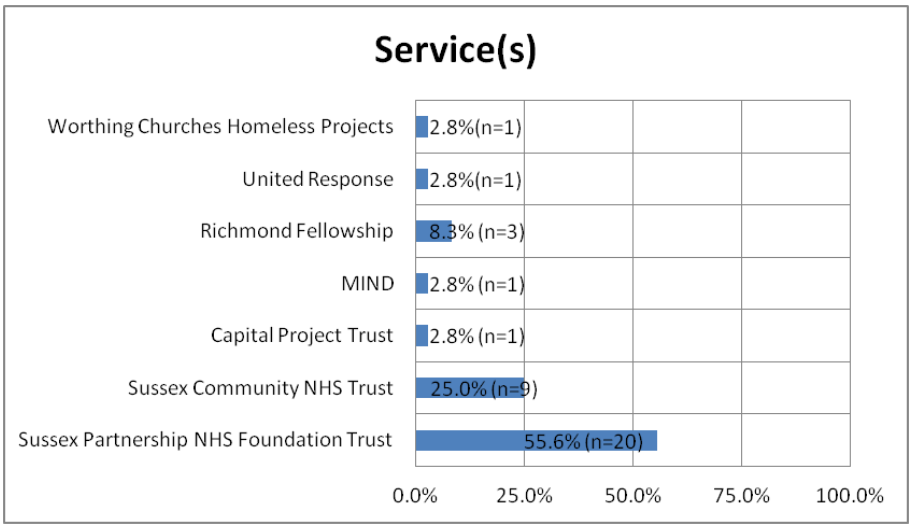
4.6 Mental Health Staff Survey

4.6.1 Services that mental health staff were employed by

Just over 55% (n=20) of respondents indicated that they were employees of Sussex Partnership NHS Foundation Trust. A further 9 (25%) of respondents stated that they were employed by the Sussex Community NHS Trust. This is reflective of a good level of engagement from the main mental health provider in West Sussex. There were no respondents from the following services:

- Re-Think- Asian Mental Health Helpline
- Mid-Sussex Alcohol Project
- Stonepillow
- General Practitioners
- The Corner House

Figure 4.35: Breakdown of services which respondents were employees of



4.6.2 Joint working with Alcohol and Drug services

People who responded to the survey were asked to rate the extent to which they agree with a set of statements relating to the joint working between their service and alcohol and drug services using a 5 point Likert scale:

5 = Strongly Agree

4 = Agree

3 = Don't Know

2 = Disagree

1 = Strongly Disagree

Responses from the survey are set out in Table 4.36 below.

Table 4.36: Rating of statement relating to joint working between mental health and alcohol/drug services.

	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
Our service works effectively with people who have co-occurring mental health and alcohol/drug problems.	5.56% 2	41.67% 15	8.33% 3	22.22% 8	22.22% 8
Our service works efficiently with people who have co-occurring mental health and alcohol/drug problems.	13.89% 5	22.22% 8	13.89% 5	30.56% 11	19.44% 7
Our staff are knowledgeable about how to respond appropriately to presenting alcohol/drug problems.	11.11% 4	41.67% 15	19.44% 7	27.78% 10	0.00% 0
Our service undertakes comprehensive assessments including alcohol and drug status.	11.11% 4	58.33% 21	5.56% 2	22.22% 8	2.78% 1
Our service undertakes comprehensive joint assessments with specialist alcohol and drug services.	0.00% 0	13.89% 5	16.67% 6	36.11% 13	33.33% 12

Our service uses a validated or common assessment tool to identify individual risks and needs.	22.22% 8	41.67% 15	13.89% 5	19.44% 7	2.78% 1
Our service has established referral routes with specialist alcohol and drug services.	2.78% 1	47.22% 17	13.89% 5	25.00% 9	11.11% 4
There are defined criteria for classification of mental health risks (low, medium and high); as well as referral to specific types of other mental health services, as well as specialist alcohol and drug services.	19.44% 7	58.33% 21	16.67% 6	2.78% 1	2.78% 1
There are effective pathways into alcohol and drug services that promote joint working.	5.56% 2	19.44% 7	13.89% 5	44.44% 16	16.67% 6
There is a defined written pathway(s) for people with co-occurring mental health and alcohol/drug problems.	2.78% 1	27.78% 10	30.56% 11	27.78% 10	11.11% 4
Our service communicates effectively with specialist alcohol and drug services.	5.56% 2	38.89% 14	13.89% 5	33.33% 12	8.33% 3
Our service has effective working relationships with specialist alcohol and drug services.	8.33% 3	30.56% 11	19.44% 7	33.33% 12	8.33% 3
Our service provides good information about alcohol and drug problems, including other sources of help available.	5.56% 2	52.78% 19	19.44% 7	22.22% 8	0.00% 0
In our service, we give equal weighting to the management of alcohol and drug and mental health problems.	2.78% 1	19.44% 7	16.67% 6	33.33% 12	27.78% 10
I am confident working with people with alcohol/drug problems.	5.56% 2	36.11% 13	22.22% 8	33.33% 12	2.78% 1
I am competent working with people with alcohol/drug problems.	5.56% 2	41.67% 15	22.22% 8	27.78% 10	2.78% 1
I am confident in addressing issues such as self harm, suicidal thinking and attempted suicide.	52.78% 19	38.89% 14	5.56% 2	2.78% 1	0.00% 0

From Table 4.36, it can be observed that there are a few statements that respondents strongly **agree** with. These are:

- "Our service undertakes comprehensive assessments including alcohol and drug status." (Strongly agree=11.11%, n=4; agree = 58.33%, n=21).
- "There are defined criteria for classification of mental health risks (low, medium and high); as well as referral to specific types of other mental health services, as well as specialist alcohol and drug services." (Strongly agree=19.44%, n=7; agree = 58.33%, n=21).
- "I am confident in addressing issues such as self harm, suicidal thinking and attempted suicide." (Strongly agree=52.78%, n=19; agree = 38.83%, n=21).

Also worth noting are certain statements that indicate strong **disagreement** statements. These are:

- "Our service undertakes comprehensive joint assessments with specialist alcohol and drug services." (Strongly disagree=33.33%,n=12; disagree=36.11% , n=13).

- "In our service, we give equal weighting to the management of alcohol and drug and mental health problems." (Strongly disagree=27.78%,n=10; disagree=33.33% , n=12).

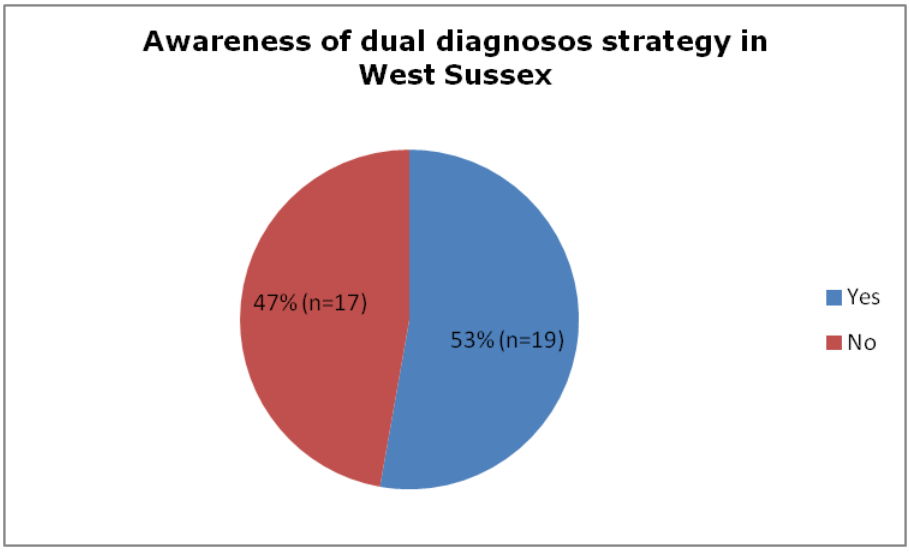
There were also some statements that indicate that there was **mixed agreement** amongst respondents. These are:

- *"Our service works effectively with people who have co-occurring mental health and alcohol/drug problems."* (Strongly Agree=5.56%, n=2; agree=41.67%, n=15; don't know=8.33%, n=3; disagree=22.22%, n=8; strongly agree=22.22%, n=8).
- *"There is a defined written pathway(s) for people with co-occurring mental health and alcohol/drug problems."* (Strongly Agree=2.78%, n=1; agree=27.78%, n=10; don't know=30.56%, n=11; disagree=27.78%, n=8; strongly agree=11.11%, n=4).
- *"Our service communicates effectively with specialist alcohol and drug services."* (Strongly Agree=5.56%,n=2; agree=38.89%,n=14;don't know=13.89%,n=5; disagree=33.33%,n=8; strongly agree=8.33%,n=3).
- *"Our service has effective working relationships with specialist alcohol and drug services."* (Strongly Agree=8.33%,n=3;agree=30.56%,n=11; don't know= 19.44%,n=7; disagree=33.33%,n=12; strongly disagree=8.33%,n=3).
- *"I am confident working with people with alcohol/drug problems."* (Strongly Agree=5.56%,n=2;agree=36.11%,n=13; don't know= 22.22%,n=8; disagree=33.33%,n=12; strongly disagree=2.78%,n=1).

4.6.3 Awareness of dual diagnosis strategy by mental health services

Over 50% (53%; n=19) of respondents were aware of the dual diagnosis strategy in West Sussex.

Figure 4.37: Breakdown of respondents' responses indicating awareness of dual diagnosis strategy.



4.6.4 Integration of mental health services and alcohol and drug services.

Respondents were asked to describe the level of integration between their service (mental health) and alcohol and drug services in West Sussex using a Likert Scale scale:

1=Very Poor

2=Poor

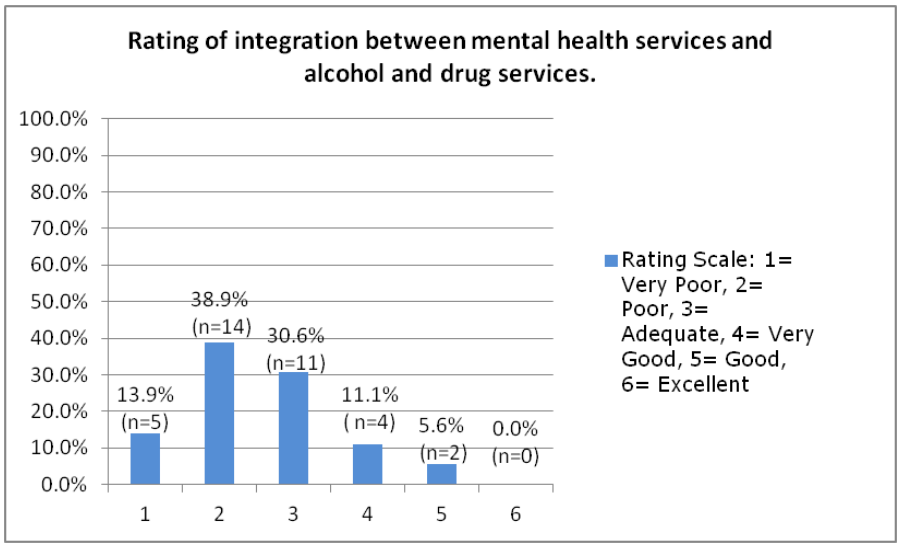
3=Adequate

4=Good

5=Very Good

6=Excellent

Figure 4.38: Breakdown of respondents rating of integration between mental health and alcohol/drug services.

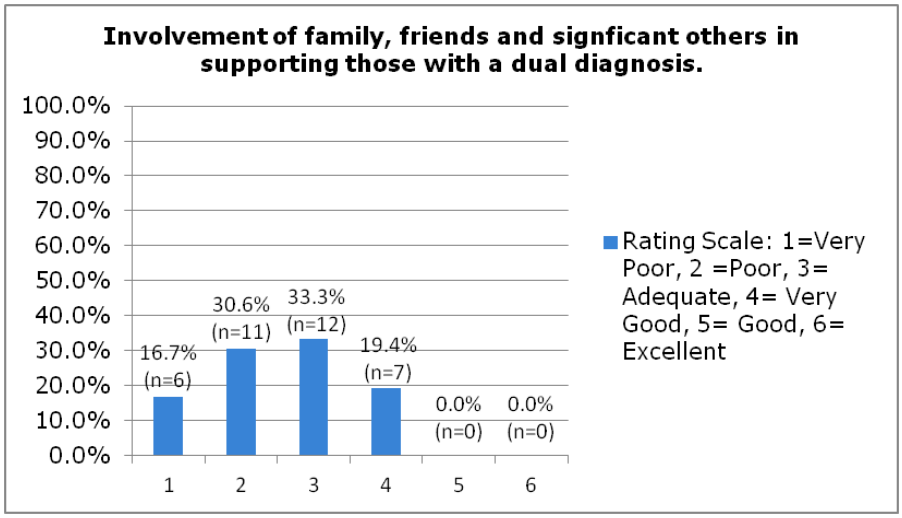


From the Figure above it can be observed those respondents who completed the online survey stated that integration between mental health and alcohol and drug services were '*poor*' (38.9%; n=14). Only 2 (5.6%) respondents indicated that they felt that integration was '*very* good'.

4.6.5 Family involvement in services

Overall, respondents indicated that family, friends and significant others had 'adequate' involvement in supporting those with dual diagnosis (33.3; n=12). 11 respondents (30.6%) felt that involvement of family, friends and significant other by services was 'poor'.

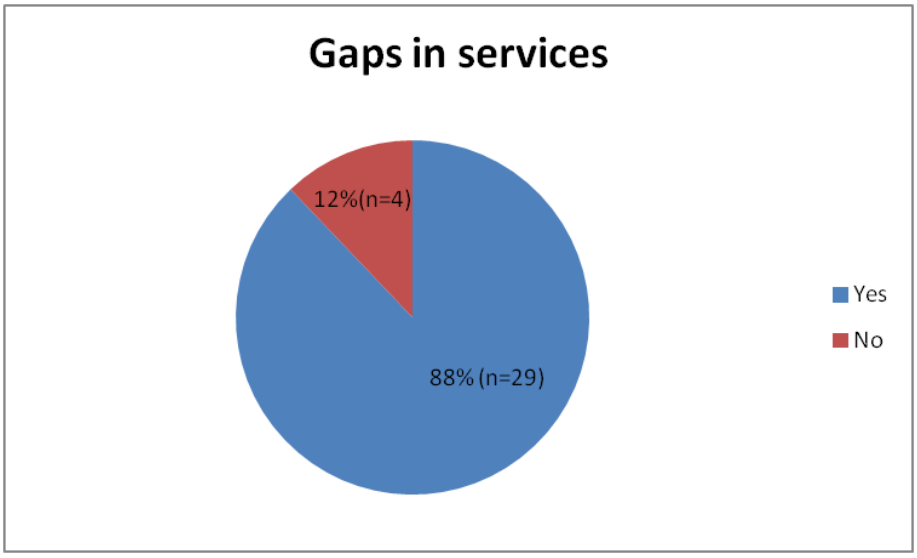
Figure 4.39: Breakdown of respondents rating of involvement of family/carers and significant other in supporting those with a dual diagnosis.



4.6.6 Gaps in services

Respondents were asked if there were any gaps in services with people with co-occurring mental health and alcohol/drug problems in West Sussex. More than 85% of those who complete this section in the survey indicated there was.

Figure 4.40: Numbers of respondents who indicated there was/was not gaps in services.



Respondents who stated that there were gaps in services for those with a dual diagnosis were asked to provide commentary. Their comments are presented below:

"Clearer pathways need to be identified with lead agencies established."

"Supporting (us to support) people who currently do not have motivation to change substance misuse behaviours, in the context of complex mental health problems, and general ambivalence about change."

"Poor communication between services, there are no medical follow ups from Addaction, even if the mental health problem is obviously linked to [the] addiction at [in] the first place. Patients are referred by us first to Addaction to work on addiction and after being sober/drug free for several months they can come back to us. In my opinion it should be rather joined work at the same time."

"Many of my team will not see clients if they smoke cannabis (even occasionally). Some will discharge clients if they drink more than a few units each week. We refer many clients to substance misuse teams, but seem to get little feedback (confidentiality, I suppose!) Lack of beds / rehab facilities for those we need to detox."

"Unclear joined up pathway between services."

"It appears that there isn't one. We insist clients deal with their drug / alcohol difficulties before we will work with them."

"When people struggle to maintain a tenancy and are faced with eviction and this is more to do with problems associated with their substance misuse rather than a relapse of their mental health problem it is difficult to get services working together to support the person. Often the mental health team is left holding the person and other agencies appear less robust in working with people who are difficult to engage."

"In some IAPT services it is actively pushed to screen people with alcohol and drug problems OUT of service despite the severity or the problem being described being different to the substance use, There is no written criteria or written referral pathway, there is no joining up of service and the limits for drink/drug use in some IAPT services are so low as to screen people out, practitioner lie about the amount being consumed or have to signpost refer to services which will not be of best benefit for the patient but will be of good benefit to IAPT waiting lists."

"Time To Talk (mental health service) doesn't work with people who are drug users or are drinking excessively; but often local drug and alcohol services can't work with people with untreated mental health problems."

"If people have any drug or alcohol problems above a very low level (anything above 20 units a week) they are denied access to our service and asked to self-refer to Addaction. This goes directly against NICE guidance on this issue and whilst this has been pointed out to management, they continue to ignore it."

"In my experience there remains a 'tennis ball' approach to working with people with dual difficulties, this has been more prevalent since the previous contract changes (not currently as aware of recent tender bid and change of provider therefore too early to say). I am aware of pathways for referrals in the acute in-patient mental health services (although don't know how effective this is) and have found out about the alcohol specialist service in the adult services which is a great resource in my field of working, but someone who could also be a resource and help with referrals for drug related difficulties would also be helpful. Pharmacy are a great link for assisting with medications contraindications and treatment (when available)."

"Often people are only able to address one issue at a time for example we have found that many service users have been turned away from statutory mental health services as it is not possible to assess whether they have a mental health need whilst under the influence and drug and alcohol services have been unable to support individuals who are not yet ready to address substance misuse/alcohol issues."

4.6.7 Future directions and improvements

Respondents were also asked to rate 4 statements in order of importance on a scale of:

1=most important; to

4=least important

Their answers are displayed in the table below.

Table 4.41: Respondents rating of 4 statements in order of importance.

	1	2	3	4
New specialist dual diagnosis service (West Sussex wide)	**30.30%** 10	**0.00%** 0	**24.24%** 8	**45.45%** 15
Improved integration of mental health and alcohol and drug services	**45.45%** 15	**30.30%** 10	**18.18%** 6	**6.06%** 2
Increased capacity of mental health and alcohol and drug services	**21.21%** 7	**18.18%** 6	**42.42%** 14	**18.18%** 6
Enhanced quality of mental health and alcohol and drug services	**3.03%** 1	**51.52%** 17	**15.15%** 5	**30.30%** 10

'Improved integration of mental health and alcohol and drug service' was the statement that respondents rated most important (45.45 %; n=17). The statement that was rated least important was 'New specialist dual diagnosis (West Sussex wide).'

Respondents were asked provide details on how they rated the statements. Their comments are presented below:

"I don't think it is necessary to set up a new dual diagnosis service, in my opinion it would just make more chaos, who is responsible for what. I would put a pressure on developing effective pathways and cooperation between services."

"I have rated the specialist dual diagnosis service at 4 as I envisage this as being a service for people with severe mental health problems and drug/alcohol use (although I may be wrong), and am aware that our AOT services work with this client group. However both acute and recovery services would benefit from increased knowledge and experience and joint working to enhance the care given to their client groups. I am aware that proactive work has been carried out to address this co-morbidity group and that some areas appear to have better resources and practices than others but this is an issue for all mental health workers and clients and therefore I believe should be standard across all of West Sussex. Despite my experiences with this client

group and involvement with various developments (including my own) relating to this area, I continue to feel a lack of knowledge and confidence in acknowledging some of the presentations and needs of my client group."

"We need much stronger links between mental health support and those working in alcohol/drug rehab."

"I work for an IAPT service and we do not work with people who have an alcohol and drug problem. Drug and alcohol services do not offer any real input with psychological issues. Therefore if you have both occurring there is not a service for you."

"Raise profile of Dual Diagnosis Strategy."

"SPFT need be kept updated re Drug and Alcohol Services i.e. a local forum to update each other and work on better close working based on specific examples where the interface between services has been unclear i.e. joined up pathway work across all partners e.g. wellbeing hubs, Third Sector, Primary and Secondary MH services."

"Drug and alcohol issues are still at times viewed separately to mental health issues and the lack of robust joint working processes effects treatment received."

Respondents were asked what the one thing they would change to improve the management of co-occurring mental health and alcohol/drug problems. Their comments are below:

Training

"Team based training around MI / building motivation; learning more about current substances."

"Training on alcohol/drug problems."

"Complete a training needs analysis, explore the training available and deliver the appropriate training."

"More staff/more training/more resources."

Accessibility to mental health services

"Accept and treat dual diagnosis patients."

"Better clinical decisions about seeing patients who may be drinking over recommended levels but are not alcoholics or habitual drug users and so could benefit from an IAPT intervention."

"Being compliant with NICE guidelines and working with people who are using slightly above recommended levels of alcohol/drugs."

"Either we would accept referrals for these people in which case we would need training to work with them, or there needs to be service which can work with them."

Joint Working between mental health and alcohol services

"More effective joint working / pathways."

"Joint working or specialist person within the team."

"Have better links between each service so if information is needed it can be shared or found out if needed to benefit the client."

"To integrate the services."

"Improved joint working and improved training and education."

Specialist dual diagnosis team/worker

"Have access to specialist advisors/consultant re specific high risk, complex clients with DD to our teams."

"An assigned liaison or dual diagnosis worker who could consult on interventions."

"Have a link dual diagnosis specialist within team."

4.6.8 Training needs of mental health staff

Respondents were asked if they had any specific training needs to be able to work more effectively with those with co-occurring mental health and alcohol/drug problems. Their comments are below:

"We receive complex needs training which looks at co-occurring issues. All front-line staff can under-take this training. Joint working between substance misuse & MH services may provide shared learning & training."

"Supporting people who are not motivated to change - including MI training for staff, harm minimisation approaches, training around substances / impact / legal highs to increase awareness and knowledge amongst staff etc. Ideally team based training, so we can discuss most relevant issues / dilemmas in this context."

"Assessment of substance use, what are the highs/lows of usage. Where to draw the line between it being the problem to it being a symptom of something else. How substance services treat substance problems the HOW of it."

"Yes. It would be helpful to be able to access training that would help us identify who we can/cannot safely work with. Generic training would not help. It needs to be clearly addressed at the provision of psychological therapies as opposed to generic interventions."

"Training on drug and alcohol use and specifically on what should be prioritised in dual diagnosis work would be helpful."

"Raising awareness of best practice guidance around appropriate interventions for support workers to deliver - including the background/principles behind these interventions. Clarifying what service is expected to provide what support - defining the eligibility criteria and expectations for local services - would enhance joint/partnership working."

"My service does not work with people who have alcohol/drug problems."

"Training on what services to signpost to and an update on what the services do."

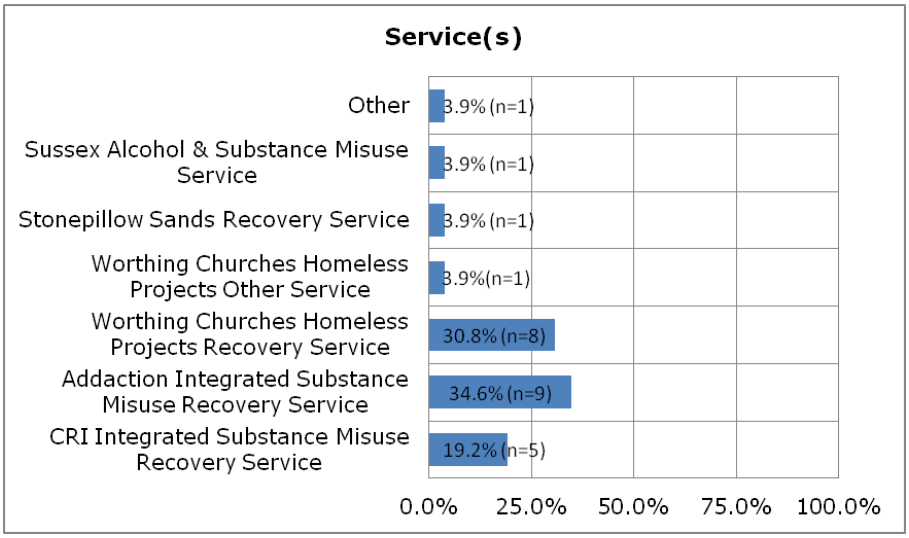
"Not currently as we do not work with such individuals."

4.7 Alcohol and Drug Staff Survey

4.7.1 Services that alcohol and drug staff were employed by

The majority of respondents who complete the alcohol and drug staff survey worked for Worthing Homeless Projects Recovery Service. One respondent indicated that they worked for Western Assertive Outreach Team.

Figure 4.42: Breakdown of services which respondents were employees of



4.7.2 Joint working with Mental Health Services

People who responded to the survey were asked to rate the extent to which they agree with a set of statements relating to the joint working between their service and mental health services using a 5 point Likert scale:

5 = Strongly Agree

4 = Agree

3 = Don't Know

2 = Disagree

1 = Strongly Disagree

Responses from the survey are set out in Table 4.43 below.

Table 4.43: Rating of statement relating to joint working between alcohol and drugs and mental health services.

	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
Our service works effectively with people who have co-occurring alcohol/drug and mental health problems.	**26.92%** 7	**53.85%** 14	**3.85%** 1	**11.54%** 3	**3.85%** 1
Our service works efficiently with people who have co-occurring alcohol/drug and mental health problems.	**19.23%** 5	**57.69%** 15	**3.85%** 1	**15.38%** 4	**3.85%** 1
Our staff are knowledgeable about how to respond appropriately to resenting mental health problems.	**15.38%** 4	**53.85%** 14	**19.23%** 5	**11.54%** 3	**0.00%** 0
Our service undertakes comprehensive assessments including mental health status.	**26.92%** 7	**65.38%** 17	**0.00%** 0	**7.69%** 2	**0.00%** 0
Our service undertakes comprehensive joint assessments with mental health services.	**3.85%** 1	**38.46%** 10	**19.23%** 5	**23.08%** 6	**15.38%** 4
Our service uses a validated or common assessment tool to identify individual risks and needs.	**15.38%** 4	**65.38%** 17	**7.69%** 2	**11.54%** 3	**0.00%** 0
Our service has established referral routes with mental health services.	**7.69%** 2	**34.62%** 9	**15.38%** 4	**38.46%** 10	**3.85%** 1
There are defined criteria for classification of mental health risks (low, medium and high); as well as referral to specific types of mental health services.	**15.38%** 4	**34.62%** 9	**11.54%** 3	**34.62%** 9	**3.85%** 1
There are effective pathways into mental health services that promote joint working.	**7.69%** 2	**30.77%** 8	**3.85%** 1	**46.15%** 12	**11.54%** 3
There is a defined written pathway(s) for people with co-occurring alcohol/drug and mental health problems.	**7.69%** 2	**26.92%** 7	**3.85%** 1	**50.00%** 13	**11.54%** 3
Our service communicates effectively with mental health services.	**11.54%** 3	**50.00%** 13	**11.54%** 3	**23.08%** 6	**3.85%** 1
Our service has effective working relationships with mental health services.	**3.85%** 1	**38.46%** 10	**19.23%** 5	**30.77%** 8	**7.69%** 2
Our service provides good information about mental health problems, including other sources of help available.	**15.38%** 4	**50.00%** 13	**3.85%** 1	**26.92%** 7	**3.85%** 1
In our service, we give equal weighting to the management of alcohol/drug and mental health problems.	**15.38%** 4	**38.46%** 10	**11.54%** 3	**23.08%** 6	**11.54%** 3
I am confident working with people with mental health problems, including those in crisis.	**11.54%** 3	**61.54%** 16	**3.85%** 1	**23.08%** 6	**0.00%** 0
I am competent working with people with mental health problems, including those in crisis.	**11.54%** 3	**57.69%** 15	**11.54%** 3	**19.23%** 5	**0.00%** 0
I am confident in addressing issues such as self-harm, suicidal thinking and attempted suicide.	**11.54%** 3	**73.08%** 19	**3.85%** 1	**11.54%** 3	**0.00%** 0

From Table 4.43, it can be observed that there are a few statements that respondents strongly **agree** with. These are:

"Our service works effectively with people who have co-occurring alcohol/drug and mental health problems." (Strongly agree=26.92%, n=7; agree = 53.85%, n=14).

"Our service undertakes comprehensive assessments including mental health status." (Strongly agree=26.92%, n=7; agree = 65.38%, n=17).

"Our service uses a validated or common assessment tool to identify individual risks and needs." (Strongly agree=15.38%, n=4; agree = 65.38%, n=17).

"I am confident in addressing issues such as self-harm, suicidal thinking and attempted suicide." (Strongly agree=11.54%, n=3; agree = 73.08%, n=19).

Also worth noting are certain statements that indicate strong **disagreement** with statements. These are:

"There are effective pathways into mental health services that promote joint working." (Strongly disagree=11.54.33%,n=3; disagree=46.15% , n=12).

"There is a defined written pathway(s) for people with co-occurring alcohol/drug and mental health problems." (Strongly disagree=11.54%,n=3; disagree=50.0% , n=13).

There were also some statements that indicate that there was **mixed agreement** amongst respondents. These are:

"Our service undertakes comprehensive joint assessments with mental health services." (Strongly Agree=3.85%,n=1;agree=38.46%,n=10;don't know=19.23%,n=5; disagree=23.08%,n=6;strongly agree=15.38%,n=4).

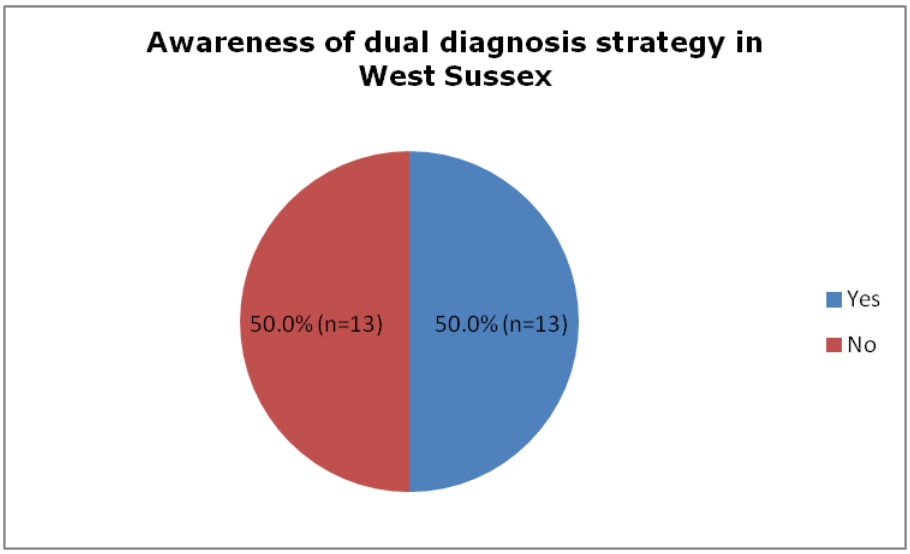
"Our service has established referral routes with mental health services." (Strongly Agree=7.69%, n=2; agree=34.62%, n=9; don't know=15.38%, n=4; disagree=38.46%, n=10; strongly agree=3.85%, n=1).

"Our service has effective working relationships with mental health services." (Strongly Agree=3.85%,n=1;agree=38.46%,n=10;don't know=19.23%,n=5; disagree=30.77%,n=8;strongly agree=7.69%,n=2).

4.7.3 Awareness of dual diagnosis strategy in West Sussex

Half (50%; n=13) of respondents were aware of the dual diagnosis strategy in West Sussex.

Figure 4.44: Breakdown of respondents' responses indicating awareness of dual diagnosis strategy.



4.7.4 Integration of alcohol and drug and mental health services

Respondents were asked to describe the level of integration between their service (alcohol and drug) and mental health services in West Sussex using a Likert Scale scale:

1=Very Poor

2=Poor

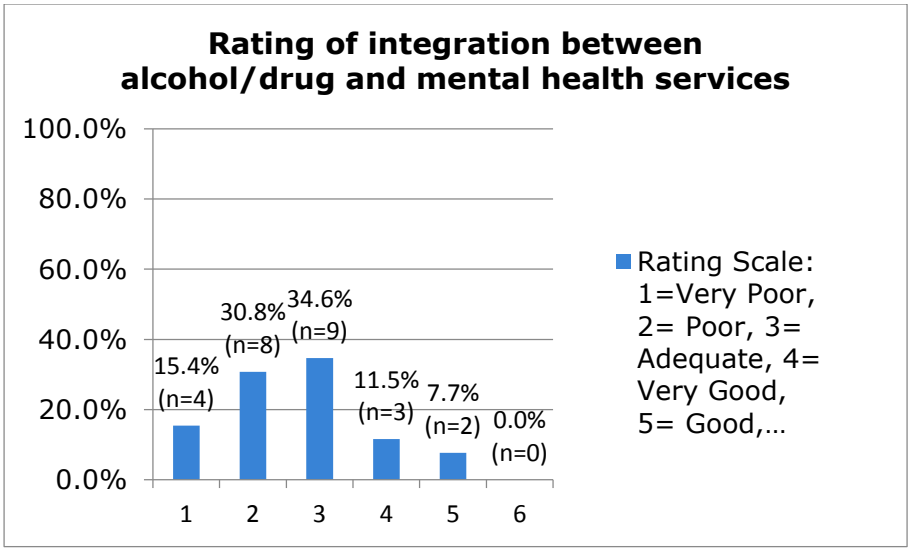
3=Adequate

4=Good

5=Very Good

6=Excellent

Figure 4.45: Breakdown of respondents rating of integration between drug and alcohol and mental health services

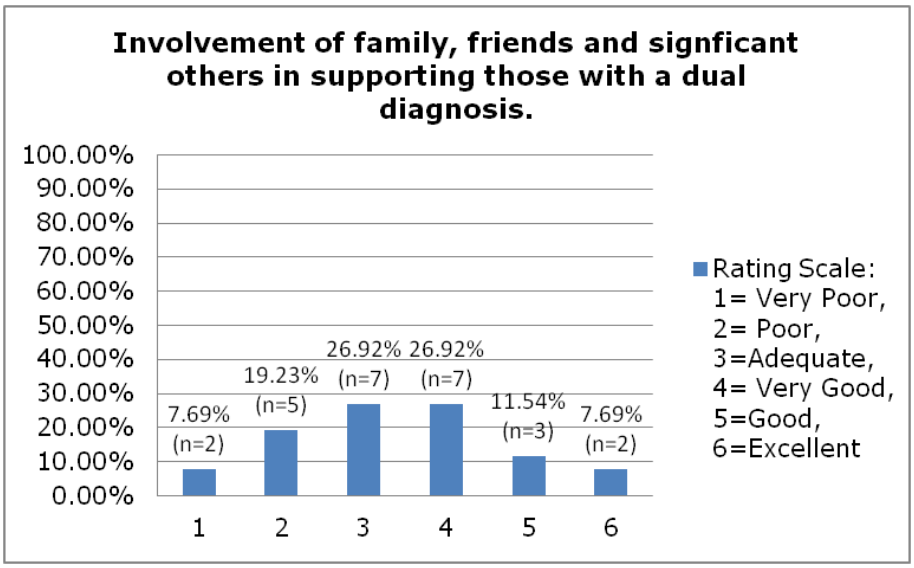


From the figure above it can be observed those respondents who completed the online survey stated that integration between mental health and alcohol and drug services were '*adequate*' (34.6%; n=9). Only 2 (7.7%) respondents indicated that they felt that integration was '*very* good'.

4.7.5 Family involvement in services

Overall, respondents indicated that family, friends and significant others had 'adequate' / 'very good' involvement in supporting those with dual diagnosis (26.92%, n=7; 26.92%, n=7, respectively). 5 respondents (19.23 %) felt that involvement of family, friends and significant other by services was 'poor'.

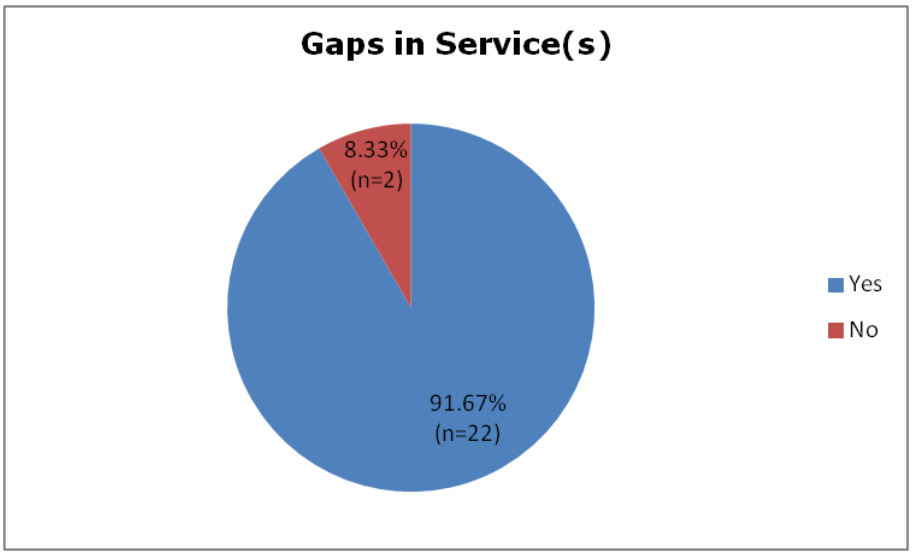
Figure 4.46: Breakdown of respondents rating of involvement of family/carers and significant other in supporting those with a dual diagnosis



4.7.6 Gaps in services

Respondents were asked if there were any gaps in services with people with co-occurring mental health and alcohol/drug problems in West Sussex. More than 90% of those who complete this section in the survey indicated there was.

Figure 4.47: Numbers of respondents who indicated there was/was not gaps in services



Respondents who stated that there were gaps in services for those with a dual diagnosis were asked to provide commentary. Their comments are presented below:

"With people that have been through lots of services and no-one seems to know what to do to help them."

"The gaps are extensive and long recognised without any movement to an integrated approach to support the individual. My experience in this region (where I have worked now for 5 years) is a constant 'batting back' referrals for clients with MH issues from MH services because they have a substance misuse issue. Even if the client is known to have a pre-existing MH condition prior to their drug use and potentially the primary factor contributing to their continued drug use; MH services have still not taken such clients on; due to their substance misuse status. This is at an unprecedented level, in my experience, and an extremely short sighted and ineffective and inefficient way of working towards supporting an individual's wellbeing and health."

"Often mental health services will say they are unable to assess people who are currently misusing alcohol or drugs and will often attribute the mental health problems as drug or alcohol induced. Drug and alcohol services will often say that the drug and alcohol use is self- medication for an underlying mental health problem. There is a need for dual diagnosis specialists across the county."

"We only have links into the mental health services via our own mental health worker. Most mental health services will only diagnose or work with a client when abstinent."

"The need for dual diagnosis working, as clients with substance misuse are normally not pick up by mental health teams due to their substance misuse. There needs to be a joint approach to make treatment effective."

"There seems a patchy response and referral path for service users with recognisable personality disorders. As a worker in a homeless prevention service I can see how failure to cope with any degree of frustration without acting this out in some way contributes to their homelessness, but

sometimes difficult even to get a diagnosis from mental health services. It feels as if mental health services are filtering out the most difficult to treat cases, and leaving it to untrained but experienced staff in homeless services to come up with creative solutions."

"Historically, Dual Diagnosis clients are not treated efficiently by mental health services, as there is a tendency to pass them on to substance misuse services."

"I am not aware of any dual diagnosis plan in West Sussex. Often clients referred to mental health services with anxiety, depression, psychosis, personality disorder are told to address their substance abuse first. I understand substances often have a negative effect on mental health, however many people self-medicate their mental health problems with substances. Without support for their mental health problems, they are less likely to reduce or abstain from substances as the symptoms they are medicating become more present. I have found that the mental health team will take on referrals of those who are expressing suicidal ideation with plans."

"Mental health workers are reluctant in working with clients that are still in active alcohol/substance misuse."

"Not clear who/where/how to refer. Clients have reported mental health services not wanting to work with them while they are using drugs."

4.7.7 Future directions and improvements

Respondents were also asked to rate 4 statements in order of importance on a scale of:

1=most important and;

4=least important.

Their answers are displayed in the table below.

Table 4.48: Respondents rating of 4 statements in order of importance.

	1	2	3	4
New specialist dual diagnosis service (West Sussex wide)	**33.33%** 8	**20.83%** 5	**12.50%** 3	**33.33%** 8
Improved integration of mental health and alcohol and drug services	**33.33%** 8	**50.00%** 12	**8.33%** 2	**8.33%** 2
Increased capacity of mental health and alcohol and drug services	**25.00%** 6	**0.00%** 0	**62.50%** 15	**12.50%** 3
Enhanced quality of mental health and alcohol and drug services	**8.33%** 2	**29.17%** 7	**16.67%** 4	**45.83%** 11

There are two statements that respondents rated as most important. Firstly, 33.33% (n=8) of respondents indicated that a '*New specialist dual diagnosis service (West Sussex wide)*' was most important, though there seems to be disagreement amongst respondents as 33.33 (n=8) of

respondents rated this statement as least important. The second statement that respondents rated as most important is '*Improved integration of mental health and alcohol and drugs services' (33.33%; n=8)*. The statement that was rated the least important was *'Enhance quality of mental health and alcohol and drug services'* (45.83%; n=11).

Respondents were asked provide details on how they rated the statements. Their comments are presented below:

"Improvements are needed between mental health services and other organisations."

"Mental health services need to have a better understanding of dual diagnoses clients."

"We need to be able to refer directly. Not having clients sent to us from mental health because they are currently using. It is all linked and the treatment should be as well."

"You need to enable change from the bottom up, start by changing the relationship between professionals, non-professional staff and service users. Top down change simply perpetuates the problems we already have."

"Services need to work closely together to provide for any gaps in provision, with an emphasis on who is the lead in this on a client by client basis.

"Lack to dual diagnosis working creates a greater workload for substance misuse workers who are not trained to deal with mental health issues."

"I would like to see a huge improvement in these fields so that all clients can be treated in one instead of 2 treatments journeys, all staff will need the training and support to do this."

"Mental health services and substance misuse services really need to improve their co-working procedures. Clients should not be ping ponged between the two services."

Respondents were asked what the one thing they would change to improve the management of co-occurring alcohol/drug and mental health problems. Their comments are below:

<u>Joint working with mental health services</u>

"Joined up approach between the services so everyone knows exactly what is happening to a specific client and work/conversations are not repeated unnecessarily."

"A more link in approach to helping these clients so all agencies are involved so aware of all the information so can manage the risks better also creates a better care plan with the client and gets support and help from all agencies at once."

"Joined up working with mental health services."

"Improved joint working and joint meetings with the mental health services"

"Encourage mental health services to work closely with substance misuse agencies."

"Better relationships with mental health services."

<u>Training</u>

"More training."

"Greater staff training around mental health."

Mental health liaison worker/ support

"A dedicated mental health liaison worker. We have a staff member who takes the lead in mental health issues mainly for advice."

"Easy available mental health support and working together effectively."

"Nominated Manager, Supervisor and workers."

4.7.8 Training needs of alcohol and drug staff

Respondents were asked if they had any specific training needs to be able to work more effectively with those with co-occurring alcohol/drug and mental health problems. Their comments are below:

"I can always benefit from extra training...always learn something."

"I have, in five years, not had or been offered any MH training of any description from my present employer, yet I work with numerous clients with MH/Dual Diagnoses issues. When one combines this with the lack of support/engagement from MH services with the majority of our clients where a need exists - then I feel we need significant training in MH issues and support. If services were to be working more closely, clients were indeed accepted to begin with and/or there was a specialist service - the MH training needs would be significantly reduced to more of that of identifying needs. Presently none of this exists."

"Any additional training in managing risk and assisting those with dual diagnosis would be very helpful any training is always useful, dual diagnosis especially and dealing with clients at the point of crisis."

"Mental health training."

"General training on working with people with dual diagnosis issues, including conditions, pathways, and responses would increase my confidence."

"Wider understanding of mental health needs would be beneficial."

"I have good knowledge of mental health but have less understanding of how substances and mental health problems interact, and especially lack knowledge of how substances interact with psychiatric mediation."

"Mental Health Training is constantly being asked for in our field because we are getting so many dual diagnosis clients now."

4.8 Generic Services Staff Survey

4.8.1 Services that 'generic service' staff were employed by

The majority of respondents who complete the survey worked for West Sussex County Council. Two respondents indicated that they worked for Think Family and one respondent indicated that they worked for Worthing Churches Homeless Projects.

Table 4.49: Breakdown of services which respondents were employees of.

Service	Responses %/n
WSCC - Domestic Abuse and Sexual Violence	25% (n=3)
West Sussex County Council	**41.7% (n=5)**
Sussex Probation Service	8.3% (n=1)
Other	25% (n=3)

4.8.2 Joint working with alcohol/drug and mental health services

People who responded to the survey were asked to rate the extent to which they agree with a set of statements relating to the joint working between their service and mental health services and alcohol/drug services using a 5 point Likert scale:

5 = Strongly Agree

4 = Agree

3 = Don't Know

2 = Disagree

1 = Strongly Disagree

Responses from the survey are set out in Table 4.50 below.

Table 4.50: Rating of statement relating to joint working between alcohol and drugs and mental health services.

	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
Our service works effectively with people who have co-occurring alcohol/drug and mental problems.	16.67% 2	25.00% 3	8.33% 1	41.67% 5	8.33% 1
Our staff are knowledgeable about how to respond appropriately to presenting mental health problems.	0.00% 0	50.00% 6	8.33% 1	33.33% 4	8.33% 1

Our staff are knowledgeable about how to respond appropriately to presenting alcohol/drug problems.	0.00% 0	66.67% 8	16.67% 2	8.33% 1	8.33% 1
Our service undertakes comprehensive mental health assessments.	0.00% 0	8.33% 1	8.33% 1	58.33% 7	25.00% 3
Our service undertakes comprehensive alcohol and drug assessments.	0.00% 0	8.33% 1	8.33% 1	58.33% 7	25.00% 3
Our service undertakes comprehensive joint assessments with mental health and/or alcohol/drugs services.	0.00% 0	25.00% 3	16.67% 2	41.67% 5	16.67% 2
Our service uses a validated or common assessment tool to identify individual risks and needs.	25.00% 3	41.67% 5	0.00% 0	33.33% 4	0.00% 0
There are defined criteria for classification of mental health risks (low, medium and high); as well as referral to specific types of mental health and alcohol/drug services.	8.33% 1	25.00% 3	25.00% 3	33.33% 4	8.33% 1
There are effective pathways into mental health services that promote joint working.	0.00% 0	25.00% 3	8.33% 1	25.00% 3	41.67% 5
There are effective pathways into alcohol/drug services that promote joint working.	0.00% 0	41.67% 5	0.00% 0	41.67% 5	16.67% 2
There is a defined written pathway(s) for people with co-occurring alcohol/drug and mental health problems.	0.00% 0	16.67% 2	41.67% 5	25.00% 3	16.67% 2
Our service communicates effectively with mental health services.	0.00% 0	50.00% 6	0.00% 0	33.33% 4	16.67% 2
Our service communicates effectively with alcohol and drug services.	8.33% 1	50.00% 6	0.00% 0	41.67% 5	0.00% 0
Our service has effective working relationships with mental health services.	0.00% 0	41.67% 5	8.33% 1	41.67% 5	8.33% 1
Our service has effective working relationships with alcohol and drug services.	8.33% 1	41.67% 5	16.67% 2	33.33% 4	0.00% 0
Our service provides good information about mental health problems, including other sources of help available.	0.00% 0	33.33% 4	25.00% 3	41.67% 5	0.00% 0
Our service provides good information about alcohol/drug problems, including other sources of help available.	8.33% 1	41.67% 5	25.00% 3	25.00% 3	0.00% 0

In our service, we give equal weighting to the management of alcohol/drug and mental health problems.	8.33% 1	41.67% 5	8.33% 1	41.67% 5	0.00% 0
I am confident working with people with mental health problems, including those in crisis.	0.00% 0	33.33% 4	16.67% 2	33.33% 4	16.67% 2
I am competent working with people with mental health problems, including those in crisis.	0.00% 0	33.33% 4	8.33% 1	41.67% 5	16.67% 2
I am confident working with people with alcohol and drug problems.	0.00% 0	33.33% 4	25.00% 3	33.33% 4	8.33% 1
I am competent working with people with alcohol and drug problems.	0.00% 0	33.33% 4	25.00% 3	33.33% 4	8.33% 1
I am confident in addressing issues such as self-harm, suicidal thinking and attempted suicide.	8.33% 1	41.67% 5	16.67% 2	25.00% 3	8.33% 1
I am competent in addressing issues such as self-harm, suicidal thinking and attempted suicide.	8.33% 1	41.67% 5	8.33% 1	33.33% 4	8.33% 1

There are some statements that respondents strongly **disagree** with. These are:

'Our service undertakes comprehensive mental health assessments.' (Strongly disagree= 25%, n=3, disagree= 58.33%, n=7).

'Our service undertakes comprehensive alcohol and drug assessments.' (Strongly disagree= 25%, n=3, disagree= 58.33%, n=7).

Also worth noting are certain statements that indicate there was **mixed agreement** amongst respondents. These are:

*'Our service has effective working relationships with mental health services.' (*Strongly Agree=0.0%, n=0; agree=41.67%, n=5; don't know=8.33%, n=1; disagree=41.67%, n=5; strongly agree=8.33%, n=1).

*"In our service, we give equal weighting to the management of alcohol/drug and mental health problems." (*Strongly Agree=8.33%, n=1; agree=41.67%, n=5; don't know=8.33%, n=1; disagree=41.67%, n=5; strongly agree=0.0%, n=0).

*'I am confident working with people with mental health problems, including those in crisis.' (*Strongly Agree=0.0%, n=0; agree=33.33%, n=4; don't know=16.67%, n=2; disagree=33.33%, n=4; strongly agree=16.67%, n=2).

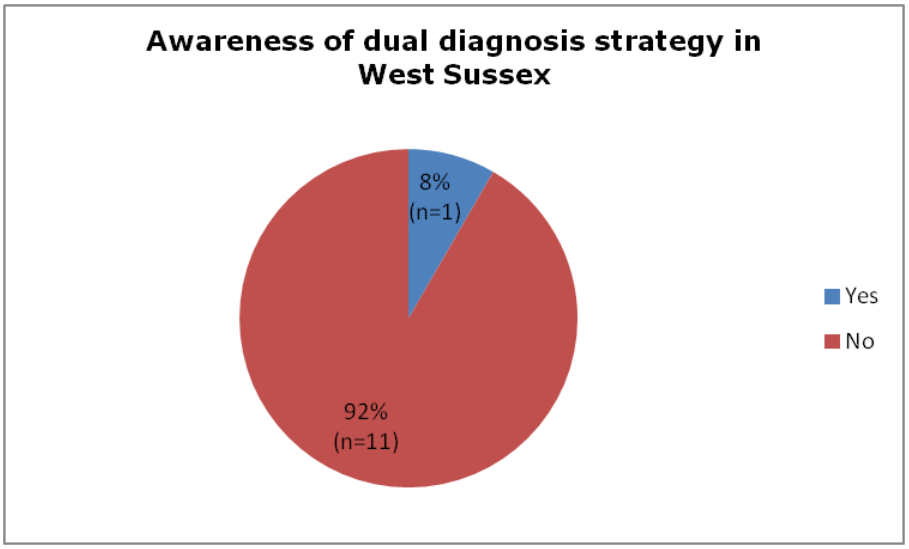
*'I am confident working with people with alcohol and drug problems.' (*Strongly Agree=0.0%, n=0; agree=33.33%, n=4; don't know=25.0%, n=3; disagree=33.33%, n=4; strongly agree=8.33%, n=1).

*'I am competent working with people with alcohol and drug problems'. (*Strongly Agree=0.0%, n=0; agree=33.33%, n=4; don't know=25.0%, n=3; disagree=33.33%, n=4; strongly agree=8.33%, n=1).

4.8.3 Awareness of dual diagnosis strategy in West Sussex

Over 90% (n=11) of respondents were not aware of the dual diagnosis strategy in West Sussex.

Figure 4.51: Breakdown of respondents' responses indicating awareness of dual diagnosis strategy.



4.8.4 Integration of generic services and other specialist services

Respondents were asked to describe the level of integration between their service (generic) and mental health services in West Sussex using Likert Scale scale:

1=Very Poor

2=Poor

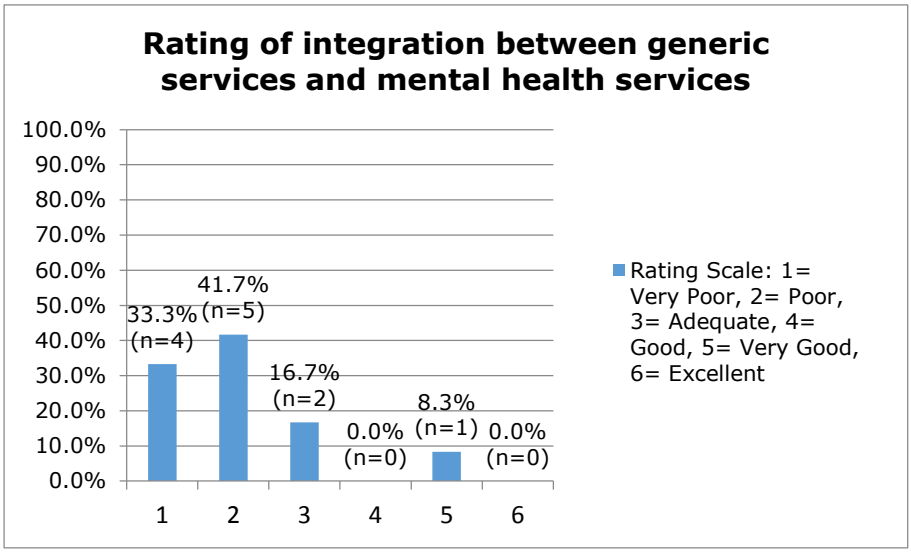
3=Adequate

4=Good

5=Very Good

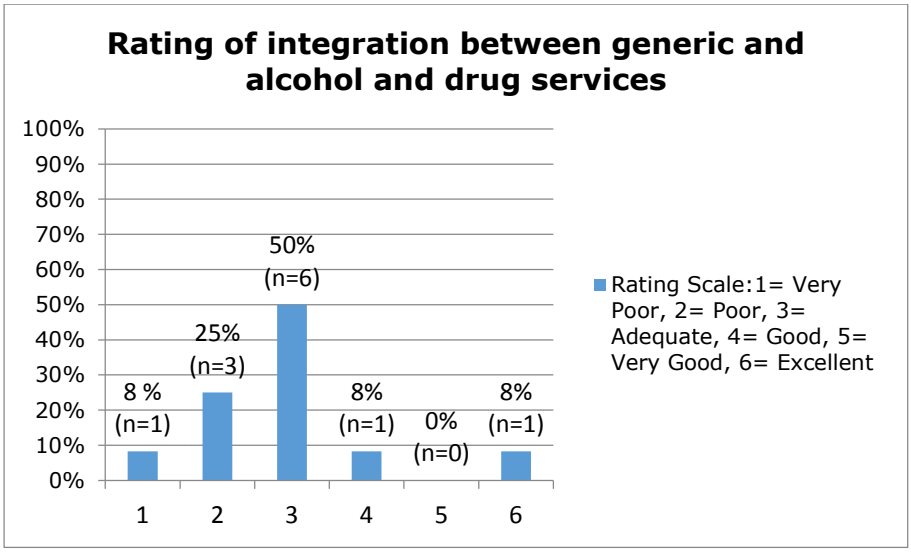
6=Excellent

Figure 4.52: Breakdown of respondents rating of integration between generic services and mental health services.



From the figure above it can be observed those respondents who completed the online survey stated that integration between generic service and mental health services were '*poor*' (41.7 %; n=5). Only 1(8.3%) respondent indicated that they felt that integration was '*good*'.

Figure 4.53: Breakdown of respondents rating of integration between generic services and mental health services.

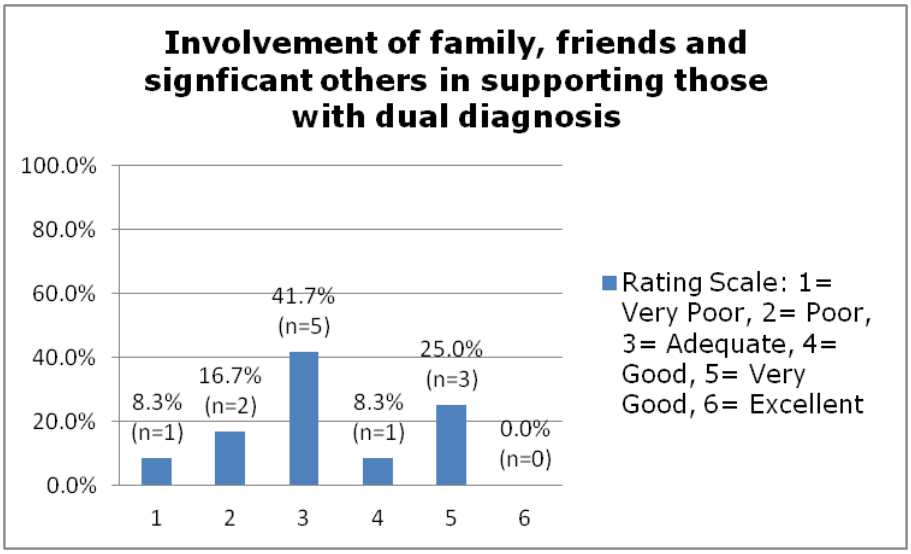


From the Figure above it can be observed those respondents who completed the online survey stated that integration between generic service and alcohol and drug services were '*adequate*''(41.7 %; n=5). Only 1(8.3%) respondent indicated that they felt that integration was '*excellent*'.

4.8.5 Family involvement in services

Overall, respondents indicated that family, friends and significant others had '*adequate*' involvement in supporting those with dual diagnosis (41.7%; n=5). 3 respondents (25%) felt that involvement of family, friends and significant other by services was '*very good*'.

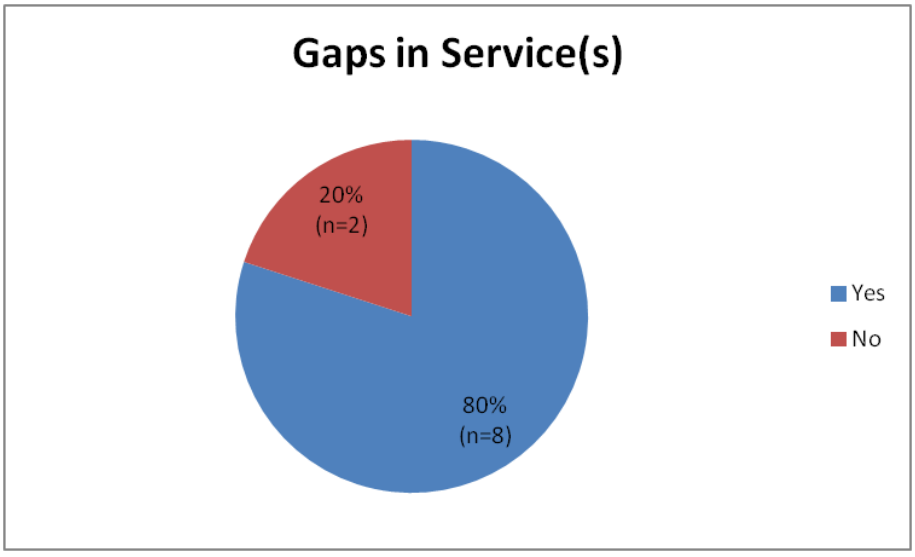
Figure 4.54: Breakdown of respondents rating of involvement of family/carers and significant other in supporting those with a dual diagnosis.



4.8.6 Gaps in services

Respondents were asked if there were any gaps in services with people with co-occurring mental health and alcohol/drug problems in West Sussex. 80% of those who complete this section in the survey indicated there was.

Figure 4.55: Numbers of respondents who indicated there was/was not gaps in services.



Respondents who stated that there were gaps in services for those with a dual diagnosis were asked to provide commentary. Their comments are presented below:

> *"Adult mental health, Linwood in Mid Sussex have not returned any of my calls 8 for 1 family alone!!! I felt very let down and frustrated because I had not clarification what the parent was actually diagnosed with and if our family plans were doing able or if I was setting the parent and the family up to fail."*

"No clear pathway. Clients "ping ponging" between services due to arguments about which need has to be addressed first."

"I have worked some cases where the different disciplines work well together but have also experienced a lack of sharing of information and thus difficulties in working together for the service to people."

"No clear access to advice for professionals as to the services available, poor multi agency workings."

"Do not have any direct need for this with the cases I hold at present but have for a number of years worked in this field. A combined service to address both areas as one and a service to support the family particularly the children in coming to terms/understanding this complex area is essential. Certainly a service that supports 9-16 yr olds with the impact of MH/substances misuse is not available."

4.8.7 Future directions and improvements.

Respondents were also asked to rate 5 statements in order of importance on a scale of:

1=most important and;

5=least important.

Their answers are displayed in the table below:

Table 4.56: Respondents rating of 4 statements in order of importance

	1	2	3	4	5
New specialist dual diagnosis service (West Sussex wide)	40.00% 4	20.00% 2	0.00% 0	10.00% 1	30.00% 3
Improved integration of alcohol and drug and mental health services	40.00% 4	30.00% 3	10.00% 1	20.00% 2	0.00% 0
Improved integration of non-specialist services and specialist services	0.00% 0	30.00% 3	20.00% 2	30.00% 3	20.00% 2
Increased capacity of alcohol and drug and mental health services	20.00% 2	20.00% 2	30.00% 3	10.00% 1	20.00% 2
Enhanced quality of alcohol and drug and mental health services	0.00% 0	0.00% 0	40.00% 4	30.00% 3	30.00% 3

There are two statements that respondents rated as most important. Firstly, 40% (n=4) of respondents indicated that a '*New specialist dual diagnosis service (West Sussex wide)*. The second statement that respondents rated as most important is '*Improved integration of mental health and alcohol and drugs services*' (40%; n=4).

Respondents were asked what the one thing they would change to improve the management of co-occurring alcohol/drug and mental health problems. Their comments are below:

"Nothing with my actual service, it is inclusive and allows us to co-work with specialist in other fields and has even invested in specialist into our team."

"Better integration with mental health/substance misuse."

"Better communication."

"More joined up working."

"Training."

"Bring into our team a mental health worker as a consultant."

"Have it as a key area for referral as it has the most significant impact on the three main areas of referral i.e. ASB, education and workless-ness."

"Direct referral point for all."

4.8.8 Training needs of alcohol and drug staff

Respondents were asked if they had any specific training needs to be able to work more effectively with those with co-occurring alcohol/drug and mental health problems. Their comments are below:

"I continue to train to improve my knowledge in this area."

"To be able to identify and signpost effectively and know who to signpost to and that those services are accessible."

"To have a greater understanding of the different types of mental health issues, the impact it has on them and their families and the most effective way of supporting them and the work of the specialist services."

"Alcohol drug and mental health training needed."

"Any training would be beneficial."

"Greater understanding of the present thinking & exploring the link of dual MH and alcohol /drug."

"Yes, basic understanding of mental health problems and support available."

CHAPTER 5: FEEDBACK FROM QUALITATIVE METHODS

5.1 Introduction

This chapter outlines key findings from the qualitative methods of the study; in particular from interviews using semi structured questionnaires (n=9); meetings (n=5) and a service user focus group (n=1). The study's seminars (n=4) and working groups (n=4) focused primarily on identifying priorities concerning improving the management of dual diagnosis in West Sussex. Recommendations outlined in **Chapter 6** are the outputs of such endeavour and focus, although this chapter highlights a flavour of the key matters expressed during the seminars and working groups. An example of this pertains to linked services, particularly employability and homelessness which featured prominently in issue-related discussions. By their own volition, two providers, Impact Initiatives (employability) and Worthing Churches Homeless Projects (homelessness) submitted papers on these important subjects which are summarised in **5.6.1** (employability) and **5.6.2** (homelessness) below. Their full reports are outlined at **Appendix III** and **Appendix IV**.

5.2 Views on Current Drug and Alcohol and Mental Health Services in West Sussex

5.2.1 How are co-occurring substance misuse and mental health disorders currently managed in West Sussex?

The general consensus of the majority of informants involved in this study is that the current management of co-occurring substance misuse and mental health disorders in West Sussex is not fit for purpose. A selection of words and phrases used by informants to describe the current arrangements include:

- inconsistent/sporadic;
- unclear/unknown;
- haphazard;
- ineffective/futile;
- unsuccessful/failing/useless;
- non-integrated;
- not realising its potential; and
- lacking value.

Other issues concerned a one size fits all model and related practice, funding constraints within both the statutory and third sector and lack training options and opportunities. The few positive comments centred on good relationships and communications between/among services; particularly mental health and substance misuse services; and substance misuse services and linked services, especially homelessness and criminal justice services.

5.2.2 The commissioning structure for people with dual diagnosis in West Sussex

Clinical Commissioning Groups (CCGs)

From 1 April 2013, there have been significant changes to the structure of the NHS in England. There are now a number of organisations, known as Clinical Commissioning Groups (CCGs) which have specific roles. A clinical commissioning group is a new NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. As commissioners of local health services, a CCG is responsible for planning the right services to meet the needs of local people, buying local health services including community health care and hospital services; and checking that the services are delivering the best possible care and treatment for those who need them.

A CCG has to work within a local budget from the NHS for local health services and work closely with other NHS colleagues and local authorities to ensure local people are receiving the best possible care.

CCGs are responsible for commissioning (planning, buying and monitoring):

- The care and treatment people may need in hospital and community health services including district nurses, physiotherapy and other therapies;
- The medicines people may be prescribed;
- Mental health services; and
- Support and services for people living with learning disabilities.

CCGs are not responsible for primary care, which includes GP practices, dentists and opticians. These areas are now commissioned by new area teams of NHS England – see below.

1. *NHS Coastal West Sussex CCG*

   In West Sussex there are three clinical commissioning groups following the changes to the NHS on 1 April 2013: NHS Coastal West Sussex CCG, NHS Crawley CCG and NHS Horsham and Mid Sussex CCG.

   NHS Coastal West Sussex CCG is led by local doctors and health professionals and covers six localities in West Sussex (Adur, Arun, Chanctonbury, Chichester, Regis and Worthing).

   The CCG is made up of the 54 GP practices in the area and is responsible for commissioning local health services for more than 482,100 people. The leadership team is made up of local doctors, hospital consultants and nurses who work alongside a local management team to ensure local services are providing the best possible care for local people.

2. *NHS Crawley CCG*

   NHS Crawley Clinical Commissioning Group (CCG) is led by local doctors and health professionals and covers Crawley and the surrounding area. The CCG is made up of 13 GP

practices in the area and is responsible for the health and wellbeing of more than 120,000 people. The leadership team is made up of local doctors, hospital consultants and nurses who work alongside a local management team to ensure local services are providing the best possible care for local people.

3. *NHS Horsham and Mid Sussex CCG*

NHS Horsham and Mid Sussex Clinical Commissioning Group (CCG) is led by local doctors and health professionals and covers four localities in West Sussex (Burgess Hill, East Grinstead, Haywards Heath, Horsham and the surrounding areas).

The CCG is made up of the 23 GP practices in the area and is responsible for the health and wellbeing of more than 225,000 people. The leadership team is made up of local doctors, hospital consultants and nurses who work alongside a local management team to ensure local services are providing the best possible care for local people.

NHS England

NHS England is a new, national organisation which has an 'area team' covering Surrey and Sussex. Their role is to deliver the Department of Health's ambitions for the NHS by working with commissioners and providers of services across the country. They will also directly commission:

- GP practices;
- Dentists;
- Pharmacists;
- Optometrists; and
- Specialised services such as HIV care or heart transplants

Local Authorities

Under the changes, West Sussex County Council has become responsible for commissioning public health services. These are services which help people live healthier lives and help prevent ill health. There are a wide range of these but examples include:

- Heath improvement work such as stop smoking services or weight management services;
- School nursing;
- Sexual health services; and
- Drug and Alcohol Support services.

In West Sussex there is one unitary authority, West Sussex County Council which is responsible for commissioning and providing social care. There are also district and borough councils which are

work closely with NHS and other partners to promote health and wellbeing services in their local areas:

- Adur and Worthing Councils;
- Arun District Council;
- Chichester District Council; and
- Horsham District Council.

Public Health England

Public Health England is a national body and works closely with local authorities' public health teams, carrying out a range of activities to protect and improve the health of everyone living in the country. Their work includes:

- Coordinating work to combat infectious diseases such as flu;
- Coordinating work to combat infections acquired in hospitals such as MRSA;
- Deliver national publicity campaigns to prevent ill health; and
- National websites such as NHS Choices (www.nhs.uk) will continue to provide a range of information about all health services and common health conditions.

NHS partners in and around West Sussex

To make sure there are the right services in place for the people in and around West Sussex, a range of local NHS providers, including local hospitals and community services are in place. These include:

- Sussex Partnership NHS Foundation Trust (which provides mental health care, support and treatment across Sussex);
- Sussex Community NHS Trust (which provides community services across West Sussex and Brighton and Hove;
- Western Sussex Hospitals NHS Trust (which provides hospital services at St Richard's Hospital in Chichester, Worthing Hospital and Southlands Hospital in Shoreham-by-Sea); and
- South East Coast Ambulance Service NHS Foundation Trust (which provides the ambulance service across Sussex, Surrey and Kent).

West Sussex Drug and Alcohol Action Team (DAAT)

The DAAT:

- Commissions services to provide a range of drug and alcohol treatment to adults and young people in West Sussex;
- Promotes a culture where recovery is the aspiration at the outset of treatment;

- Works with relevant agencies, covering issues such as housing, employment, public health, recovery and criminal justice; and
- Works with customers to promote the development of recovery communities.

5.2.3 The range of services available for individuals with dual diagnosis in West Sussex

Specialist dual diagnosis services operating in West Sussex

There are no specialist dual diagnosis services in West Sussex. However, Worthing Churches Homeless Projects (WCHP) employ a Dual Diagnosis worker who works across all WCHP services in West Sussex including their specialist alcohol and drug recovery service. Sussex Partnership NHS Foundation Trust formerly employed a dual diagnosis specialist who was a qualified mental health nurse with relevant additional substance misuse training. However, this Nurse Consultant (Dual Diagnosis) post has been vacant since December 2013; and it is unclear whether the post will be replaced in the future. Generally, there is a paucity of specialist dual diagnosis professionals in both West Sussex and the country as a whole. As context, England only has approximately 11 Nurse Consultant (Dual Diagnosis) posts.

Specialist alcohol and drug services operating in West Sussex

The following alphabetically sequenced services, which operate in West Sussex, can be classified as specialist alcohol and drug services:

1. *Addaction: Integrated Drug and Alcohol Service*

Addaction, a UK charity, delivers a wide range of services and interventions, as illustrated in the table below:

Clinical	Psycho-Social	Recovery Support
Ind. Healthcare Provider	PSI Framework	Mutual Aid Programme
Recovery In Shared Care	Non-Opiate Engagement	Resilience Programme
Recovery Framework	Age Specific Services	Aspire
BBV Peer Education	Teens & Toddlers	Recovery Champions
Early Years & Pregnancy	YP Core Offer	Recovery Coaches
Hepatitis C Interventions	Veterans	Social Enterprise
Needle & Syringe Programme	Residential Rehabilitation	Street Drinking
Hospital Liaison	Offending Behaviour Programme	

Up until May 2014, Addaction, in collaboration with Crime Reduction Initiatives (CRI), delivered a West Sussex wide, recovery-focused integrated drug and alcohol service. The service offered:

- Open access;
- Needle and syringe programme;
- Substitute prescribing;
- Medically assisted recovery; and
- Structured psychosocial treatment provision.

Following a competitive public procurement tendering process, the collaboration between Addaction and CRI was replaced by a collaboration between CRI and Central and North West London NHS Foundation (CNWL) Trust in May 2014.

2. *Carers Support West Sussex: Families & Friends Network*

Carers Support West Sussex, a local charity provides a regional wide Families & Friends Network which supports anyone affected by someone else's drinking or drug use. Individuals receive free information, advice and support. The network provides:

- information about drugs and alcohol;
- local drop-in services and support groups;
- individual appointments, at a time and place that suit you; and
- quarterly newsletter.

3. *Central and North West London NHS Foundation: Integrated Drug and Alcohol Service*

Central and North West London NHS Foundation (CNWL), in collaboration with CRI, deliver an integrated drug and alcohol treatment and recovery service across all five areas of West Sussex (Bognor Regis, Burgess Hill, Chichester, Crawley and Worthing). Services are Care Quality Commission registered and provide a range of specialist substance misuse interventions for individuals and families affected by alcohol/drug misuse. The service comprises of multi-disciplinary teams which include consultant addiction psychiatrists; clinical psychologists; nurses; non-medical prescribers; peer support workers and 'experts by experience' recovery staff. The service works in partnership with local voluntary sector substance misuse services and mutual aid organisations including Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and SMART recovery. The service treats all kinds of substance misuse problems and specialises in providing treatment for those with severe

dependency or complex needs. The service provides assessment and personalised care planned treatment and recovery packages. The service provides:

- Alcohol treatment, including community detoxification and psychosocial support to either control drinking or maintain abstinence;
- Heroin treatment (medication assisted recovery on oral or injectable substitute prescribing and recovery support OR detoxification and recovery support);
- Stimulant treatment (crack, cocaine, methamphetamine, etc.);
- Cannabis treatment;
- 'Club Drugs' and 'legal highs' treatment;
- Blood-borne virus testing and treatment;
- Needle exchange schemes; and
- Carer and family support including couples and family therapy.

The service also works closely with other professionals, providing:

- A&E and acute hospital liaison;
- Joint care planning and co-ordination of care;
- Drug testing and treatment in custody suites and probation; and
- Training in substance misuse, particularly complex needs and 'club drugs'.

4. *CRI: CARAT service (HMP Ford)*

CRI, a national charity, works in collaboration with HMP Ford (HM Prison Service), based in Arundel, West Sussex. The CARAT service aims to identify and support all offenders coming into HMP Ford who have problems with substance use. The service encourages such individuals to abstain or reduce their drinking/drug taking to reduce harm to themselves, other individuals and wider society. Working closely with other key teams within the prison such as Drug Intervention Programmes team, the service offers psychosocial interventions to provide an holistic approach to support planning. Interventions offered include:

- 1-1 key work; and
- Group work (covering topics such as drug and alcohol awareness, relapse prevention, harm minimisation, overdose aid, blood borne viruses, healthy living skills and relaxation).

The purposes of interventions are:

- To support and encourage service users to increase awareness of the effect of drug use;
- To reduce the risk of harm to self and others;
- Identify potential change;

- Identify high risk situations and developed coping strategies;
- Improve physical and mental well-being; and
- Motivate, engage and retain clients in treatment.

5. *CRI: Counselling Service*

CRI provide a West Sussex wide counselling service. At the time of the study fieldwork, this service appears to be coming to an end as a discrete service. However, it is possible that counselling will become a part of the integrated drug and alcohol service.

6. *CRI: Integrated Drug and Alcohol Service*

CRI, a national charity, in collaboration with CNWL (NB: previously Addaction to May 2014), deliver a countywide, recovery-focused, integrated drug and alcohol service across West Sussex. A key aim of the service is to offer a safe, drug free environment to anyone affected by drugs or alcohol. From initial triage assessment, service users can decide on the level of support they require, from needle exchange to structured daily groups or referral to other appropriate agencies. The service covers offers:

- Open access;
- Substitute prescribing;
- Medically assisted recovery;
- Structured psychosocial treatment;
- Needle and syringe programme;
- Assessment;
- Referral;
- Structured day programme;
- Drug Rehabilitation Requirement;
- Auricular acupuncture;
- One-to-one support;
- Health awareness;
- Life skills;
- Employment/training/education;
- Structured and therapeutic group activities;
- Evening relapse management programme; and
- Drug advice information service.

The CNWL element of the integrated service focuses primarily on medically assisted recovery through substitute prescribing, whilst CRI predominately provides structured psychosocial interventions.

7. *CRI: Mid Sussex Alcohol Project*

CRI delivers a confidential outreach service providing advice and information to young people aged 11-25 on the risks associated with the misuse of alcohol. The service offers:

- Advice and information to young people on the harm & risks associated with the misuse of alcohol;
- Advice and information to young people affected by a parent or carer's alcohol misuse;
- Education and information sessions to young people, adults and professionals;
- Referral into specialist services; and
- Alcohol awareness.

8. *CRI: Young Persons Substance Misuse Service*

CRI provide a countywide outreach Young People's Substance Misuse Service in West Sussex. The service offers free, flexible and confidential treatment and support for young people aged 18 and under, who have complex drug and alcohol issues. Treatment is provided mainly at Tier 3 (specialist) level, with clinical and medical support provided to the team through CNWL (as required). The service addresses all aspects of the young person's life and supports the Every Child Matters five outcomes. The service works in partnership with a range of Tier 2 substance use services across the county. The service provides:

- Holistic assessment;
- 1-1 care planned support/intervention;
- Structured outreach appointment;
- Prescribing or meeting other clinical need;
- Drop-ins in schools, colleges and other young people service;
- Relapse prevention and harm reduction support;
- Specific targeted activity & education with vulnerable groups;
- Professional and community support;
- Advocacy;
- Chlamydia screening;
- Sexual health support;

- Needle exchange;
- Service user involvement; and
- Partnership working.

9. *Needle & Syringe Programmes*

Needle and syringe programmes, often referred to as needle exchanges, are completely confidential and widespread throughout West Sussex. They supply a variety of different sized needles and syringes and other items, as well as providing safe disposal of used equipment. Traditionally used by drug users, needle exchanges also cater for people using performance or image-enhancing drugs such as anabolic steroids and growth hormones. Pharmacies tend to provide pre-prepared packs of needles, while agencies have loose equipment to be chosen from as well as information and advice on safer injecting techniques. All provide suitable 'sharps bins' for safe storage. Needle exchanges can be found at many pharmacies and agencies across West Sussex displaying the logo to the left. No registration is required: individuals can simply turn up and ask for what they need.

10. *Ravenscourt Trust: Residential Detoxification & Rehabilitation Service*

Ravenscourt Trust, a local Bognor Regis based charity, provides a residential detoxification and rehabilitation service for people with alcohol and/or drug addiction. The service has a capacity of 17 beds and caters for both males and females from anywhere including West Sussex. The service is abstinence-based and derives from the Twelve Step Facilitation model. The service can be linked to secondary stage support including Ravenscourt Trust's Structured Day Service move on accommodation via other service providers. The duration of the programme is flexible, although 3-6 months residencies in the primary stage are commonplace.

11. *Ravenscourt Trust: Structured Day Service*

In addition to its 17-bed residential detoxification and rehabilitation service, Ravenscourt Trust, also provides a Bognor Regis based Structure Day Service for people with alcohol and/or drug problems. The service aims to work with up to 48 people per annum from within West Sussex. The service is abstinence-based and derives from the Twelve Step Facilitation model. The service can be linked to primary stage detoxification/rehabilitation in Ravenscourt Trust's residential service. The duration of the programme is flexible, although 3-month engagements are commonplace.

12. *Stonepillow: Sands Recovery Service*

Stonepillow, a local charity, provides a 12-bed residential rehabilitation service known as 'Sands' for people aged 18 and over with drug and/or alcohol problems, based in Bognor Regis. The service targets people who are abstinent from substances and require stabilisation, as well those who have completed a rehabilitation programme who require secondary support. 'Sands' also provides support to people with co-occurring mental health problems. Typical 'Sands' residents may include:

- People who have completed a residential rehabilitation programme and have requested a 2nd stage programme;
- People needing ongoing therapeutic support post-detoxification;
- People needing access to education/employment/training; and
- People requiring general housing and support.

'Sands' also provides outreach support for a number of individuals. 'Sands' residents can volunteer at Stonepillow's Restore project, where they learn practical skills restoring furniture and electrical goods, as well as administration skills. Upon discharge from 'Sands', an individual can continue their recovery journey by being housed in Stonepillow's move-on accommodation. This provides individuals with supported housing, as well as continued access to vital tools to sustain recovery. Specialists, including Stonepillow's Substance Misuse Strategy Coordinator, maintain contact with such residents and support them with maintaining abstinence, as well as their long-term goals such as health, employment, family and community and independent living. 'Sands' has introduced peer mentoring as an aid to recovery, enabling those who have completed the service to encourage and support others at an earlier stage of their own recovery.

13. *Stonepillow: ASURA*

ASURA stands for 'Abstinence Service User Recovery Assistant'. It is the peer-led part of Stonepillow's abstinence-based recovery service. As a provider of accommodation and community recovery services, Stonepillow recognises the expertise and importance of working alongside current and past service users, known as ASURA Recovery Champions. ASURA provides:

- Workshops and drop-ins for people with alcohol/drug problems;
- Structured group work in abstinence based services;
- 1-1 support and mentoring;
- Co-facilitating community training; and
- Co-authoring policies; and procedures and reviewing strategy.

14. *Worthing Churches Homeless Projects: Recovery Service*

Worthing Churches Homeless Projects' (WCHP) residential recovery service is based in Worthing. The service was established to work with people seeking recovery from alcohol/drug problems; and access is via an assessment at WCHP's St Clare's, Day Centre. Through an in depth programme, residents explore and reflect upon possibilities of change. Many are in need of medical help and re-building shattered lives; and the service as be seen as a place of hope, as well as refuge. When individuals move in to the service, they undertake stabilisation which supports their recovery goal setting including whether or not abstinence is desirable. Residents can remain at the service for up to 2 years whilst they learn to manage their lives. Whilst resident in Stage 1 (20 beds), individuals have individually tailored 1-1 support. Upon successful completion, residents can move to Stage 2 (5 beds), where they live independently but continual support is at close hand close, if required.

Specialist mental health services operating in West Sussex

The following alphabetically sequenced services, which operate in West Sussex, can be classified as specialist mental health services:

1. *Coastal West Sussex Mind*

Coastal West Sussex Mind aims to promote mental health and wellbeing throughout Shoreham, Worthing, Littlehampton, Bognor Regis, Chichester, Bognor Regis, Midhurst and surrounding areas. Originally formed of two organisations – Chichester Mind and Worthing & Arun Mind – they have been providing services and support across the Coastal West Sussex area for over 40 years. The services directly support over 700 people annually. In May 2013, the boards of trustees of the two organisations decided that they could become more effective by joining together to create a single organisation. The process of the merger is now complete and a new organisation called Coastal West Sussex Mind has been set up. Coastal West Sussex Mind is affiliated to National Mind but financially and operationally independent.

2. *Combat Stress Helpline (0800 138 1619)*

The Combat Stress Helpline is a new and innovative service operated by Rethink Mental Illness in partnership with Combat Street. The service is for veterans, their families and friends. The helpline is open 24/7 and provides emotional support, a listening ear, signposting service and a range of information to people of all ages. The helpline is available to people throughout England, Scotland, Wales and Northern Ireland, and is accessed by a national freephone number. The helpline is delivered in partnership between Rethink, Combat Stress UK and The Department of Health.

3. *Frame of Mind*

Frame of Mind is a local community interest company which provides vocational training and wellbeing places for local adults with Mental Health Issues, Learning Disabilities and Dementia. Part of the Frame of Mind service is delivered in partnership with Sussex Learning Solutions which enables people to access adult numeracy, customer care, literacy and IT courses.

4. *MindOut*

MindOut is a mental health service run by and for lesbians, gay men, bisexual and transgender (LGB&T) people. Based in Brighton and Hove, the organisation provides local services as well as a number of national initiatives. Services include:

- advice;
- information;
- advocacy;
- peer support;
- wellbeing activities;
- events;
- food & allotment project;
- bespoke training in LGB&T Affirmative Practice for mental health and substance misuse service providers;
- mental health promotion; and
- anti-stigma campaigns to improve the mental health of people and communities.

MindOut delivers a range of LGB&T wellbeing courses, activities and events in West Sussex. The aim is to provide useful ideas for LGB&T people to live well and learn and share ideas about ways to improve and maintain good wellbeing and mental health. Courses delivered include:

- Mindfulness Meditation;
- Self-esteem; and
- Challenging stigma.

5. *Rethink Mental Illness: Advocacy Service*

Rethink Mental Illness provides an advocacy service in West Sussex. The service provides a Mental Health Advocate worker at the Dene Hospital secure unit for women in Burgess Hill, West Sussex. The service aims to empower and encourage, as far as practicable, those who use the service to take a lead in securing the rights and services to which they are entitled. This is central to Rethink's core emphasis on hope and recovery for all. The advocacy service is designed to help safeguard the rights of those who use the service in regard to mental health policy and law, and as citizens. The service provides support to ensure views are heard, represents people and helps to resolve issues and protect them if they are particularly vulnerable or are unable to make informed decisions.

6. *Richmond Fellowship*

Richmond Fellowship, a national charity, works towards a society that values everyone with mental health problems and aims to make recovery a reality. The philosophy is that each person is unique, and should have the opportunity to take control over his or her life; and to develop new meanings and purposes. The approach concentrates on the person and his or her individual needs, choices and aspirations, rather than on diagnostic categories or labels. Services enable people to actively take part in decisions about their support and have as much control over this support as possible, helping them achieve new levels of self-confidence and independence. Services include:

- Residential: care homes and 24hr hour supported housing schemes provide round the clock support for individuals, often as a step down from a stay in hospital or as an alternative to being admitted to hospital.
- Supported living: accommodation as a registered social landlord with staff available to help people develop their independent living skills while our floating support workers provide similar help in people's own homes.
- Community-based: support on a group or individual basis to help individual's access social networks and peer support, and engage in everyday mainstream opportunities.
- Employment: support people who are recovering from mental health problems return to paid employment, voluntary work or training and help employees with mental health problems, including stress, anxiety and depression, to stay in work.

7. *Samaritans (08457 909090)*

Every six seconds, somebody contacts the Samaritans, a UK charity via its national helpline number for help with distress. The service operates 24 hours a day, 365 days a year. The organisation has over 200 branches across the UK and Republic of Ireland. Since 1984, Samaritans has received over 68 million contacts in which people felt able to speak, type or write. The Samaritans has over

20,000 volunteers to support its general work including outreach and public awareness. 648 branch volunteers support the Listener scheme in prisons.

8. *The Capital Project Trust*

CAPITAL stands for 'Clients And Professionals In Training and Learning'. The CAPITAL Project Trust is a local West Sussex charity promoting empowerment, peer support and mental health service user involvement. The organisation exists to improve the lives of people experiencing mental and emotional distress. It is a service-user led organisation working to empower people in West Sussex with experience of mental distress to have a voice in how mental health services can be improved. CAPITAL members work as experts by experience, becoming involved in training, research, evaluation and consultation. The charity offers bespoke training to mental health professionals, service-users and other members of the community as well as contributing to mental health modules taught at local universities and colleges. Services include:

- peer led training to improve understanding of mental health issues and how services work, as well as building confidence and assertiveness skills, including training for trainers and meeting skill;
- monthly meeting in three localities across West Sussex (Adur, Arun and Worthing, Northern and Western);
- quarterly members' meetings in Billingshurst;
- volunteering opportunities;
- weekly drop-in at Capital's offices;
- group advocacy and mutual peer support; and
- social events.

9. *Sussex Community NHS Trust: 'TimeToTalk' and Proactive Care*

Sussex Community NHS Trust

Sussex Community NHS Trust is the main provider of NHS community health services across West Sussex (Brighton & Hove in East Sussex). The trust provides a wide range of medical, nursing and therapeutic care to over 8,000 people a day. The organisation helps people plan, manage and adapt to changes in their health, to prevent avoidable admission to hospital and to minimise hospital stay. The Trust provides Proactive Care as a better way to support people with complex health and care needs and their carers. The aim of Proactive Care is to help people stay as healthy as possible, and to live independently in the community for as long as possible. Older people and people with long-term health problems too often find that the health and care support they need is fragmented or difficult to use. The Trust and partners provide health and care services to support but also encourage people to look after themselves more effectively; for example with better exercise and diet, or by taking any medication properly.

Proactive Care is delivered through integrated, multi-disciplinary teams; usually based in the same location. The team will deliver proactive care to wherever the individual is: in their own home, in a care home and in hospital. The team is made up of health and care workers from areas such as:

- community nursing;
- adult social care;
- occupational therapy;
- physiotherapy;
- mental health;
- prevention assessment service; and
- pharmacists and pharmacy technicians.

The Trust is also coordinating its services with other organisations including:

- West Sussex County Council;
- Sussex Partnership Foundation NHS Trust; and
- Western Sussex Hospitals NHS Trust.

The Trust provides a 'TimeToTalk' service which is a talking therapy. 'TimeToTalk' is a friendly and approachable service offering talking therapies to people who are struggling with:

- stress, worry and general anxiety
- depression
- panic attacks
- agoraphobia
- phobias
- social anxiety
- Obsessive Compulsive Disorder (OCD)
- Post-Traumatic Stress Disorder (PTSD)
- health anxiety
- Post Natal Depression (PND)
- low self esteem
- low confidence
- relationship difficulties
- bereavement and reactions to loss

A team of trained and supervised, psychological therapists support individuals in GP surgeries and community venues. A range of talking therapy treatments are provided, in line with

national guidelines such as the national programme of Improving Access to Psychological Therapies (IAPT) and the National Institute of Clinical Excellence (NICE). Interventions include:

- Cognitive Behaviour Therapy;
- Inter Personal Therapy;
- Counselling;
- Mindfulness Based Cognitive Therapy;
- Guided Self Help;
- Eye Movement Desensitisation and Reprocessing (EMDR);
- employment support;
- signposting;
- courses and workshops; and
- books on prescription.

10. *Sussex Partnership NHS Foundation Trust: Community Mental Health Services*

Sussex Partnership NHS Foundation Trust works with partners in and beyond West Sussex to provide healthcare for people affected by mental health, learning disability, substance misuse and imprisonment. The trust started as Sussex Partnership NHS Trust in April 2006 and became a Foundation Trust with teaching status in 2008. The organisation provides a range of community based mental health services to people aged 18 and over with moderate to severe mental health issues. The service removes the age barrier at 65, providing a complete service for everyone aged over 18. Community services hubs are based at local Assessment and Treatment Centres (ATCs) throughout West Sussex:

- Adur Arun and Worthing: Liverpool Gardens, Worthing, is the main clinical site with appointments and referrals (and some clinical services) based at Swandean, Worthing. There are local clinics in Littlehampton and Shoreham.
- Chichester, Bognor and Midhurst: Chapel Street Clinic, Chichester, is the main site with local clinics at the Bedale Centre, Bognor Regis, and Midhust Cottage Hospital.
- Crawley, Horsham and Mid Sussex: New Park House, Horsham and Linwood Community Mental Health Centre, Haywards Heath are the main sites with local clinics in East Grinstead, Burgess Hill and Crawley.

The overall service focuses on recovery and supporting people to remain at home whilst receiving high quality care. Community teams bring mental health professionals together, including specialist nurses, psychologists, psychiatrists, therapists and other specialist clinicians. The service tailors individual treatment and care around assessed need, delivering high quality psychosocial interventions. The service aims to provide quick assessments, early treatment and clear care pathways for people with different conditions. People with the most

complex needs are offered enhanced support through a strengthened Care Programme Approach (CPA). Examples of complex needs are:

- Schizophrenia, schizoaffective disorder, manic episode and bipolar disorder;
- Complex depression, anxiety disorders including phobias, panic, OCD, PTSD, trauma and dissociative disorder, eating disorders and personality disorder;
- Co-existing conditions such as substance misuse problems, learning disabilities and physical disabilities; and
- Organic mental health problems, primarily dementia.

11. *Sussex Partnership NHS Foundation Trust: Adult Crisis and Inpatient Care*

Sussex Partnership NHS Foundation Trust's crisis team provides 24-hour support and treatment to people aged 18 and over within (and beyond) West Sussex who need extra intensive support. The crisis teams support people in their own homes which can prevent the need for a hospital admission. In some cases, more intensive or specialised clinical help is required. In such cases, the Trust's crisis team can arrange admission to one of the organisation's specialist hospital units for more intensive care and support. The standard is that everyone who clinically needs an inpatient bed will get one; and as close to home as possible. People referred to the crisis service will be seen within four hours. Teams based in Hospital A&E departments will see people within two hours. The inpatient services in West Sussex are:

- Meadowfield Hospital, Worthing;
- Oakland Centre for Acute Care, Chichester; and
- Langley Green Hospital, Crawley.

12. *Sussex Partnership NHS Foundation Trust: Sussex Mental Healthline (0300 500 0101)*

Sussex Partnership NHS Foundation Trust provides the Sussex Mental Healthline, a telephone service available to anyone concerned about their own mental health or that of a relative or friend experiencing mental health problems including stress, anxiety and depression. The service is also available to carers and healthcare professionals. The service is available Monday to Friday 5pm – 9am & 24 hours at weekends/bank holidays; and operates a no appointment system. Normal calls are limited to 20 minutes to allow maximum accessibility to the service, except in cases of extreme distress. The aims of the Sussex Mental Healthline are:

- to encourage callers to make choices about the way their own mental health needs may be met; and
- to provide immediate support for people experiencing distress.

The Healthline is important as clients, relatives, carers and other groups have all identified a personal need for access to information and support outside of working office hours. The Healthline is staffed by a team of dedicated and trained operators. Although the Healthline is not a counselling service, all operators listen and help callers to identify and clarify their immediate problems and to explore ways of coping or suggest alternative avenues of help. The Healthline offers comprehensive information on how to access mental health services. In addition it provides details about a wide range of support and voluntary organisations, both local and national. Operators will also send out information requested on various mental health issues including anxiety, depression, psychosis, stress, bipolar affective disorder, obsessive compulsive disorders, support groups, advocacy services and support groups and complaints procedures. Calls to the Sussex Mental Healthline are confidential. In circumstances where a caller has or is expressing an immediate intent to commit a serious criminal act, endanger themselves, others, or when a child is at risk, the Healthline will inform emergency services.

13. *Sussex Partnership NHS Foundation Trust: Recovery Orientated Community Kit*

Sussex Partnership Foundation NHS Trust has developed a Recovery Orientated Community Kit (ROCK). The ROCK is a toolkit designed to help people have more choice and control in all aspects of their life and their mental wellbeing recovery journey.

Generic services (linked to specialist alcohol and drug/mental health services) operating in West Sussex

The following alphabetically sequenced services, which operate in West Sussex, can be classified as generic services:

1. *Crawley Open House*

Crawley Open House provides support and services to anyone in need and suffering the effects of homelessness, unemployment, loneliness, discrimination, or other forms of social exclusion. Riverside House provides both a direct access hostel and a day centre for adults in need. The hostel has a 24-bed capacity and caters for homeless men and women; regardless of their issues, needs and history. Issues such as alcohol and substance misuse mental health problems, severe relationship breakdowns, recent release from hospital or prison are commonplace. Residents can stay for up to 28 days. A team of specialist workers are available during the day to offer further support to residents and day centre visitors. The Drop-in Day Centre can be accessed by anybody who needs help, advice or just the company of somebody who cares. Visitors to the day centre can access services that include:

- a health team working with mental health and substance misuse issues;
- an advice worker specialising in benefit advice;

- a resettlement team to explore housing options;
- workshops and classes;
- hot food and drinks;
- internet access; and
- empathy and kindness.

2. *Impact Initiatives*

Impact Initiatives is a Sussex charity which works with other charities, not-for-profit organisations and private and public funders to set up and manage projects and services that support local people of all ages. Impact Initiatives services are extremely varied and support children, families, young people, adults and older people. They are developed where a gap in existing services has been identified and help Sussex people live healthy and fulfilling lives. The aim of this is to provide high quality, flexible and personal support services for local people where and when they need it most. Services aim to give individuals and communities the support they need to improve their quality of life and feel a part of a wider community.

3. *Lifecentre*

Lifecentre specialises in counselling survivors of rape and sexual violation, whether this has been a recent incident or historical. The service is open to all male or female survivors, adults and Under18s, regardless of race, colour, nationality or ethnic origin, gender, disability, sexual orientation, educational status or religion. The service offers helpline support with separate telephone helpline services for Under18s and adults, an email and text helpline service for all age groups, run by appropriately trained volunteers. The service offers face to face counselling with professionally trained counsellors to survivors, adults or Under18s and to their supporters including close family members or friends, or partners of survivors affected relationally by sexual violation. This includes couples' counselling. Lifecentre works to promote public awareness of the issues which surround trauma-inducing life experiences, particularly those of sexual violation; and develops services which will encourage and empower survivors of such events to find a voice. The service promotes the physical, mental, social, cultural and spiritual well-being of its service users.

4. *NHS 111 Service*

NHS 111 is a new service to make it easier for people to access local NHS healthcare services in England. People can call 111 when they need medical help fast but it's not a 999 emergency. NHS 111 is a fast and easy way to get the right help, whatever the time. NHS 111 is available 24 hours a day, 365 days a year.

The NHS 111 service is staffed by a team of fully trained advisers, supported by experienced nurses and paramedics. They ask the caller questions to assess their symptoms, then give the person the healthcare advice they need or direct them straightaway to the local service that can help best. That could be A&E, an out-of-hours doctor, an urgent care centre or a walk-in centre, a community nurse, an emergency dentist or a late-opening chemist. Where possible, the NHS 111 team will book an appointment or transfer the caller directly to the relevant people. If NHS 111 advisers think the caller needs an ambulance, they will immediately arrange for one to be sent.

5. *Stonepillow Other Services*

Stonepillow offers shelter, information and support to empower homeless and vulnerable people to make positive changes in their lives. The aim is to create a safer environment that promotes social inclusion with practical assistance and without prejudice.

6. *United Response*

United Response is a national charity. The organisation now supports people with learning disabilities, mental health needs and physical disabilities to take control of their lives. The charity believes that people with disabilities are equal participants in society and should have the same rights and opportunities as everyone else. As well as providing support, the charity runs campaigns on the latest social care issues, organises fundraising schemes and events, and provides guidance and information via its website, as well as through various publications. Services provided depend on each person United Response works with. Services may include:

- 24-hour support for people with complex needs;
- job coaching;
- outreach support for someone with a mental health need; and
- work with people to be in control of the support they choose.

7. *West Sussex County Council: Social Work Services (Adult)*

West Sussex County Council, in particular its Social Work (Adults) department, works closely with the NHS, voluntary and community sectors to support people with mental health difficulties. The council ensures that people experiencing a mental health crisis get professional assessment, care and treatment quickly. The council also supports and works closely with West Sussex Wellbeing, details of which are outlined below. The council employs Approved Mental Health Professionals (AMHPs). This service operates 24/7. These staff have been specially trained and are authorised to carry out Mental Health Act assessments for people in crisis, on the council's behalf. Their ongoing

training and support is overseen by a governance panel operated by the council. AMHPs work closely with medical practitioners and partner agencies to find the best solutions for customers and carers. Sometimes this may require an admission to a mental health hospital for further assessment and care. Most AMHPs have a professional background in social work, but they may also be qualified nurses, occupational therapists or psychologists who have undertaken specialist Mental Health Act training.

8. *West Sussex County Council: Social Work Services (Children & Young People)*

West Sussex County Council, in particular via its Social Work (Children & Young People) department supports children and young people with and affected by mental health issues in conjunction with NHS, voluntary and community sector partners. The council employs Approved Mental Health Professionals (AMHPs) – see section immediately above. In addition to providing direct support to children and young people, the council has published guidance on its website for professionals and other stakeholders in West Sussex who are supporting, or have concerns for, a child or young person's emotional wellbeing. Its purpose is to help support those caring for and supporting children and young people and to promote good outcomes. The key areas covered in the guidance are:

- Responsibility: everyone who works with children or young people has a role to play in supporting their mental wellbeing. What this means in practice will depend on someone's job.
- Further help: most children grow up coping with emotional strains and distress with the support of their family, friends and sometimes school staff. If someone is working with a child who needs more help there are several places to go to get advice.
- Specialist services: the needs of children and young people with complex, severe or persistent problems are met through a range of specialist services.
- Commissioned local services: local or school-specific needs can often be best met through commissioning that complements countywide provision.
- Emotional resilience: findings from an evidence review on how to build and sustain emotional resilience in children and young people are important.

9. *West Sussex County Council: West Sussex Wellbeing*

West Sussex Wellbeing is a friendly and impartial advice and information service from West Sussex County Council and other partners. As well as using the website, people can find out more about local activities and support services; and how to access such, by talking to Wellbeing Advisors over the phone or in person. People can get support for things like getting fitter, doing exercise, eating nutritiously, dealing with stress, kicking a habit such as smoking, or simply improving their general wellbeing. The majority of services are completely free to users. The wellbeing service promotes a healthy mind and supports people with mental health issues and problems.

Big White Wall is an online, safe, anonymous service supporting people experiencing emotional or psychological distress. It is an online community of people with common mental health problems who are supported to self-manage their own mental health. One of the most important elements of the service is the ability to talk freely, whilst remaining completely anonymous. The range of support options offered includes peer support, wellbeing tests, online resources to aid self-care, creative art and writing therapies. Trained Wellbeing Advisers are on hand at all times to provide extra support and ensure that everyone is safe. Big White Wall is available 24/7 and is intended for anyone aged 16 or over. There is a charge to use this service, although the service is free nationally for veterans, serving personnel in the armed forces and their families. Support is available for people with different types and degrees of mental health issues including people feeling suicidal.

10. *Worthing Churches Homeless Projects Other Services*

Worthing Churches Homeless Projects (WCHP), a local charity provides a variety of services, many of which are accessed through its Worthing based St Clare's Day Centre. Services primary target people affected by homelessness. WCHP believe that everyone has the right to a home, regardless of the difficulties and issues they may face in their lives. The organisation believes in showing those who need help that the wider community is there to support them and to offer hope for a better future. The charity works with some of the most vulnerable and excluded individuals in Worthing. People who access WCHP services are offered the specialist support they need to achieve and sustain independent living and recovery. Services include:

- Day Centre;
- accommodation services;
- short term assessment hostel;
- recovery service; and
- move on service.

National Mental Health Charities

Below is a list of national mental health charities:

1. *Centre for Mental Health*

The Centre for Mental Health is a national charity which dates back to 1995. Previous names have included the National Unit for Psychiatric Research and Development (NUPRD), the Research and Development for Psychiatry (RDP) and more recently, the Sainsbury Centre for Mental Health. The charity wants people facing or living with mental ill health to have a fairer chance in life. Its mission is to inform policy and practice based on high-quality evidence, presented impartially, and often

collaboratively. The lives of people with mental health conditions continue to be harder, poorer and shorter than they should be. The organisation challenges policies and practices which stop people with mental health conditions getting a fair chance in life. The centre promotes positive mental health care and lasting change in people's lives. The aim is to inspire hope, opportunity and a fair chance in life for people of all ages living with or at risk of mental ill health. The organisation acts as a bridge between the worlds of research, policy and service provision; and promotes the use of high-quality evidence and analysis. The centre encourages innovation and advocates for change in policy and practice through focused research, development and training. It works collaboratively with others to promote more positive attitudes in society towards mental health conditions and those who live with them.

2. *Combat Stress*

Combat Stress is a national veterans' mental health charity. Mental ill-health affects ex-service men and women of all ages. Right now, the organisation is supporting over 5,400 Veterans aged from 19 to 97; often providing a vital lifeline for these people and their families. The organisation vision is for veterans to live free from the harmful effects of psychological wounds. Services aim to provide timely, effective clinical treatment and welfare support to veterans. Combat Stress, in partnership with Rethink Mental Illness, provides a 24-hour Helpline (0800 138 1619) for veterans, service personnel and their families.

3. *MIND*

MIND is a national charity. It provides advice and support to empower anyone experiencing a mental health problem. The organisation campaigns to improve services, raise awareness and promote understanding. Its goals are:

- Staying well: Support people likely to develop mental health problems, to stay well.
- Empowering choice: Empower people who experience a mental health problem to make informed choices about how they live and recover.
- Improving services and support: Ensure people get the right services and support at the right time to help their recovery and enable them to live with their mental health problem.
- Enabling social participation: Open the doors to people with experience of mental health problems participating fully in society.
- Removing inequality of opportunity: Gain equality of treatment for people who experience both mental health and other forms of discrimination.
- Organisational excellence: Make the most of our assets by building a culture of excellence.

MIND has a network of over 150 local 'Minds' across England and Wales which vary in size and the services that they offer. In 2012, local 'Mind's worked with over 280,000 people in services. Services include:

- supported housing;
- crisis;
- helplines;
- drop-in centres;
- employment and training schemes;
- counselling; and
- befriending.

Each local Mind is an independent charity run by local people, for local people. Each is responsible for its own funding and the services it provides, but all are affiliated to Mind. This affiliation ensures that each one meets Mind's quality standards of governance and service delivery. Local Minds respond to issues within their communities in a range of ways, including:

- involvement in the planning of local mental health services;
- local campaigning on mental health issues, linking with Mind's national campaign work; and
- activity aimed to raise awareness of, and change attitudes towards, mental health.

4. *Mental Health Foundation*

Mental Health Foundation is a national charity working for an end to mental ill health and the inequalities that face people experiencing mental distress, living with learning disabilities or reduced mental capacity. The organisation develop and run research and delivery programmes which provide evidence and expertise to know what works and how to intervene earlier. The foundation uses learning to help everyone by offering straightforward and clear information on every aspect of mental health and learning disabilities. It provides advice; and also helps people help the people they care about too in their families, communities and workplaces. The charity influences policymakers and advocate for changes in services, using firm evidence and the voices of people with direct experience of the issues. The organisation campaigns on issues that affect public mental health and wellbeing and the lives of people who have, or are close to someone with a learning disability. It aims to inspire the development of a society free from stigma and discrimination, where everyone can achieve their potential to flourish and thrive.

5. *Rethink Mental Illness*

Rethink Mental Illness is a national charity which helps people affected by mental illness by challenging attitudes, and changing lives. The organisation believes a better life is possible for people affected by mental illness. Rethink supports almost

60,000 people every year across England to get through crises, to live independently and to realise they are not alone. The organisation also campaigns nationally to change attitudes and influence policy concerning mental health; as well as locally for needed support. Rethink provides advice and clear, relevant information on everything from treatment and care to benefits and employment rights to anyone affected by mental health problems. The charity has over 200 mental health services and 150 support groups across England. Services provided include psychological therapies, crisis, recovery houses, peer support and housing services. Rethink also provides a national Advice Service Helpline (0300 5000 927) which operates from 10am to 2pm Mondays to Fridays.

6. *SANE*

SANE is a national charity working to improve quality of life for people affected by mental illness. SANE has three main objectives:

- to raise awareness and combat stigma about mental illness, educating and campaigning to improve mental health services;
- to provide care and emotional support for people with mental health problems, their families and carers as well as information for other organisations and the public; and
- to initiate research into the causes and treatments of serious mental illness such as schizophrenia and depression and the psychological and social impact of mental illness.

SANE provides emotional support and information to anyone affected by mental health problems through its helpline, email services; and online support forum where people share their feelings and experiences. Services are provided by trained volunteers. The organisation also provides a Caller Care service which is led by professional staff and provides on-going support to help people alleviate a crisis phase or get through difficult circumstances.

7. *Time to Change*

Time to Change is England's biggest programme to challenge mental health stigma and discrimination. Mental health problems are common but nearly nine out of ten people who experience them say they face stigma and discrimination as a result. This can be even worse than the symptoms themselves. The aim is therefore to start a conversation and empower people with mental health problems to feel confident talking about the issue without facing discrimination; as well as the three quarters of the population who know someone with a mental health problem to talk about it too. The programme includes a range of projects, engaging people in all sectors and communities, encouraging them to start a dialogue and hopefully leading to a change in behaviour. Projects include:

- A national high-profile marketing and media campaign, aimed at reaching 29 million adults to change their attitudes and behaviour towards people with mental health problems.
- Community activity and events that bring people with and without mental health problems together.
- Work with children and young people, to change their attitudes and behaviour towards mental health.
- A £2.7m grants scheme to fund grassroots projects, led by people with mental health problems that will engage communities in meaningful conversations about mental health.
- A programme to support a network of people with experience of mental health problems to take leadership roles in challenging discrimination, within their own communities and as part of Time to Change.
- Strategic work with organisations from all sectors to improve policy and practice around mental health discrimination.
- A programme of media engagement to improve media reporting and representations of mental health issues.
- Focused work with Black and Minority Ethnic communities, starting with African and Caribbean audiences.

8. *Together*

Together is a national charity providing a range of mental health support services and advocacy. The organisation believes that people with mental health issues have the right and the abilities to lead independent, fulfilling lives as part of their communities. People who use Together services influence and shape the support they receive from; and the way our services are run. The charity understands that everyone who seeks support is different and their needs are unique; therefore enabling people to lead their own recovery at their own pace by supporting their decisions about the care they receive. The organisation offers a variety of support to help people deal with the personal and practical impacts of mental health issues including:

- one-to-one support in the community;
- supported accommodation; and
- advocacy to help people understand and express their needs.

5.2.4 What interventions are currently used to treat dual diagnosis?

The National Institute for Health and Care excellence (NICE) is currently developing a guideline entitled, 'Dual diagnosis: meeting people's wider health and social care needs when

they have a severe mental illness and misuse substances'. The anticipated publication date is September 2016.

5.2.5 Currently, is there sufficient provision of services to meet aggregated needs?

The majority view is 'no', there are insufficient resources. A minority expressed views that the overall budget might actually be sufficient to meet the needs; however, the budget needs to be reengineered to match patient/client needs; rather than as a result of long term custom and practice.

With regard to services, every agency involved in the study reported that they could do more as well as better with increased resources. Third sector organisations in particular raised several funding issues including: a low amount, short term funding temporary funding, over onerous funding streams and having to use charitable unrestricted reserves to maintain current or former levels of service provision. A lack of peer mentoring and advocacy services for people with dual diagnosis/complex problems seems to be a particular concern for some stakeholders from the voluntary sector and recovery networks.

5.2.6 Currently, is there sufficient provision of interventions to meet aggregated needs?

Again, some study informants reported a lack of interventions to meet aggregated needs. Peer support including crisis support was highlighted as a main issue. The Sussex Community NHS Trust's Time to Talk service which provides time limited interventions (in line with the mental health commissioning framework) for people experiencing common mental health problems such as depression and anxiety sees a high volume of people per year (over 10,000); however, several informants reported issues concerning accessibility (including exclusion) criteria, the range of interventions available, staff experience, staff training and time restrictions.

5.2.7 Are there any current services which are not needed, partially or fully?

There was no evidence found to suggest that any current service is not needed, partially or fully. However, some stakeholders felt that there was an over reliance on medication as part of treatment; when combined or alternative talking/other therapies might be more effective and cost effective in the longer term. As highlighted above, there are also views that the current budgets for specialist substance misuse and mental health services should be realigned to better meet the needs and desires of people with and affected by dual diagnosis; underpinned by robust needs assessment.

5.2.8 Are there any current interventions which are not needed, partially or fully?

No current interventions were identified as being no longer required; fully or partially.

5.2.9 Which services are under resourced?

There are effectively no services that offer appropriate psychological therapies to people whose needs are more complex, and who might therefore need longer term interventions. This applies across a spectrum of conditions, such as complex trauma. Specialist substance misuse services do not employ dual diagnosis workers or mental health workers to support dually diagnosed clients. This is not implying that specialist substance misuse services are under-resourced as this is not seen to be the case by the research team, based on the findings of the West Sussex Alcohol and Drugs Needs Assessment study undertaken by Figure 8.[130]

5.2.10 Which interventions are under resourced?

As previously highlighted, peer support and TimetoTalk services appear to be under resourced.

5.2.11 Are any of these specific groups not sufficiently catered for?

In addition to people with dual diagnosis themselves, there is limited evidence from the study fieldwork that the following groups with related dual diagnosis are not sufficiently catered for in West Sussex:

- Families and carers of people with dual diagnosis
- Young people in care settings
- Young people in the care system transitioning between CYP-adult services
- Ethnic minorities
- Migrant workers including undocumented migrants
- Homeless & roofless people
- People who misuse over the counter medication
- People who use / misuse legal highs
- People who directly experience non fatal overdose
- Hidden drinkers / drug users

There is no evidence from the study fieldwork that the following groups with related dual diagnosis are not sufficiently catered for in West Sussex:

- Children affected by parental substance misuse
- Women (including maternity)
- Domestic abuse victims
- Other victims of crime

[130] Op. cit. Perkins et al (2014).

- Ex-offenders
- Offenders (in prison or community) including transitioning between
- People involved in prostitution
- People with a physical disability
- People with learning disability
- People affected by drug related deaths

5.3 Views on Accessibility and Integration of Services

5.3.1 What works particularly well for services which treat people with dual diagnosis?

Apart from:

1) the occasional comment regarding effective relations and communications among specialist and generalist workers;

2) a specific model/resource provided by Worthing Churches Homeless Projects which deploys a Dual Diagnosis workers across all of its core services;

3) peer mentoring/support for people recovering from alcohol/drugs dependency and mental health disorders;

there were few examples offered up to the researchers of what works particularly well for services which treat people with dual diagnosis. This in itself is particularly concerning as many of the views in the study were expressed by practitioners. Interestingly, feedback from a service user focus group (in Worthing Churches Homeless Projects' Residential Recovery Service) was, for the most part, complementary in terms of the quality of the service clients were currently receiving.

Feedback from developing recovery networks which promote self help and mutual aid through peer support and other approaches was also largely positive. The commissioners for substance misuse services were also affirmed for commissioning the dual diagnosis study which is seen as fundamental to integrating commissioning systems and their effectiveness for key customers. A mental health agency (Sussex Partnership NHS Foundation Trust) previously employed a specialist Dual Diagnosis Nurse which was seen as an important role in developing dual diagnosis integrated pathways across West Sussex; however, the role holder has since moved to another organisational role (December 2013) and the post was vacant at the time of the study fieldwork.

5.3.2 How do people with dual diagnosis access services?

People with dual diagnosis access services in a number of ways including: self referral, referrals from their GP, family/carer, friend, colleague/employer, significant other, advocate, club, support group, alcohol/drug service, mental health service, police, prison, social work, probation, hospital, support group, solicitor, and other.

5.3.3 Are services well advertised?

In short, services are considered to be generally poorly advertised.

5.3.4 How are services advertised?

Services are advertised on company websites, other websites, social media, local press, addiction and mental health journals, conferences/seminars, in service premises, libraries, community centres, health centres, pharmacists, schools, colleges, universities and by word of mouth.

5.3.5 Do people self-refer or are they referred by an agency or other source?

People with dual diagnosis self refer and are also referred by others including: GP, specialist agencies, generic agencies and other sources.

5.3.6 Is there immediate access to services or waiting times?

Waiting times was not widely reported as an issue by informants. On the contrary, access, at least for initial assessment, to specialist mental health and alcohol/drug services was seen as fairly efficient and responsive. A few issues were highlighted concerning the time to see a GP and the time to see psychiatrists within mental health services; more so as part of treatment, following assessment, rather than awaiting assessment. As is perhaps the norm and expected, some dually diagnosed patients expressed concern about the time and difficulty in accessing hospital based mental health treatment, albeit not as part of their current care plans. Interestingly, the West Sussex based prison featured positively regarding the accessibility of integrated and largely effective services for people with complex needs including dual diagnosis. Specialist substance misuse services were also generally viewed as responsive in addressing client needs.

5.3.7 Are waiting times reasonable – specify time?

As previously highlighted, waiting times were generally not reported as a major issue in this study.

5.3.8 How well do services integrate and work together, in terms of:

- Joint assessment?
- Joint care planning?
- Joint review?
- Communication
- Information sharing?

Taken as a whole, all of the five key components outlined immediately above which are commonly associated with effective integrated working are generally currently lacking in West Sussex. There is

no single shared assessment process in vogue in West Sussex. There was little evidence of consistent or productive joint assessment for people with and affected by dual diagnosis including those endeavouring to access residential services. An exception of this appears to be Worthing Churches Homeless Projects (WCHP) assessment process which endeavours to involve more than their own agency including the individual's carer/family member/significant other. WCHP also employs a Dual Diagnosis Worker who works across all their services. There were some but limited examples of joint assessment activity provided by Addaction and CRI, specialist substance misuse service providers and the two main mental health providers, Sussex Partnership NHS Foundation Trust and Sussex Community NHS Trust. Equally, there were some positive comments concerning the role of GP's in joint assessment, although again, this was seen as a priority area for improvement. Family involvement in joint assessment is clearly lacking, particularly but not solely within mental health services.

Like joint assessment, joint care planning and joint review was also sporadic. There were no positive examples of joint care planning reported, and notional references to joint review in cases where dually diagnosed patients are receiving statutory treatment under the Mental Health Act. On the contrary, multi-disciplinary case conferences in prisons are the norm and appears to working well according to some specialist mental health and substance misuse resources. Similarly, multi-disciplinary case conferences concerning the management of wider criminal justice, domestic abuse/violence, community safety issues regularly take place and appear to be working well. Much of this endeavour is led by West Sussex County Council's Domestic and Sexual Violence team, working cohesively with the police, victims groups, community groups, charities and other community safety agencies and personnel including community champions/activists and elected members (Counsellors).

Communication and information sharing is generally seen as lacking by study informants. There were exceptions reported to the research team; however, these centred on personal relationships between workers, particularly ground level practitioners rather than middle or senior management; or fundamentally, system norms. From the evidence available, it is rather the case that communication and information sharing is generally intermittent and infrequent in practice; vital areas for pressing attention.

5.4 Recovery

In terms of defining 'recovery', the 2010 UK Drug Strategy states that "recovery involves three overarching principles: 1) wellbeing; 2) citizenship; and 3) freedom from dependence. It is an individual, person-centred journey, as opposed to an end state; and one that will mean different things to different people. We must therefore, put the individual at the heart of any recovery system". (HM Government, 2010, p.18)

5.4.1 To what extent has the UK recovery agenda impacted upon local services treating dual diagnosis

Stakeholders were given 4 rating choices, namely 1) no impact; 2) very little impact; 3) moderate impact; and 4) significant impact. No contributors reported that the UK recovery agenda has had significant impact upon local services treating dual diagnosis. Thereafter, the first three choices were fairly evenly split among informants.

5.4.2 What needs to be done in order to make services more recovery-orientated?

The main improvement area centred on developing recovery networks, amalgamating learning and practice from mental health and substance misuse sectors which have certainly have tremendous but little cross fertislisation to date. Recovery organisations such as EXACT and peer support and mentoring activities operated by several mental health organisations (Sussex Partnership NHS Foundation Trust, Richmond Fellowship, Capital Project, Mind); specialist substance misuse services (Addaction, CRI, Ravenscourt Trust) and generic services (Stonepillow, Worthing Churches Homeless Projects) are seen as vital in the developing recovery enterprise. There are good examples of recovery champions and peer mentors in use throughout West Sussex which is encouraging for moving forward.

5.4.3 What do service users, specialist services, generic services and planners/commissioners need to do in order to promote and facilitate recovery?

It is widely recognised that some progress has been made in recent years to promote and facilitate recovery from alcohol/drug and mental health problems in West Sussex. In practice, services generally view practice and strategy purely as a commissioner: contractor arrangement; rather than being underpinned by shared values and standards, goals/objectives/aspirations, similar measurables, etc. Based on limited evidence, a barrier of professional snobbery might be at play in West Sussex whereby smaller providers can be seen by large providers in the sector as unnecessary, of lesser importance and of inferior quality. In essence, service providers need to be less egotistic, insular, selfish and political; and 'come to work' for service beneficiaries first and foremost. A change agent or change agents are generally seen as a solution to changing the vision, culture, policy and practice for people with and affected by dual diagnosis.

5.5 Underpinning knowledge, Improvement and the Future

5.5.1 What are the key gaps that need to be addressed pertaining to dual diagnosis in terms of:

System:

The key system gap seems to be the lack of a West Sussex strategy and action plan framework for the management of dual diagnosis in West Sussex. Another gap pertains to the allocation of mental

health funds by West Sussex County Council and the three West Sussex based Clinical Commissioning Groups to specialist dual diagnosis service provision.

Services and interventions:

Sussex Community NHS Trust's TimetoTalk service provides time limited psychological therapies to people experiencing depression and anxiety. The service is not equipped to deal with more complex cases as their staff require specialist training and expertise which the organisation is not in a position to facilitate. Another major issue is the need to offer longer term interventions for people with dual diagnosis which TimetoTalk is not currently commissioned to provide.

There also needs to be wider investment in the provision of psychological therapies for people with dual diagnosis to supplement what is currently offered. This does not need to be restricted to delivery solely by qualified or trainee psychologists; but could be delivered by a wide range of other health and social care professionals with relevant core training.

5.5.2 How should identified gaps be addressed?

This study has identified a number of gaps or improvement areas which have informed recommendations. These are summarised in **5.5.7** and further explained in **Chapter 6**.

5.5.3 How would you describe the current system which aims to respond to the dual diagnosis challenge?

The general consensus is that current system in West Sussex which aims to respond to the dual diagnosis challenge is only partially effective and requires gradual overhaul, underpinned by accurate and up to date intelligence and an integrated review and development structure.

5.5.4 Is the current response system:

- Defined?
- Known about?
- Understood by key stakeholders?

In short, the current response system for managing dual diagnosis is generally not defined (certainly in terms of system definition), known about or understood by key stakeholders. A good example is the lack of knowledge of Sussex Partnership NHS Foundation Trust's dual diagnosis strategy. Of the few informants that are aware of this important strategy document, most see the strategy as essentially organisation, rather than West Sussex or system wide.

5.5.5 What are the priorities for future investment?

As usual, there is a long wish list in terms of priorities for future investment. The key priorities are articulated in Chapter 6 as recommendations. These are summarised, as follows:

- Establish a multi-agency dual diagnosis integrated working group.
- Resource dual diagnosis change agents.
- Create a working definition for the term, 'dual diagnosis' including scope; and disseminate this widely to relevant stakeholders.
- Learn from experience and emerging evidence; and forge alliances to support dual diagnosis recovery communities.
- Promote empowerment and positive recovery from dual diagnosis.
- Generate an interim alcohol/drugs and mental health services partnership working guide for the current and short term management of dual diagnosis.
- Map alcohol/drugs & mental health services.
- Produce an assessment and risk framework for the management of dual diagnosis.
- Create a dual diagnosis pathway(s).
- Design an information sharing protocol between alcohol/drugs and mental health services.
- Develop a data collation system incorporating dual diagnosis statistics, alcohol/drug related deaths, suicides and correlations.
- Produce a dual diagnosis strategy.
- Construct an integrated working guide involving alcohol/drugs, mental health, housing, employability and other relevant services; as well as recovery communities.
- Undertake a training needs analysis and develop a training schedule for specialist and generic staff and other stakeholders including carers/families affected by dual diagnosis.
- Undertake regular needs assessments and specific, targeted research; e.g. dual diagnosis and young people.

5.5.6 List the following statements in terms of importance to you

Stakeholders rated these four statements in the following order of importance (1 most important and 4 least important):

1. Improving the integration of services
2. Enhancing the quality of services
3. Increasing the capacity of services
4. Expanding the range of services

5.5.7 List the following statements in terms of priority for West Sussex

Stakeholders prioritised the 6-point list, as follows (1 most important and 6 least important):

1. Continuation of current approach to managing dual diagnosis with improved integration
2. Development and pilot of new approach with linked dual diagnosis workers in specialist alcohol and drug and mental health services
3. Development and full roll out of new approach with linked dual diagnosis workers in specialist alcohol and drug and mental health services
4. General continuation of current approach to managing dual diagnosis
5. Development and pilot of specialist dual diagnosis service
6. Development and full roll out of specialist dual diagnosis service

5.5.8 Would you like to see the creation of a specialist dual diagnosis service?

Virtually every informant consulted does not want to see the creation of a specialist dual diagnosis service. Reasons include:

- There is simply not the appetite for a specialist dual diagnosis service.
- A dual diagnosis service is a step too far.
- A dual diagnosis service is not a tried and tested model.
- There is a lack of evidence regarding treatment options for managing dual diagnosis.
- There is a lack of trained and qualified dual diagnosis staff.
- There is a lack of dual diagnosis training.
- There are improvements areas for specialist substance misuse services, as well as mental health services; both internally and in terms of integration.
- Commissioners are still adapting to changes and joint arrangements and budgets.
- The focus needs to be on better organisational practice; improved integration; and real and effective partnership working.

5.6 Linked services

Linked services such as those providing services concerning homelessness employability and benefits, volunteering/community deeds, youth work, counselling, criminal justice, family/parenting, relationships/befriending, outdoor activities/leisure, etc. featured deeply in stakeholder feedback. This was particularly the case during working groups which facilitated debate on specific priorities identified by participants themselves. In the context of co-existing mental health and alcohol and drug problems, the significance of linked services in the effectiveness of dual diagnosis related practice and policy should not be underestimated; despite the perception by some specialist mental health and substance misuse providers that linked services are generic services and rather less important in the recovery agenda.

5.6.1 Employability

Appendix III outlines a paper presented to the study by Impact Initiatives concerning employability and dual diagnosis. Some key points are:

- 56% of an employment specialist's current caseload have shared mental health needs.
- Client on methadone programme - no mental health support offered.
- Employed client – long term mental health needs, but following a crisis and drinking; mental health services would not engage, resulting in client nearly losing job.
- Challenges/inhibitors include:
    - Lack of integration
    - Poor communications between services
    - Lack of ongoing support; even when things are going well
    - Fear of joined up support
    - Support services restrictive funding Vs overwhelming client demand
    - Low expectations
    - Lack of aspirations
    - Out of date skills
    - Fear of failure
    - Self sabotage
    - Reliance on goodwill of family and friends
- Ways forward:
    - Building knowledge, awareness and competence
    - Good communications between service
    - Organisational ethos
    - Health and work service
    - Service users sharing experiences

5.6.2 Homelessness

Appendix IV outlines a paper presented to the study by Worthing Churches Homeless Projects (WCHP) concerning employability and dual diagnosis. Some key points are:

- The nature and scale of dual diagnosis within WCHP

  Between September 2012 and August 2013, WCHP supported 151 clients with substance misuse issues, of which 110 (72.8%) also had a concurrent mental health need. Within their Recovery Project, 70% of clients in March 2014 had a dual diagnosis with variable levels of complexity

including: schizophrenia, personality disorders, bi-polar, post traumatic stress disorder and anxiety disorders.

- The particular issues presented by dual diagnosis clients

  Clients are comprehensively assessed for substance misuse and mental wellbeing. Dual diagnosis is not a barrier to accessing WCHP services. However, clients with greater complexities of need require more resources and a coordinated approach to their treatment journeys. Particular challenges have been addressing the over reliance on prescribed medication and negotiating prescribing regimes that establish the best quality of life while still managing mental health illness. Abstinence from drugs or alcohol can in the short term elevate mental health conditions or produce new symptoms; particularly in clients who have been self medicating for many years, initially reducing the positive effects of recovery.

  Brokering support from specialist mental health services can be challenging and historically there has been a tendency for some agencies to refer into WCHP's residential services and then withdraw their support. Accessing quality accommodation at the end of a successful treatment journey has been an ongoing challenge for WCHP services, with environmental factors being key in maintaining long term mental well being and a sustainable recovery.

  Particularly complex cases can present challenges especially in the absence of a diagnosis or where there has been a lack of commitment from other specialist services to engage and access. The requirement for a period of abstinence has been required by some services, even before carrying out assessments, resulting in treatment delays and frustrations for staff and clients alike.

- Explanation of and comments on service integration and partnerships

  WCHP work closely with mental health services locally; in part facilitated by their mental health nurse. Their relationship with other services is, in part, based on their need to access accommodation and support for their clients; therefore the relationship could be considered to be somewhat one sided. WCHP's relationship with local substance misuse services is stronger and more balanced with resources and skills being shared more openly including joint negotiation of individual support plans.

- The perceived impact of WCHP's approach

  According to WCHP, the wraparound nature of their services and the intensity and longevity of the support they provide results in good outcomes for more complex dually diagnosed clients, reducing and preventing revolving door cases; and preventing clients being pushed between services through a coordinated approach adopted for their treatment.

- Suggested changes and improvements for people with/affected by dual diagnosis
  - There is a need in the area and region for more holistic based treatment services with a joined up approach between services.
  - There is a need for an increased and more diverse range of community based accommodation options.
  - There is also a need for the development of recovery orientated services and communities.

- There is a need to develop more responsive direct access service provision for more complex cases, particularly in dealing with crisis situations; and thus preventing escalation and isolation.
- The development of dual diagnosis peer mentors and more service user consultation and involvement in how services are developed would be useful.
- Joint training between substance misuse services and mental health service may well help to break down some of the barriers, resulting in increased understanding, better continuity of services;
- and skilling up multi-disciplinary/agency workers in better dealing with more complex dual diagnosis cases.

- Other relevant matters

  Funding has been an ongoing issue for WCHP with the development of existing services and new initiatives largely being met from their reserves; and at their own organisational risk. Issue of insecure funding, very short term funding and complex, often over onerous funding streams never disappear. Funding issues cause serious difficulties in developing, diversifying, improving and growing services to meet the needs of people with dual diagnosis. The focus is often on survival and sustainability, rather than expansion.

C

HAPTER 6: RECOMMENDATIONS

6.1 Introduction

This chapter sets out the policy and practice recommendations. There are 15 recommendations in total for deliberation by West Sussex public health commissioners responsible for; or with a core stake or avid interest in, services for people with or affected by dual diagnosis. Recommendations are derived from evidence gathered and analysed from the review of literature, surveys and fieldwork, including study informants. This evidence has been distilled to develop the set of recommendations outlined below:

6.2 Recommendations

6.2.1 Establish a multi-agency dual diagnosis integrated working group

Dual diagnosis does not appear to have a high profile among commissioners or service providers in West Sussex, although it is apparent that the profile is now on the increase, along with a stated budget commitment. There are also low levels of expectations from people suffering from dual diagnosis and others affected by dual diagnosis in relation to whether dual diagnosis will be successfully tackled and resourced in West Sussex. Accordingly, there is a fundamental need to establish a dual diagnosis integrated working group to oversee strategic and operational practice developments and to increase the profile and range of responses to dual diagnosis.

6.2.2 Resource dual diagnosis change agents

Notwithstanding the clear commitment of substance misuse and mental health commissioners who are keen to improve services in West Sussex for people with dual diagnosis; there is simply no dual diagnosis champion or change agent currently in existence in West Sussex. As a solution, joint substance misuse and mental health commissioners are asked to consider resourcing two dual diagnosis change agents. Whilst recognising that there are suitably qualified dual diagnosis specialists in the county, the reality is that the number of such professionals is extremely limited. Furthermore, there is a need for change agents to break down cultural barriers on both sides of the substance misuse and mental health services divide. Accordingly, this report firmly recommends that two change agents are recruited for a fixed term period (e.g. 12 months initially); one of whom is a suitably qualified and experienced specialist from the alcohol and drug sector, with the other a specialist from the mental health sector. The key aim of these posts will be to encourage greater focus on dual diagnosis in services, align strategy and operational practice (including the Payment by Results agenda); ensure quality and promote consistent practice (including joint assessment and development of local dual daignosis pathways).

6.2.3 Create a working definition for the term, 'dual diagnosis' including scope; and disseminate this widely to relevant stakeholders

In practice, there is no commonly accepted definition of dual diagnosis. Within the practice context of West Sussex, the main formal definition of dual diagnosis is outlined in Sussex Partnership NHS Foundation Trust's Dual Diagnosis Strategy 2011 – 2016 (September 2011) which originally derives from the Department of Health's *Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide* (May 2002) which states:

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

- *a primary psychiatric illness precipitating or leading to substance misuse*
- *substance misuse worsening or altering the course of a psychiatric illness*
- *intoxication and/or substance dependence leading to psychological symptoms*
- *substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses."*

In addition to the bulleted list above, the term, dual diagnosis is also commonly used for an often complex spectrum of mental health and alcohol/drug problems including misuse of prescribed medication and over the counter drugs. In the policy and practice context of West Sussex, it is imperative that a working definition for the term, 'dual diagnosis' is created including scope; and disseminated widely to relevant stakeholders. When initially consulted, most study informants were unaware of the above definition; others had differing meanings; whilst a few people in recovery from dual diagnosis had never even heard of the term before. This process may also assist in identifying training needs of the workforce and in creating care pathways for dual diagnosis (see below).

6.2.4 Learn from experience and emerging evidence; and forge alliances to support dual diagnosis recovery communities

Throughout West Sussex, there has been some momentum gained in respect of ground level and bottom up recovery communities; for both mental health; and addictive behaviour, particularly concerning alcohol and drugs. However, in terms of recovery initiatives, there appears to be very little formal cross-fertilisation in respect of people with co-occurring substance misuse and mental health problems. There is opportunity to maximise learning from both of these individual recovery networks and forge alliances to support the emergence of dual diagnosis recovery communities; for which there is a demonstrable need.

6.2.5 Promote empowerment and positive recovery from dual diagnosis

People can and do recover in successful and sustainable ways from dual diagnosis. This is particularly highlighted in Chapter 3 of this final report which outlines the personal life experiences of three people who are in recovery from dual diagnosis; and apparently living gratifying lives. There is a greater need in West Sussex to promote and empower positive recovery from dual diagnosis.

Currently, the level and nature of such dual diagnosis specific promotion is very limited; lacking even. The term, 'dual diagnosis' is rarely used or understood, even with specialist substance misuse and mental health services' staff. A Dual Diagnosis Specialist Nurse who acted as a champion for a service provider who produced a dual diagnosis strategy (see **Section 6.2.11**), has moved to another role within their organisation and, at the time of writing, it is unclear whether the specialist dual diagnosis post will be replaced. Visibility of recovery for both mental health and drug / alcohol use is critical to demonstrate the power and possibility of recovery for all.

6.2.6 Map alcohol/drugs & mental health services

Throughout the study, the research team was impressed by the range of alcohol/drug and mental health services in West Sussex and the general commitment of staff and volunteers. The views of service users, families/carers as well as staff from specialist as well as generic services were consistent in terms of the lack of a map of substance misuse, mental health and other support services. Stakeholders view this development as a priority improvement area; again one which seems fairly straightforward to achieve. This final report might also assist commissioners or a designated individual or group to produce a current map of alcohol/drugs and mental health services in West Sussex. This mapping will help assess and monitor the provision of dual diagnosis services in West Sussex, including joint work and advertising of local services.

6.2.7 Produce an assessment and risk framework for the management of dual diagnosis

There is compelling need to develop and implement a consistent assessment and risk framework for the management of dual diagnosis across West Sussex. Currently, risk and need assessments and care pathways are unknown, unclear or sporadically applied by practitioners across the county. This is seen by stakeholders as poor and counterproductive practice, but an issue easily rectified. A new framework will help identify and mitigate risks around working with dual diagnosis, improve staff confidence and competence in working with co-existing mental health and substance misuse problems; and help to consistently meet the identified needs of people with dual diagnosis.

6.2.8 Create detailed dual diagnosis care pathways

There are no current dual diagnosis pathways in West Sussex; or certainly the research team was not made aware of any during the study fieldwork. This has resulted in what appears to be sporadic practice, integrated working and partnerships between key providers such as specialist alcohol and drug services, mental health services and GP services. There is a fundamental need to create dual diagnosis pathways to guide appropriate referral, improve joint working practice and mitigate risks in working with dual diagnosis. This should include those with lower level mental health and substance misuse needs who may not be known or referred to either specialist service.

There is an expectation and stated optimism amongst senior managers that mental health Payment by Results (PbR) brings a real opportunity for clarifying the care pathways to a level of detail that everyone can understand. After assessment, service users are divided into 21 clusters. Each cluster

has a service specification about what the cluster will provide with standard outcomes and measures on which future commissioning will be based. This approach will underpin the description of the offer and expected outcomes available to the service user through PbR. This level of transparency hasn't previously been available through the old block contract approach.

The opportunity of PbR is collaboration. Collaboration to identify the appropriate approaches to resolve transition issues, and collaboration to agree clear outcomes for people. By working in this way to develop the necessary (detailed) pathways, the finances should then be able to be applied appropriately to help incentivise organisations to demonstrate impact. The threat and risk of PbR is therefore not being clear about these pathways and applying finances in the wrong way.

An alcohol and drug misuse care pathway should be clearly identified within the current Mental Health Cluster specifications with a recognition that Cluster 16 is the likely focus of a dual diagnosis pathway - primarily for highly complex and severe cases. The other clusters are likely to link more appropriately to less severe/complex presentations; but there needs to be collaborative working across relevant multiple stakeholders to achieve agreement of what that will be (who does what, when and how with whom).

6.2.9 Design an information sharing protocol between alcohol/drugs and mental health services

The current lack of an information sharing protocol is seen by stakeholders as extremely problematic, a priority improvement area; one that is easily achievable. The development of this protocol should involve the main substance misuse providers and mental health providers as well as GP's and other relevant stakeholder agencies, including families and those affected by dual diagnosis.

6.2.10 Develop a data collation system incorporating dual diagnosis statistics, alcohol/drug related deaths, suicides and correlations

West Sussex is expanding its data collation systems and related initiatives to help measure results including client outcomes, to support learning and continuous improvement; to enhance quality and customer satisfaction; and to ensure best value. An example of this concerns data and intelligence collation and analysis in respect of drug related deaths. This recommendation suggests widening this initiative to include dual diagnosis prevalence statistics, non-fatal self-harm, emergency health and emergency admissions, suicides and its' determinants; including alcohol/drug related deaths information.

6.2.11 Produce a West Sussex dual diagnosis strategy

The Sussex Partnership NHS Foundation Trust has already published an organisational dual diagnosis strategy, which is a positive step forward for the region. However, the document is largely unknown within the mental health sector, never mind outwith it. Furthermore, stakeholders who declared knowledge of this important document see it purely as an organisational document, rather than a county wide (West Sussex) document. In short, there is a need to produce an overarching West

Sussex dual diagnosis strategy (including all relevant statutory, non-statutory and community stakeholders, as well as both service user and family/carer representatives).

6.2.12 Generate an interim alcohol/drugs and mental health services partnership working guide for the current and short term management of dual diagnosis

It will clearly take time for commissioners to formulate, implement and monitor a robust action plan based on or influenced by this final report to realise improvement areas and other business aspirations. As an interim measure and to facilitate a 'quick win', it will be useful to generate an interim alcohol/drugs and mental health services partnership working guide for the current and short term management of dual diagnosis in West Sussex. Presently; and notwithstanding the individual nature of treatment and care packages for people with dual diagnosis, there is no consistent practice for managing this challenge. This guide should be based on current best practice for dual diagnosis from West Sussex and elsewhere in the UK.

6.2.13 Construct an integrated working guide involving alcohol/drugs, mental health, housing, employability and other relevant services; as well as recovery communities

This study has highlighted inconsistencies in integrated working within, between and across specialist substance misuse and mental health services; and other crucial linked services such as housing and employability, as well as recovery communities. In the longer-term there would be great benefit in developing and agreeing an integrated working guide involving alcohol/drugs, mental health, housing, employability and other relevant services; as well as recovery communities.

6.2.14 Undertake a training needs analysis and develop a training schedule for specialist and generic staff and other stakeholders including carers/families affected by dual diagnosis

In practice, training opportunities in relevant mental health related topics and dual diagnosis for all levels of staff including management and volunteers working in specialist alcohol and drug services is minimal or even non-existent. Even when such training is available and accessible, it can be either unaffordable or not of high priority due to budget constraints and the need for substance misuse services to focus on their core business. This is a similar problem for mental health staff who normally undertake a minimum level of substance misuse training as part of their initial qualification/training and extending to their ongoing processional learning and development. GP's, pharmacists, paramedics, hospital accident and emergency staff, generic service provider staff such as homelessness, employability and counselling; recovery champions; and families of people with dual diagnosis are examples of other key stakeholder groups which require more dual diagnosis training. In short, there is a clear need to undertake a training needs analysis and develop a training schedule for specialist and generic staff and other stakeholders including carers/families affected by dual diagnosis.

6.2.15 Undertake regular needs assessment and specific, targeted research; e.g. dual diagnosis and young people

The substance misuse and mental health commissioners in West Sussex are commended for contracting this dual diagnosis study, following the recent authorisation and undertaking of the West Sussex alcohol and drugs needs assessment. However, there is a need to continue to undertake regular needs assessments; as well as specific, targeted research such as dual diagnosis and young people.

6.3 Summary

One study participant strongly expressed a view that West Sussex commissioners should focus on creating a new specialist dual diagnosis service, incorporating specialist staff from substance misuse and mental health services; underpinned by co-location. Two other informants tentatively supported the notion of a new specialist dual diagnosis service, albeit in the medium to longer term when improved integration and practice had been realised; underpinned by a fresh strategy and framework. Three other informants were unsure whether to opt for an improved integrated model or the creation of a new special dual diagnosis model. Two of these personnel, suggested that a pilot could take place and be independently evaluated to inform the future dual diagnosis service model for the region.

No study informant expressed a view to stick with the current models of managing dual diagnosis in West Sussex; whereby there is little integration between substance misuse and mental health services. Similarly, the vast majority of commentators were against creating a specialist dual diagnosis service, preferring rather to improve integration and partnership working between the main specialist alcohol/drug and mental health services; as well as other important linked services. In summary, whilst recognising the polarisation of some views, the vast majority of stakeholders who participated in the study forcefully expressed opposition to creating a new specialist dual diagnosis service. Interestingly, this majority viewpoint contradicts a previous finding of Figure 8's West Sussex Alcohol and Drugs Needs Assessment report[131] which supported exploring the concept of a new specialist dual diagnosis service.

[131] Op. cit. Perkins et al (2014).

APPENDICES

Appendix I: Interview Schedule

Activity 1 (i-viii):

Event 1: Cross Regional Workshop (South) - Part 1 [13 ATTENDED]

A/E No.	Event/Activity	Venue	Address	Date	Time
1/1	Regional Workshop (South) - Part 1	Chichester - Assembly Room	North Street, Chichester PO19 1LQ	Thu 13/2/14	13.30-16.30

N.	Facilitators	Name	Title / Designation	Employer
1	DMC, MM	Niall Reid	Recovery Project Manager	WCHP
2	DMC, MM	Tina Lashbrook	Mental Health Nurse	WCHP
3	DMC, MM	Karen Bassett	Operations Manager	Lifecentre
4	DMC, MM	Vikki Fenwick	Public Health Programme Manager – PH Directorate	WSCC
5	DMC, MM	Loretta Lunn	Mental Health Liaison Practitioner - Healthcare - HMP Ford	Sussex Partnership NHS Foundation Trust
6	DMC, MM	Ann Marie Garratt	Team Leader	Richmond Fellowship
7	DMC, MM	Nicole Hazelton	Service User	WCHP
8	DMC, MM	Marc Glynn	Service User	WCHP
9	DMC, MM	Joel Corey	Chairman - Chichester EXACT / MD - EXACT Central CIC	EXACT
10	DMC, MM	Robin John Woznicki	Treatment Manager	Ravenscourt Trust

11	DMC, MM	John Christopher	Service Manager	Addaction
12	DMC, MM	Katherine Cox	Pharmacist	Boots
13	DMC, MM	John Alward	Service User	Chichester EXACT / C-Plus

Event 2: Cross Regional Workshop (North) - Part 1 [4 ATTENDED]

A/E No.	Event/Activity	Venue	Address	Date	Time
1/2	Regional Workshop (North) - Part 1	Crawley Library - Longlea Room	Southgate Ave, Crawley RH10 6HG	Fri 14/2/14	13.30-16.30

N.	Facilitators	Name	Title / Designation	Employer
1	DMC, MM	Malcolm Nicholas	Health Team Manager	Crawley Open House
2	DMC, MM	Matthew Stonely	Manager	CRI
3	DMC, MM	Corinne Hall	Nurse Practitioner	Addaction
4	DMC, MM	Debbi French	Peer Mentor / Family Member	CRI / Carers Support WS

Event 3: Working Group (A) – Part 1 [6 ATTENDED]

A/E No.	Event/Activity	Venue	Address	Date	Time
1/3	Working Group (A) – Part 1	Chichester - Crush Bar Room	North Street, Chichester PO19 1LQ	Thu 27/2/14	14.00-16.00

N.	Facilitators	Name	Title / Designation	Employer
1	DMC	Niall Reid	Recovery Project Manager	WCHP
2	DMC	Marc Glynn	Service User	WCHP

3	DMC	Cheryl Spittle	Recovery Lead	CRI
4	DMC	Cathy Salisbury	Specialist Substance Misuse Social Worker	WSCC
5	DMC	Joel Corey	Chairman - Chichester EXACT / MD - EXACT Central CIC	EXACT
6	DMC	Liz Fryer	Team Leader – Nurse & Non Medical Prescriber	Addaction

Event 4: Working Group (B) – Part 1 [11 ATTENDED]

A/E No.	Event/Activity	Venue	Address	Date	Time
1/4	Working Group (B) – Part 1	Crawley Library - Billbuck Room	Southgate Ave, Crawley RH10 6HG	Fri 28/2/14	10.00-12.00

N.	Facilitators	Name	Title / Designation	Employer
1	DMC	Matthew Stonely	Manager	CRI
2	DMC	Tina Lashbrook	Mental Health Nurse	WCHP
3	DMC	Nicole Hazelton	Service User	WCHP
4	DMC	Ann Marie Garratt	Team Leader	Richmond Fellowship
5	DMC	Maxine Thomas	Service Manager	Impact Initiatives
6	DMC	Amanda Shepheard	Team Leader - Impact Workability	Impact Initiatives
7	DMC	Julie Burnett	Recovery Coach	EXACT
8	DMC	Mike Larter	Service User	EXACT
9	DMC	Polly (Olivia) Friedman	Support Worker	Richmond Fellowship
10	DMC	Timothy Simmons	Service User	Richmond Fellowship / MIND / Capital Project
11	DMC	Karen Pooley	Vice Chair	EXACT

Event 5: Working Group (A) – Part 2 [11 ATTENDED]

A/E No.	Event/Activity	Venue	Address	Date	Time
1/5	Working Group (A) – Part 2	Chichester - Old Court Room	North Street, Chichester PO19 1LQ	Wed 12/3/14	14.00-16.00

N.	Facilitators	Name	Title / Designation	Employer
1	DMC	Niall Reid	Recovery Project Manager	WCHP
2	DMC	Cheryl Spittle	Recovery Lead	CRI
3	DMC	Cathy Salisbury	Specialist Substance Misuse Social Worker	WSCC
4	DMC	Vernon Cohen	Recovery Worker	Coastal West Sussex Mind
5	DMC	Marc Glynn	Service User	WCHP
6	DMC	Joel Corey	Chairman - Chichester EXACT / MD - EXACT Central CIC	EXACT
7	DMC	Nadia Anderson	Service Manager - Western	Working Age Mental Health Services
8	DMC	Liz Fryer	Team Leader – Nurse & Non Medical Prescriber	Addaction
9	DMC	Maxine Thomas	Service Manager	Impact Initiatives
10	DMC	John Alward	Service User	Chichester EXACT / C-Plus
11	DMC	Karen Bassett	Operations Manager	Lifecentre

Event 6: Working Group (B) – Part 2 [9 ATTENDED]

A/E No.	Event/Activity	Venue	Address	Date	Time
1/6	Working Group (B) – Part 2	Crawley Library - Longlea Room	Southgate Ave, Crawley RH10 6HG	Thu 13/3/14	10.00-12.00

N.	Facilitators	Name	Title / Designation	Employer
1	DMC	Tina Lashbrook	Mental Health Nurse	WCHP

2	DMC	Georgina Parish	Outreach Worker	WCHP
3	DMC	Nicole Hazelton	Service User	WCHP
4	DMC	Ann Marie Garratt	Team Leader	Richmond Fellowship
5	DMC	Kevin O' Hara	Service User	Crawley EXACT
6	DMC	Timothy Simmons	Service User	Richmond Fellowship / MIND / Capital Project
7	DMC	Karen Pooley	Vice Chair	EXACT
8	DMC	Debbi French	Peer Mentor / Family Member	CRI / Carers Support WS
9	DMC	Vikki Fenwick	Public Health Programme Manager – PH Directorate	WSCC

Event 7: Cross Regional Workshop (North) - Part 2 [6 ATTENDED]

A/E No.	Event/Activity	Venue	Address	Date	Time
1/7	Regional Workshop (North) - Part 2	Crawley Library - Longlea Room	Southgate Ave, Crawley RH10 6HG	Mon 24/3/14	13.30-16.30

N.	Facilitators	Name	Title / Designation	Employer
1	DMC, MM	Corina Gibson	Team Leader - IDVA Services	WSCC
2	DMC, MM	Vikki Fenwick	Public Health Programme Manager – PH Directorate	WSCC
3	DMC, MM	Malcolm Nicholas	Health Team Manager	Crawley Open House
4	DMC, MM	Creighton Jones	Team Manager	Addaction
5	DMC, MM	Kevin O' Hara	Service User	Crawley EXACT
6	DMC, MM	Clare Toon	Clinical Effectiveness Officer	WSCC - Public Health

Event 8: Cross Regional Workshop (South) - Part 2 [10 ATTENDED]

A/E No.	Event/Activity	Venue	Address	Date	Time
1/8	Regional Workshop (South) - Part 2	Chichester - Old Court Room	North Street, Chichester PO19 1LQ	Tue 25/3/14	09.30-12.30

N.	Facilitators	Name	Title / Designation	Employer
1	DMC, MM	Marc Glynn	Service User	WCHP
2	DMC, MM	Tina Lashbrook	Mental Health Nurse	WCHP
3	DMC, MM	Cheryl Spittle	Recovery Lead	CRI
4	DMC, MM	Cathy Salisbury	Specialist Substance Misuse Social Worker	WSCC
5	DMC, MM	Polly (Olivia) Friedman	Support Worker	Richmond Fellowship
6	DMC, MM	Ann Marie Garratt	Team Leader	Richmond Fellowship
7	DMC, MM	Karen Bassett	Operations Manager	Lifecentre
8	DMC, MM	Joel Corey	Chairman - Chichester EXACT / MD - EXACT Central CIC	EXACT
9	DMC, MM	John Christopher	Service Manager	Addaction
10	DMC, MM	Clare Toon	Clinical Effectiveness Officer	WSCC - Public Health

Activity 2: Meetings

A/E No.	Event/Activity	Venue	Address	Date	Time
2/NA	Meetings	West Sussex wide	West Sussex wide	Various	Various

N.	Facilitator	Name	Title / Designation	Employer / Organisation	Venue	Date	Time

1	DMC	Tom Insley	Senior Manager - Mental Health Commissioning; WS Joint Commissioning Unit	WSCC	Horsham, Mid Sussex & Crawley CCG, Crawley Hospital, West Green Drive, Crawley RH11 7DH	Thu 13/2/14	09.00 – 10.30
2	DMC	Clare Toon	Clinical Effectiveness Officer	WSCC - Public Health Directorate	Morrisons, Worthing	Mon 10/3/14	11.00
3	DMC	Marc Glynn	Service User	WCHP	Old Court Room, Chichester	Wed 12/3/14	16.30
4	DMC	Nicole Hazelton	Service User	WCHP	Longlea Room, Crawley Library	Thu 13/3/14	12.30
5	DMC	Joel Corey	Chairman - Chichester EXACT / MD - EXACT Central CIC	EXACT	Old Court Room, Chichester – followed up by telephone discussion (30/3/14 at 11.30)	Tue 25/3/14	13.00

Activity 3: Mental Health Providers Forum

A/E No.	Event/Activity	Venue	Address	Date	Time
3/1	West Sussex Mental Health Providers Forum (n=27)	Billinghurst Centre	Roman Way, Billinghurst RH14 9EW	Fri 15/3/14	09.00 – 13.00

Activity 4: Service User Focus Group

A/E No.	Event/Activity	Venue	Address	Date	Time
4/1	Focus Group with dual diagnosis service users (N=6)	WCHP	Delaney House, 14-16 Selden Road, Worthing BN11 2LL	Tue 11/3/14	14.00

Activity 5: Interviews

A/E No.	Event/Activity	Venue	Address	Date	Time
5/NA	Interviews (with key stakeholders)	West Sussex wide	West Sussex wide	Various	Various

N.	Interviewer	Name	Title / Designation	Employer / Organisation	Venue	Date	Time
1	DMC	John Holstrom	Chief Executive	WCHP	13 Grafton Road, Worthing, BN11 1QP	Mon 10/3/14	09.30 – 10.30
2	DMC	Sarah Herlem	Mental Health and Well-being Outreach Worker	Friends, Families & Travellers	Community Base, 113 Queens Road, Brighton BN1 3XG	Mon 10/3/14	13.00
3	DMC	Rachel Kundasamy	Locality Manager	Richmond Fellowship	70 Park Street, Horsham, RH12 1BX	Mon 10/3/14	15.30
4	DMC	Jane Brown	Locality Manager	Carers Support West Sussex	WCHP, Delaney House, 14-16 Selden Road, Worthing BN11 2LL	Tue 11/3/14	16.15
5	DMC	Darryl Hobden	Sen. Ind. Domestic Violence Advisor - Worth Services	WSCC	Centenary House, Durrington Lane, Worthing BN13 2PQ	Wed 12/3/14	09.00
6	DMC	Trish Harrison	Principal Manager - Domestic and Sexual Violence	West Sussex County Council	Forum Room, Centenary House, Durrington Lane, Worthing BN13 2PQ	Wed 12/3/14	10.30
7	DMC	Martin Pannell	General Manager - Chichester Assessment and Treatment Service	Sussex Partnership NHS Foundation Trust	Chapel Street Clinic, Chapel Street, Chichester PO10 1BX	Wed 12/3/14	12.00

8	DMC	Dr Anita Green	Nurse Consultant in Education and Training	Sussex Partnership NHS Foundation Trust	Mill View Hospital, Neville Ave, Hove, EN3 7HY	Thu 13/3/14	14.30
9	DMC	Clare Oakwood	Chief Executive	Capital Project	Billinghurst Centre, Roman Way, RH14 9EW	Fri 14/3/14	13.00
10	DMC	Andy Biddle	Services Manager	CRI	Telephone	Fri 4/4/14	16.00
11	DMC	Dr Geoff Mothersole	Consultant Counselling Psychologist / Clinical Director for Psychological Therapies - Time to Talk	Sussex Community NHS Trust	Telephone	11/4/14	08.00

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Appendix III: Paper from Impact Initiatives re. Dual Diagnosis & Employability

The experience of Impact Initiatives

- 56% of one employment specialist's current caseload have shared mental health needs.
- Job Seeker Allowance (JSA) sanctions when someone not doing 10 job search activities in a week.
- Suicidal client – no mental health support offered.
- Client on methadone programme - no mental health support offered.
- Employed client – long term mental health needs, but following a crisis and drinking; mental health services would not engage, resulting in client nearly losing job.

Challenges and Barriers

- Poor communications between services
- Lack of joined up support
- Fear of joined up support
- Support services restrictive funding Vs overwhelming client demand
- Low expectations
- Lack of aspirations
- Poor work history
- Out of date skills
- Fear of failure
- Self sabotage
- Reliance on goodwill of family and friends

Inhibitors to success

- Lack of integration
- Lack of ongoing support; even when things are going well
- Mandatory welfare programmes
- Employment Support Allowance (ESA)
- Universal credit

Ideas to build a way forward

- Building knowledge, awareness and competence
- Good communications between service
- Organisational ethos
- Health and work service
- Service users sharing experiences

Maxine Thomas

Service Manager, Impact Initiatives

12 March 2014

Appendix IV: Paper from WCHP re. Dual Diagnosis & Homelessness

worthing churches homeless projects

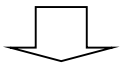
The nature and scale of dual diagnosis within WCHP

Between September 2012 and August 2013, Worthing Churches Homeless Projects (WCHP) supported 151 clients with substance misuse issues, of which 110 (72.8%) also had a concurrent mental health need. Within our Recovery Project, 70% of our clients in March 2014 had a dual diagnosis with variable levels of complexity including: schizophrenia, personality disorders, bi-polar, post traumatic stress disorder and anxiety disorders.

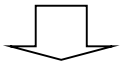
Ways in which we currently manage this challenge

WCHP's Recovery Model

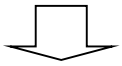
Stop or Reduce using



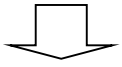
Building Resilience



Building New Relationships



Finding joy and passion in new life activities



Giving back to others

A brief explanation of our recovery model

Stop or Reduce

- Drinks and drugs diaries completed to establish level, context and environment of use.
- Both harm minimisation and abstinent based approaches offered.
- Managed withdrawal provided from alcohol and other substances.
- Negotiating of appropriate prescribing and substitute prescribing regimes and reviewing of prescribing needs.
- The offer of secure safe accommodation, essential in ensuring effective engagement in treatment.
- Multi agency working/jointly agreed and negotiated support plans.

Building Resilience

- Individualised relapse prevention plans and support.
- Developing refusal and avoidance skills.
- Acceptance that life is not always good and developing the skills and resources to deal with this.
- Developing healthier lifestyle in absence of addiction including healthy eating, good sleep hygiene and exercising to reinforce the benefits of recovery.
- WRAP programme.
- Specialist support from our mental health nurse.
- 1 to 1 support and group work programmes.

Building New Relationships

- Losing old relationships with substance misusing peers.
- Developing new relationships and building positive support networks
- Rebuilding relationships lost through addiction with families and significant others
- Shifting from a relationship with a substance to a new relationship with self, others and wider society.

Finding joy and passion in new life activities

- The introduction or re-introduction of hobbies and interests that are at conflict with addiction, filling the void left by addiction
- Choosing a more meaningful life that introduces a new passion and excitement for living ensuring that recovery is a long term viable option.

Giving back to others

- Engaging in voluntary work or employment or training activities that involve giving back and contributing positively to others and the wider community.

Our assessments adopt a holistic approach; not seeking to separate and isolate mental health and substance misuse conditions. Assessments take place as soon as clients access our services, most often through our open access day centre, where we employ a multidisciplinary team including: a specialist substance misuse worker, a mental health nurse and a qualified social worker. Staff provide brief interventions and refer clients on to our residential services, all of which work with dual diagnosis.

Our current provision includes a short stay assessment hostel with a move on provision and a specialist residential drug and alcohol service that provides managed withdrawal from alcohol and long term intensive support for up to two years. In addition to this, WCHP own a number of houses within our community which provide long term accommodation options with support, if required.

Our mental health nurse acts as a specialist resource for the whole organisation; providing support and training to staff, giving them the confidence and skills to manage client's mental health issues including sleep deprivation, anxiety and depression. Our services use Wellness Recovery Action Plan (WRAP) with dually diagnosed clients to support clients to effectively manage their own mental well being and to increase their understanding of themselves.

Our mental health nurse coordinates more complex cases through the treatment system, ensuring continuity of treatment from other services and reviewing prescribing regimes. As part of her role, she is seconded to support a specialist homeless GP service; entrenching her practice within both the voluntary and statutory sector. Additionally, she facilitates a 'hearing voices group', an anger management programme; and provides intensive one to one support for clients with more complex cases.

Our services are recovery focused; not only looking at recovery from addiction but also recovering mental well being with negotiated and agreed individualised support plans relapse prevention plans. In recovery we will look to introduce a new passion and excitement for life that makes recovery a viable long term option including new hobbies and interests, training, education, rebuilding relationships with support to access voluntary work and work opportunities.

Other specific activities offered include auricular acupuncture, yoga groups, relaxation groups, art and games groups, on site gym with personal trainer, music group, independent counselling services and a bespoke group work programme.

When dual diagnosis clients are ready to move on, the transition at this highly stressful time is managed by their key worker in liaison with our mental health nurse. Once clients have moved on to independent living, outreach support is provided through our dedicated outreach team who provide regular visits with complementary support from our mental health nurse. In order to help combat isolation in the community, we operate an outreach café where clients meet once a week to

socialise, support each other and receive support from staff. The café also offers structured activities such as art and games.

WCHP provision ensures wraparound services for dually diagnosed clients; from assessment to treatment and support, with accommodation and support to live independently in the community.

The particular issues presented by dual diagnosis clients

Clients are comprehensively assessed for substance misuse and mental wellbeing. Dual diagnosis is not a barrier to accessing our services. However, clients with greater complexities of need require more resources and a coordinated approach to their treatment journeys.

These more complex cases historically have integrated well into our residential services, although many clients progress well within a community setting. Particular challenges have been addressing the over reliance on prescribed medication and negotiating prescribing regimes that establish the best quality of life while still managing mental health illness. Abstinence from drugs or alcohol can in the short term elevate mental health conditions or produce new symptoms; particularly in clients who have been self medicating for many years, initially reducing the positive effects of recovery.

Brokering support from specialist mental health services can be challenging and historically there has been a tendency for some agencies to refer into our residential services and then withdraw their support. Accessing quality accommodation at the end of a successful treatment journey has been an ongoing challenge for our services, with environmental factors being key in maintaining long term mental well being and a sustainable recovery.

Explanation of and comments on service integration and partnerships

We work closely with mental health services locally; in part facilitated by our mental health nurse. Our relationship with other services is, in part, based on their need to access accommodation and support for their clients; therefore the relationship could be considered to be somewhat one sided.

Our relationship with local substance misuse services is stronger and more balanced with resources and skills being shared more openly including joint negotiation of individual support plans.

Particularly complex cases can present challenges especially in the absence of a diagnosis or where there has been a lack of commitment from other specialist services to engage and access. The requirement for a period of abstinence has been required by some services, even before carrying out assessments, resulting in treatment delays and frustrations for staff and clients alike.

The perceived or known impact of our approach

The wraparound nature of our services and the intensity and longevity of the support we provide results in good outcomes for more complex dually diagnosed clients, reducing and preventing revolving door cases; and preventing clients being pushed between services through a coordinated approach adopted for their treatment.

Suggested changes and improvement to improve the plight of people with or affected by dual diagnosis

There is a need in the area and region for more holistic based treatment services with a joined up approach between services. There is a need for an increased and more diverse range of community based accommodation options. There is also a need for the development of recovery orientated services and communities.

There is a need to develop more responsive direct access service provision for more complex cases, particularly in dealing with crisis situations; and thus preventing escalation and isolation.

Currently in order to fill local gaps in provision, we are developing local recovery communities; and planning to develop recovery community houses based on the 'Oxford House' model. For more complex clients who struggle to stop using and live communally, we will be building 6 separate independent accommodation units attached to one of our services; providing an opportunity for assessment, stabilisation and engagement as part of a multi agency response. We have already secured funding for the staffing of this initiative and half of the capital funding for the building of the units.

Any other relevant comments

The development of dual diagnosis peer mentors and more service user consultation and involvement in how services are developed would be useful.

Funding has been an ongoing issue for WCHP with the development of existing services and new initiatives largely being met from our reserves; and at our own organisational risk. Issue of insecure funding, very short term funding and complex, often over onerous funding streams never disappear. Funding issues cause serious Disabilities Disabilities in developing, diversifying, improving and growing services to meet the needs of people with dual diagnosis. The focus is often on survival and sustainability, rather than expansion.

Joint training between substance misuse services and mental health service may well help to break down some of the barriers, resulting in increased understanding, better continuity of services; and skilling up multi-disciplinary/agency workers in better dealing with more complex dual diagnosis cases.

Niall Read

Recovery Project Manager

Worthing Churches Homeless Projects

4 April 2014