Mental Health STRATEGIES

St.Helens Council

HALTON BOROUGH COUNCIL

NHS Halton and St Helens

Halton and St Helen's PCT

Joint Dual Diagnosis Commissioning Strategy 2009 - 2012

1st September 2009
MHS1165

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EXECUTIVE SUMMARY

Introduction

This document constitutes the Dual Diagnosis Commissioning Strategy for Halton and St. Helens Primary Care Trust.

The Strategy sets out the commissioning intentions of Halton & St. Helens Primary Care Trust in partnership with strategic partners and stakeholders over the next three years

It is based on both the requirements of national policy, and a clear understanding of what local people want from services.

Strategy objectives

Halton and St Helens Mental Health Commissioners wish to develop and deliver a dual diagnosis strategy for mental health and substance misuse (drug and alcohol), specific to the needs of the people of Halton and St Helens.

Scope

This document takes account of the above, but focuses upon the needs of those individuals who have a substance misuse problem (including alcohol) ***and*** an identified mental health need. 'Substances' in this context include illicit drugs of all classifications, prescribed medication, and legal substances including alcohol.

The strategy covers the whole adult age range of people Halton and St Helens and all tiers of support (i.e., public health, primary care, social care, secondary care and tertiary care). It is concerned with prevention, awareness, early intervention, treatment, after care and recovery.

Method

This strategy has been developed using the following activities:

Questionnaires: Service-mapping questionnaires circulated to local service providers. These were reviewed to identify services and interventions available matched against 'Tiers of Service' as identified by NTA.

Focus groups: three focus groups were organised and attended by primary, secondary, and 3rd Sector staff from health, social care and criminal justice agencies. A separate commissioning focus group was well attended. Themes from these group discussions are detailed later in this report

Interviews: a number of one-to-one interviews have been completed as well as small group interviews and site visits to services. The emerging themes are detailed later in this report.

Desk-based analysis*:* A national demographics and prevalence analysis has been undertaken.

Best Practice review: A best practice review has been completed.

Service user engagement: Two separate engagement meetings were held with services users with a dual diagnosis, one organised by CIC and the other by Arch. In both meetings

approximately fifteen people attended and gave consistent feedback.

Definition

The Dual Diagnosis Strategy Development steering group agreed the following definition for the project.

> ***Dual Diagnosis is the 'The co-existence of mental health and substance misuse problems'.*** (*Dual diagnosis: Mental health and substance misuse*. Rethink and Turning Point, 2004)

It is the view of the Dual Diagnosis Strategy Development Steering Group that this definition covered the widest number of people with dual diagnosis issues.

This definition is in line with the 'Changing Habits' report and the 'Commissioning Behaviour Change (Kicking Bad Habits)' report[1]

Principles and Values of Commissioning

This section examines the influencing policy and guidance on commissioning. It has established that the 'Fitness for Purpose' processes will be adopted. That, World Class Commissioning competencies, will be utilised. It identifies the principle commissioning priorities and high level outcomes it wishes to achieve. These, together with the 'future focus of commissioning and service development' set the strategic direction of travel for the next three years.

Best Practice Review

In this section, tables are presented demonstrating the best practice issues or interventions for alcohol and substance misuse.

The table covers the Tiers of intervention, typical service user, point of access, interventions, who delivers the intervention, the outcome for the service user and finally the effectiveness of the intervention.

A diagram demonstrating a good practice pathway for dual diagnosis is presented. This diagram supplements the 'model of care' and 'care pathway' as described in the relevant sections of this strategy.

A key message throughout the review is that 'community based support and recovery' is the expectation and that residential and inpatient care is for those people where the severity and risks posed require a period of continuous 24hour care.

DRIVERS FOR CHANGE

National Context

In this section a review of key policy has aimed to give an overview of the national perspective and highlight the key drivers for change. Particular note should be taken of the

[1] Boyce T. et al. (2008) *Commissioning and Behaviour Change: Kicking Bad Habits Final Report*. King's Fund

Models of Care, Substance Misuse and Alcohol and the NTA's review of treatment effectiveness [2](2002).

Local Commissioning Context

The commissioning context is complex. There is one Primary care Trust, two Local Authorities, two DAAT's and two LITs

There is value in developing a joint commissioning board to commission services for those with both mental health and substance misuse issues.

Provision of Services

A range of agencies currently provides, dual diagnosis services, across the two localities. Service provision would appear to be inequitable across the two localities with different service availability, range, and choice.

Population / Deprivation

In this strategic document, the main issues of population and deprivation will be highlighted. A more detailed account of Halton and St. Helens demographics may be found in the respective Joint Strategic Needs Assessments, or local authority data.

[2] *Models of Care for the Treatment of Drug Misusers. National Treatment Agency for Substance Misuse*. National Treatment Agency for Substance Misuse. 2002
Models of Care for Treatment of Adult Drug Misusers: Update 2006. National Treatment Agency for Substance Misuse. July 2006
D. Raistrick et al. *Review of the Effectiveness of Treatment for Alcohol Problems*. National Treatment Agency for Substance Misuse. November 2006

The total population is 297k composed of 119.5k in Halton[3] and 177.5k in St Helens.

The population of Halton is projected to increase by 6% to 126,500 by 2021. An increase of 43% of the 65 plus age group is estimated to grow from 16,400 in 2006 to 23,500 in 2021.

The Population of St Helens is currently 177,600[4] and is projected to increase by 1% up to 2015. St Helens mirrors the national trend. Like Halton will see an increase in the 65 plus population. By 2015 1:5 people will be over 65 years old.

Deprivation

Twenty three percent of the Lower Super Output Areas (LSOAs) in St. Helens are in the top 10% most deprived areas in England and 27% for Halton. However, some areas are ranked as much less deprived. For both Halton and St. Helens 8% of their LSOAs are in the top 25% least deprived areas.

Prevalence

Based on our analysis within Halton and St Helens Primary Care Trust footprint there is projected to be, be 36,900 cases of neurotic disorder (one individual may have more than one type of neurotic disorder). Of this identified population, 590 cases are likely to be moderate to severe alcohol dependence.

[3] http://www.statistics.gov.uk/statbase/Product.asp?vlnk=15106

[4] http://www.statistics.gov.uk/statbase/Product.asp?vlnk=15106

The analysis further identifies a projected 3096 cases of neurotic disorder and some form of drug dependence.

To the informed reader these figures may appear the wrong way around.
For the avoidance of doubt however, 590 cases (an individual may have more than one disorder –see page 30) will experience a moderate to severe **alcohol dependence. Whereas 3096 cases will experience a drug dependence. In this context drug dependence refers to 'any drug' and will include those who are drinking alcohol at harmful / hazardous levels.**

These figures were calculated as follows:
4% of men with any neurotic disorder had moderate/severe alcohol dependence and 0% for women (see http://www.statistics.gov.uk/downloads/theme_health/Tobacco_etc_v2.pdf page 66). Halton and St Helen's male neurotic disorder population is 14,756 and so, 4% of 14756 is **590**.

There is estimated to be 12% of males with any neurotic disorder who have ***any*** drug dependence (inc. cannabis, amphetamines, crack, cocaine, ecstasy, tranquillizers and opiates) and 6% for females (see page 70 of Tobacco report).

Applied to Halton and St Helen's male neurotic population this equals 0.12 x 14,756=**1771** and for female neurotics 0.06*22,097=**1326.** Therefore, the total for males and females equals **3096** as documented.

Adult CMHTs can expect between 17 and 32 patients with dual diagnosis every six months based on **current eligibility criteria**. Should eligibility change to be more inclusive the expectation would be that this figure would increase. Adult Inpatient units can expect between 48 and 95 dual diagnosis patients every six months.

It is acknowledged that the numbers of individuals experiencing some form of dual diagnosis is likely to be higher than that identified here. This is likely to be the result of a restrictive definition and / or eligibility criteria. The demand therefore for appropriate services is not captured.

Halton and St. Helens reported 116 appropriate referrals to their Substance Misuse Service team. The figures in the table below are calculated using the 116-referral figure and the prevalence rates from the COSMIC study

Estimated Number of Mental Health Cases in Halton and St. Helens PCT's SMS Service April 08 to October 08 (6 months period)

Disorder	Number of cases
Psychotic disorder	13
Personality disorder	61
Depression and/or anxiety disorder	112
Severe depression	45
Mild depression	67
Severe anxiety	32

Performance

Substance Misuse service users retained in treatment

Halton and St. Helens DAAT NTA data suggests that they perform less well than their statistical neighbours (ranked 8 out

of 11) but better than the England average. It also shows us that Halton and St Helens are keeping more drug users in sustained treatment (12 weeks+) than they were the previous year in 2006/7 (but all of the neighbours did better than the previous year except for Ashton PCT.) All of Halton and St Helen's statistical neighbours outperformed their local PCT plan for how many drug misusers they would have in treatment. Halton and St. Helens outperformed less than the comparator average but more than the England average.[5]
The table below show data from '2008/09 quarter 2 adult drug treatment partner information reports' St Helens and Halton 31st October 2008. This table shows the difference in performance between Halton and St Helens.

Data from 2008/09 quarter 2 adult drug treatment partner information reports. Halton & St Helens 31st October 2008

	St Helens	Halton
Adults in effective treatment 1/7/07 to 30/6/08	1025	709
% retained in treatment 12 weeks or more period 1/7/07 to 30/6/08	85%	76%
% not in effective treatment period 1/7/07 to 30/6/08	13%	23%

Stakeholder Feedback

As one would expect from such a wide stakeholder mix there was a wide range of views expressed, yet there were some striking themes that emerged as issues in a consistent manner, these included the following.

- Alcohol rather than substance misuse was the major issue
- The blocks and gaps in service provision were at Tier 2 and the interface with Tier 3.
- People with dual diagnosis are far more prevalent than definitions record. Few people who abuse alcohol or other substances do not have some underlying mental health need. Likewise, very many people with a mental health diagnosis will 'self prescribe' with other substances – be that alcohol, variations on their medication routine or illicit drugs.
- Many services were difficult to access due to the exclusion (rather than inclusion) criteria of many services. This meant there was little ownership: all services recognised the need to help the individual, but felt it was not their responsibility to deal with it.
- Too often, the above situation meant interventions only occurred when a crisis presented itself and the criminal justice system was invoked.
- Staff groups work in a silo culture of mental health, substance misuse or alcohol workers without recognising their skills and the needs of their service users were far more cross cutting than that.

There was also a consensus articulated as to how future services should be developed, as follows.

[5] *Drug Misusers in Treatment: Primary Care Trusts Overview – New National Targets 2007/2008*. Healthcare Commission. Available from http://www.healthcarecommission.org.uk/guidanceforhealthcarestaff/nhsstaff/annualhealthcheck/annualhealthcheck2007/08/qualityofs/drugmisusersintreatment.cfm

- Services should work much better together and 'share the care' more often.

- Services need to be more holistic and recognise the wider needs, including;
  - The family context
  - Worklessness and its impact on the individual and their family
  - The underlying causes of offending behaviour
  - Housing issues
  - Domestic Violence
  - Looked After Children
  - Education and social problem solving

- Services should be recovery and outcome focused.

- There is need for services to be consistent across the Halton and St Helen's footprint and therefore they should be commissioned consistently to eliminate service gaps and provide equity.

- There needs to be better performance management systems to ensure services deliver what they are supposed to do.

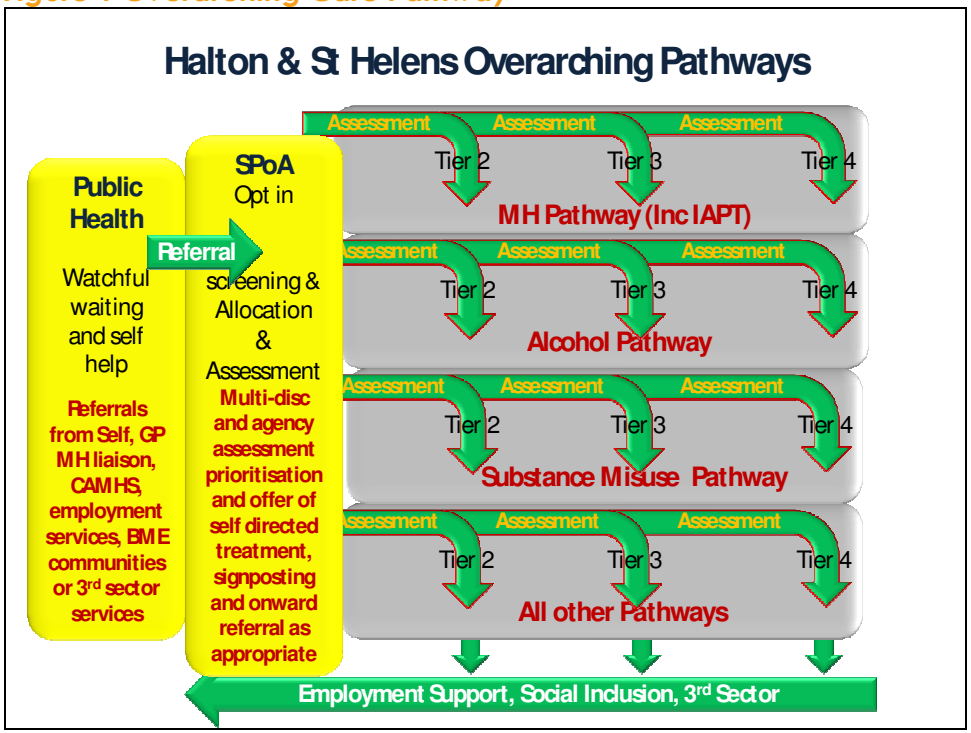
- More resources need to be devoted to primary care with an emphasis on promotion, prevention, and early intervention.

Where we need to get to

Model of Care / Care Pathway

The proposed model of care to be adopted based on a 'shared care – integrated approach' is set out. It has stated the basic principal of Dual Diagnosis Care being led by Mental Health Services whether this is in Primary or Secondary Care. To facilitate this, the role of Advanced Practitioner will be developed and work in conjunction with Dual Diagnosis Workers in Secondary Care. Figure 1 shows a Care Pathway that is aimed at ensuring an equitable and integrated approach is delivered.

Figure 1 Overarching Care Pathway



Conclusion – Commissioning Intentions

This strategy has set out the definition of Dual Diagnosis to be adopted. This definition embraces the principle of inclusion. That is, those who need a service will be offered care and treatment and that eligibility criteria will not stand in the way of accessing care.

The model of care to be adopted is based on best practice and the principle of 'mainstreaming'. This model is based on the practice of 'integrated and shared care.' The care pathway to be adopted seeks to reinforce the practice of integration. Mental Health will take a lead in the coordination of care for those experiencing both a mental health problem and a substance misuse dependency. The report recognises that alcohol, especially at the Tier 2/3 interface presents the greatest pressures for current services. To facilitate improvement in this deficit the role of Advanced Practitioner in Primary care will be developed and a review of the role of Dual Diagnosis Worker in secondary care will be undertaken.
A range of actions is now necessary to implement this strategy. A more detailed account of these actions can be found within the chapter entitled Conclusion and Commissioning Intentions

Actions

These action include:

- Reconfigure the current commissioning mechanisms.
  Aim. To develop coordinated commissioning and a performance management process equitable across

Halton & St Helens, including all stakeholders delivering care along the pathway.

- Establishing the model of care and single care pathway
  Aim. To establish clarity of entry and exit points within services.

- Implementation of the single point of entry.
  Aim. To ensure service users access the right services at the right time.

- The development of a work force plan.
  Aim. Ensure that all staff at all levels have the appropriate skills and qualification to deliver the care and treatment required.

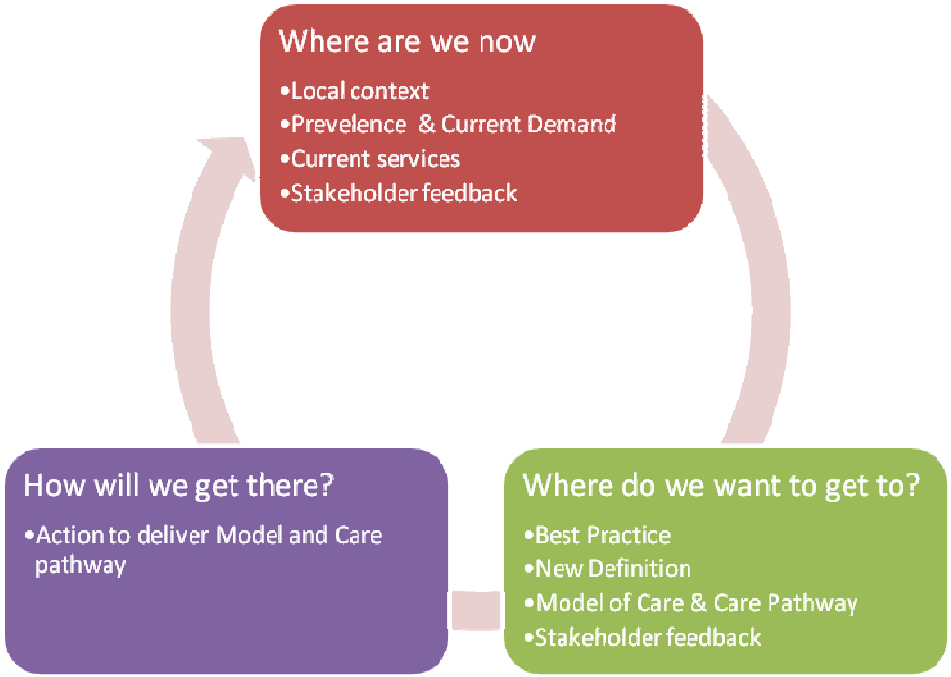
- The development of service specifications in line with the new NHS standard contract
  Aim. To ensure appropriate and inclusive eligibility criteria, and smooth interface between services. That all individuals have access to crisis services when required, irrespective of their dependence on substances.

- The development of a specific Dual Diagnosis service user forum in Halton
  Aim. To facilitate service user engagement and the provision of peer support.

- The development of a Provider Forum.
  Aim. To promote integrated working between providers, to assist identify blockages and barriers to service delivery.

- Commissioning will be based on the priorities identified to meet the identified capacity and capability issues of delivering the future model of care and care pathway.
  Aim: Prioritisation of commissioning. Achieve best value.

- To ensure that this strategy is complemented and a 'strategic fit' it is recommended that the current Mental Health Strategy be reviewed/updated as soon as practicable.



INTRODUCTION

This document constitutes the Dual Diagnosis Commissioning Strategy for Halton and St. Helens Primary Care Trust.

The Strategy sets out the commissioning intentions of Halton & St. Helens Primary Care Trust in partnership with strategic partners and stakeholders over the next three years

It is based on both the requirements of national policy, and a clear understanding of what local people want from services

This dual diagnosis strategy will provide an overall framework for performance and service improvement. The aim is to provide a contextual background, consider organisational priorities, benefits, risks, and contain action plans to deliver a programme of work on dual diagnosis. It will set out a vision and general principles that all the partners can sign up to, and help develop services for service users and carers that will have a positive impact on their health and quality of life.

The report will approach the subject in the following sequential order.

- Identifying the strategies objectives and scope
- Methods
- Review of literature and best practice, including government policy directions
- Review the local context, including what is currently provided and by whom
- Demographics and performance
- Identify themes from stakeholder engagement events
- Describe a new model of care and care pathway

- Provide the framework to list initiatives to achieve the desired outcomes
- Appendices include more detailed supporting evidence.

STRATEGY OBJECTIVES

The purpose of this strategy is to develop a strategic approach to meet the needs of those with a dual diagnosis (drug and alcohol) across the whole of Halton and St Helens locality

STRATEGIC CONTEXT & SCOPE

Halton, St Helens and the surrounding areas have complex needs. There are pockets of high levels of deprivation, sitting alongside the relative wealth of some commuters, all within well established and relatively newly developed communities.

The recent reconfiguration of PCT boundaries, coupled with increasingly stronger links to the Local Authority and more robust commissioning frameworks (including World Class Commissioning), all provide the opportunity to better co-ordinate services to meet the needs of those individuals with the complex range of needs associated with mental health, substance and alcohol misuse and their related health and social care/welfare domains.

Like most areas, previously each locality and service sector has developed services in relative isolation. However, this new context provides the opportunity to achieve economies of scale and scope, to build upon 'what works', and better integrate successful interventions for individuals along the 'whole dual diagnosis pathway'.

Mainstream mental health services have a responsibility to address the needs of people with a dual diagnosis. Substance misuse services should not be ghetto services. Where they exist, specialist teams of dual diagnosis workers should provide support to mainstream mental health services.

It is therefore essential that local care pathways be fully integrated be they in primary, secondary, mental health or substance misuse in their orientation. Robust care planning procedures at an individual level and clear strategic integration at a corporate level all need to be achieved.

The mechanism to accomplish all of this is robust integrated commissioning at a local level.

By its very nature any dual diagnosis, or co-morbidity, spans more than one domain and excludes others. The current mental health strategy for Halton and St Helens is due for review and work has commenced within the locality negotiating a '**single point of access' (SPoA)** its scope, role and function**. Each DAAT has a Harm Reduction Strategy.** At the time of writing an Alcohol Strategy is also being developed.

This document takes account of the above, but focuses upon the needs of those individuals who have a substance misuse problem (including alcohol) ***and*** an identified mental health need.

Individuals who have a mental health need but who do not have a substance misuse problem are excluded from the strategy. Similarly, those who have a substance misuse problem but do not have identified mental health problem are also excluded.

'Substances' in this context include illicit drugs of all classifications, prescribed medication and legal substances including alcohol.

The strategy covers the whole adult age range of people Halton and St Helens and all tiers of support (i.e., public health, primary care, secondary care and tertiary care). It is concerned with prevention, awareness, treatment, after care and recovery.

The development of a Dual Diagnosis Commissioning Strategy would in the normal course of events 'follow on' from an over arching **Mental Health Strategy.**

At the time of writing the mental health, strategy is due for review. Consequently reference to overall mental health policy and general health and social care policy and guidance needs to be stated. These significantly affect a developing model of care, and integrated working.

METHODS

This section will outline the strategy's process of development and methods used.

Questionnaires: Service-mapping questionnaires were circulated to local service providers. These were reviewed to identify services and interventions available and matched against 'Tiers of Service' as identified by the NTA.

Focus groups: three focus groups were organised and were attended by primary, secondary, and social care staff as well as 3rd Sector staff, from a wide range of health, social care and criminal justice agencies. A separate commissioning focus group was well attended. Themes from these group discussions are detailed later in this report

Interviews: a number of one-to-one interviews have been completed as well as small group interviews and site visits to services. The emerging themes are detailed later in this report.

Desk-based analysis*:* A national demographics and prevalence analysis has been undertaken.

Best Practice review: A best practice review has been completed.

Service user engagement: Two separate engagement meetings were held with services users with a dual diagnosis, one organised by CIC and the other by Arch. In both meetings approximately fifteen people attended and gave consistent feedback.

DEFINING DUAL DIAGNOSIS

At its most simple, the *Dual Diagnosis in Mental Health Inpatient and Day Hospital Settings* (DH 2006 p.1) document, defines it

as ". a diagnosis of mental illness and a diagnosis of substance misuse disorder".

The term "dual diagnosis" poses many problems as it simply refers to the presence of more that one clinical diagnosis. Historically this has referred to those individuals with a severe and enduring mental health problem and a substance misuse problem. This term does not inform commissioners or providers in any detail of the health and social care needs of this group of service users. Dual Diagnosis is a term used to define an increasingly large section of service users that have both a mental health and substance use problem. This term is progressively including people with substance use problems such as alcohol dependence that also have anxiety disorders, and people with schizophrenia who have problems with cannabis use.

The Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide (2002 p.7) states that 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.

These definitions are secondary care focussed and would limit the range of service users who would be considered under these definitions / description.

The Changing Habits[6] report brings together intelligence from the North West region on the treatment needs and current service provision for service users with a 'dual diagnosis'. The aim of this is to promote the recovery of individuals.

This report illustrates

> 'Dual Diagnosis is a 'whole system' multi-agency issue affecting a broad cross section of adults, with varying levels of severity and impact on the individual, their friends and family, as well as local communities
>
> A population based approach to commissioning and managing integrated Dual Diagnosis service provision, which utilises existing resources to support the maximum number of people across broad spectrum of need within local Dual Diagnosis treatment populations.'[7]

[6] Needham, M. (2007) *Changing Habits North West Dual Diagnosis Intelligence Report.* CSIP North West
[7] Needham, M. (2007) *Changing Habits North West Dual Diagnosis Intelligence Report.* CSIP North West

The 'Changing Habits' report suggests a more encompassing and wide ranging description of who may benefit from accessing services.

The needs of children and young people experiencing these difficulties will be different to those experienced by adults and to older adults. There, will also be cultural and ethnic differences within dual diagnosis, as well as gender and sexuality issues.

For the purposes of this report the Dual Diagnosis Strategy Development steering group agreed to adopt the following definition.

> ***Dual Diagnosis is the 'The co-existence of mental health and substance misuse problems'.*** (From *Dual diagnosis: Mental health and substance misuse*. Rethink and Turning Point, 2004)

It is the view of the Dual Diagnosis Strategy Development Steering Group that this definition covered the widest number of people with dual diagnosis issues.

This definition is in line with the 'Changing Habits'[8] report and the 'Commissioning Behaviour Change (Kicking Bad Habits)' report[9]

[8] Needham, M. (2007) *Changing Habits North West Dual Diagnosis Intelligence Report*. CSIP North West
[9] Boyce T. et al. (2008) *Commissioning and Behaviour Change: Kicking Bad Habits Final Report*. King's Fund

PRINCIPLE AND VALUES OF COMMISSIONING

The guiding principles by which the project was conceived, developed and evaluated were cognisant of wider imperatives including the following.

World Class Commissioning[10]: places Primary Care Trusts and their commissioning partners at the forefront of leading the future NHS at a local level. Great emphasis is placed on quality interventions that meet the local demand, provide value for money, and are measured by their outcome rather than mere activity.

The 'Darzi' Review[11]: Lord Darzi's review of the NHS, ***High Quality Care for all***, sets the agenda for future NHS services, ensuring they are fair, effective, personal and safe. It called for PCTs to commission comprehensive well-being and prevention services, in partnership with local authorities and local partners, based on local identification of need. It called for the NHS to focus on six key goals: reducing smoking rates, tackling obesity, treating drug addiction, improving sexual health, improving mental health and reducing alcohol harm.[12]

Putting People First[13] and Transforming Social Care[14]: sets the vision for the radical reform of social care by promoting strong

[10] DH. (2007) *World Class Commissioning: Vision*
[11] Lord Darzi. *High Quality Care for All: NHS Next Stage Review Final Report*. (Cm 7432, 2008)
[12] DH. (2008) *The Operating Framework for 2009/10 for the NHS in England*
[13] DH. (2007) *Putting People First: A Shared Vision and Commitment to the Transformation of Adult Social Care*
[14] *LAC(DH)(2008)1: Transforming Social Care*

local leadership in the promotion of individualised care build upon the principles laid out in **Our Health Our Care Our Say[15].**

Various mental health strategies[16] [17] highlight the need to develop better treatment responses for dual diagnosis.
Halton and St Helens Primary Care Trust 'Ambition for Health Strategy' sets out the Primary Care Trust outcomes and ambitions. These ambitions have come from understanding of the needs of our local population, and our desire to ensure that we are able to deliver two critical outcomes: These are:

Improving health and tackling inequalities in health
"To work with partners and local people to promote a positive experience of good health and equal opportunities for health, not simply an absence of disease".

Delivering effective and efficient health and related services
"To provide effective and efficient health care services that place the needs of the patient at their core"

Our ambitions are:

- To support a healthy start in life
- To reduce poor health that results from preventable causes
- To ensure that when people do fall ill from some of the major diseases, they get the best care and support
- To provide services which meet the needs of vulnerable people
- To make sure people have excellent access to services and facilities
- To play our part in strengthening disadvantaged communities

Fitness for Purpose

Commissioning a Patient-led NHS saw the reconfiguration of PCTs as the first stage in delivering a robust infrastructure from which to strengthen the commissioning function of PCTs. Stage two focuses on ensuring that PCTs are fit for purpose. This process looks at Strategic Planning, Care Pathway Management, Provider Management and Monitoring and Remediation.

Changing Habits[18]

This report offers a direction of travel to enable local stakeholders to test out how to overcome some key issues:
Ensuring individuals engaged with Community Drug Teams receive access to mental health treatment including psychological therapies, improving joint working and co-ordinating service provision/investment such as Primary Care Mental Health Services and 'shared care' services and promoting treatment choice such as abstinence from cannabis through wider smoking cessation initiatives.

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[15] DH. *Our Health, Our Care, Our Say: A New Direction for Community Services.* (Cm 6737, 2006)
[16] DH. (1999) *National Service Framework for Mental Health*
[17] Appleby, L. (2004) *National Services Framework 5 years on*. DH
[18] Needham, M. (2007) *Changing Habits North West Dual Diagnosis Intelligence Report.* CSIP North West

Kicking Bad Habits:

This report assesses existing and innovative methods the health service can use to persuade people to live more healthy lifestyles, including providing information and personal support and offering financial incentives. This report aims to help those within the NHS
and beyond who are tasked with finding cost-effective solutions to the problems caused by unhealthy lifestyles and behaviour. It examines four bad habits; smoking, alcohol misuse, poor diet and lack of exercise.

New Contract Guidance

Wherever possible a coordinated approach to commissioning is to be adopted. This will assist in best value and a coordinated care pathway approach.
A Stepped Commissioning Framework for Dual Diagnosis[19] will be developed in Halton and St Helens. This will facilitate a 'whole system approach' to the development of services. This commissioning strategy is the first phase of this process.

The priorities of Halton & St. Helens Dual Diagnosis commissioning group include:

- The further development of mechanisms for involving service users and their carers in the commissioning reform of Dual Diagnosis services

- To deliver the complete commissioning cycle in relation to the services covered by this approach

- Undertake commissioning at a number of levels and bring them into a cohesive whole system approach.

- Review commissioning mechanisms and structures to facilitate a coordinated approach and to achieve best value. Developing a governance framework to ensure there is clarity and agreement about where decisions and commitments are made. Working towards a focus on commissioning for the outcomes set out in the national commissioning framework.

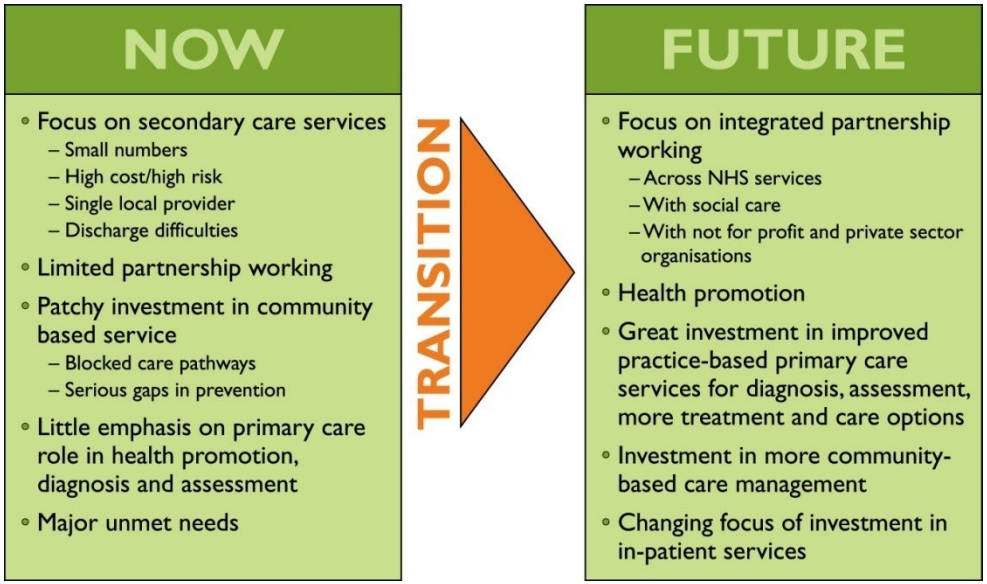
- Ensure that national policy is implemented in a way that takes account of local circumstances and needs.

- The commissioning partners will ensure that there are improvements in health and well being and reductions in health inequalities and social exclusion. This will include improved quality, effectiveness, and efficiency of services, together with increased choice and a better experience of care. Critical to the improved experience of care is the continued partnership working across health and social care and further developing a shared and integrated model of care.

The following diagram adapted from 'The Commissioning Friend for mental health services' indicates a broad direction of travel for the development and commissioning of future dual diagnosis services.

[19] Needham, M. (2007) *Changing Habits North West Dual Diagnosis Intelligence Report*. CSIP North West

Figure 2 Future focus of commissioning and service development



Outcomes

Halton and St Helens are moving toward a more 'outcome focussed' approach toward commissioning and the table below begins to identify key outcomes that will be measured.

The mechanism for monitoring these outcomes will be subject to a key action plan to implement the strategy. This will entail the setting of these outcomes as core markers within the new contracts and agreeing the core KPI that show progress on these outcomes.

HIGH LEVEL OUTCOME
Improved patient outcomes
Increased independent living
Recovery and socially inclusive focus
Improved vocational and social outcomes
Decreased hospital admissions and readmissions
Increased patient choice
Increased positive risk taking
Local, agreed, targets met
Best value
Training of staff in assessing use of alcohol and drugs and how to handle patients who are drunk or under the influence of drugs

NATIONAL CONTEXT

Accurate diagnosis and selecting the appropriate treatments for dual diagnosis can be difficult as symptoms can overlap. It is therefore essential not to make early assumptions.

Weaver et al (2002): Substance misuse is often not picked up by mental health teams, similarly substance misuse teams often failed to spot mental health problems, thus highlighting a need for more staff training and routine assessment

Prevalence

Rethink's Briefing (2006) highlights the psychiatric problems commonly associated with dual diagnosis as Depressive disorder, Anxiety disorder, other psychiatric disorders such as schizophrenia and personality disorder

Substance misuse among those with mental health problems is common. A study by Weaver et al (2002) reported that 74.5% of users of drug services and 85.5% of users of alcohol services experienced mental health problems. 44% of mental health service users reported drug use and/or were assessed to have used alcohol at hazardous or harmful levels within the past year.

In terms of co-morbidity, alcohol is the most commonly misused substance. S. Banejee et al. *Co-existing Problems of Mental Disorder and substance Misuse (Dual Diagnosis)* College research Unit, 2002 found that people diagnosed with a mental health problem have a significantly greater risk of substance misuse, those with schizophrenia are more likely to misuse alcohol

The Weaver study (2002) came up with the following prevalence estimates

	Prevalence estimates	
	% Drug treatment pop.	% Alcohol treatment pop.
Psychotic disorder	7.9	19.4
Personality disorder	37	53.2
Depression and/or anxiety disorder	67.6	80.6

Severe depression	26.9	46.8
Mild depression	40.3	33.9
Severe anxiety	19	32.3

The *Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice* (2002) found prisons have a high prevalence of drug dependency and dual diagnosis.

D'Silva & Ferriter. *Substance use by the mentally disordered committing serious offences –a high-security hospital study*. The Journal of Forensic Psychiatry & Psychology Vol 14 No 1 April 2003 178–193 reports that in high secure hospitals, between 60 and 80% of patients have a history of substance use prior to admission.

Impact on Individuals

Both substance misuse and untreated mental illness are linked to higher levels of suicide. Substance misuse is also associated with increased rates of violence and suicidal behaviour. A review of inquiries into homicides committed by people with a mental illness identified substance misuse as a factor in over half the cases, and substance misuse is over-represented among those who commit suicide.

National Audit of Violence 2003-2005, Healthcare Commission and Royal College of Psychiatrists, identified alcohol and drug misuse as the main trigger for violence in mental health services

Treatment

Historically substance misuse and mental health problems were dealt with separately, clients with both problems were usually treated by one service provider or the other, meaning that some areas of their problems went undiagnosed or not dealt with effectively. The Weaver study (2002) reported that 38.5% of drug users with psychiatric disorder were not receiving any treatment for their mental health problem.

The *Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice* (2002) introduced the 'mainstreaming'. The term was used to recommend that the care co-ordination for people with severe and enduring mental illness and substance misuse should be the responsibility of a mental health team. The idea was that patients should not be moved between different services where there could be a risk of the whole problem not being treated. It recommended more collaboration between mental health teams and substance misuse teams.

Hindrances to overcome

Homelessness is frequently associated with substance misuse problems, *Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice, 2002*. Homelessness almost trebles a young person's chance of developing a mental health problem. Assertive outreach to these groups and in-reach to hostels are necessary.

The Weaver study (2002) highlighted the typical characteristics of co-morbid patients and the subsequent impact this has on treatment adherence. The study found that co-morbid patients were perceived as more chaotic and aggressive, making them less compliant with care plans.

The Mental Health Policy Implementation Guidance, Dual Diagnosis Good Practice Guide[20]

This guide summarises current policy and good practice in the provision of mental health services to people with severe mental health problems and problematic substance misuse. The substances concerned include legal and illegal drugs, alcohol and solvents, but not tobacco. It represents an addition to the Mental Health Policy Implementation Guide which supports implementation of the NSF for Mental Health.

Substance misuse is usual rather than exceptional amongst people with severe mental health problems and the relationship between the two is complex. Individuals with these dual problems, deserve high quality, patient focused, and integrated care. **This, should be delivered within mental health services.** This policy is referred to as "mainstreaming." Patients, should not be shunted between different sets of services or put at risk of dropping out of care completely. "Mainstreaming" will not reduce the role of drug and alcohol services, which will continue to treat the majority of people with substance misuse problems and to advise on substance misuse issues. Unless people with a dual diagnosis, are dealt with effectively by mental health and substance misuse services, these services as a whole will fail to work effectively.

Dual diagnosis in mental health inpatient and day hospital settings[21]

This guidance covers the assessment and clinical management of patients with mental illness being cared for in psychiatric inpatient or day care settings who also use or misuse alcohol and/or illicit or other drugs*. It also covers organisational and management issues to help mental health services manage these patients effectively.

The key message is that the assessment and management of drug and alcohol use are core competences required by clinical staff in mental health services.

The guidance aims to:

- encourage integration of drug and alcohol expertise and related training into mental health service provision;
- provide ideas and guidance to front-line staff and manages to help them provide the most effective therapeutic environments
- help mental health services plan action on dual diagnosis†.

The management of dual diagnosis is a significant concern for both mental health policy and practice.

This was highlighted by the National Director for Mental Health, Professor Louis Appleby, in his 2004 report to the Secretary of State for Health on the implementation of the National Service Framework for Mental Health[1]:

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[20] DH. (2002)*The Mental Health Policy Implementation Guidance, Dual Diagnosis Good Practice Guide*

[21] DH. (2006) *Dual Diagnosis in Mental Health Inpatient and Day Hospital Settings*

Services for people with 'dual diagnosis' – mental illness and substance misuse –are the most challenging clinical problem that we face.[22]

Closing the Gap (DH, 2006)

Closing the Gap: A Capability Framework for Working Effectively with People with a Combined Mental Health and Substance Use Problems draws on existing national occupational standards in mental health,
substance misuse and other fields to bring together one set of competencies for working with people with a dual diagnosis. There are three levels: core, generalist and specialist.[23]

[22] DH. (2006) *Dual Diagnosis in Mental Health Inpatient and Day Hospital Settings*
[23] Hughes, L. (2006) *Closing the Gap*. DH

BEST PRACTICE REVIEW

Informed by the above research and guidance, this section captures the best practice issues or interventions for mental health, alcohol and substance misuse. The following tables cover the Tiers of intervention, typical service user, point of access, recommended interventions, who delivers the intervention, the outcome for the service user and finally the effectiveness of the intervention.

A diagram demonstrating a good practice pathway for dual diagnosis is also presented. This diagram will supplement the 'model of care' and 'care pathway' as described in the relevant sections of this strategy.

Alcohol

Figure 3 Best Practice Review Alcohol – The Four Tiers of Intervention

Tiers of Intervention	Typical Service User	Point of Access/Settings	Involves/Interventions	Carried out by	Outcome for the Service User	Effectiveness
Tier 1: Alcohol-related information and advice, screening, simple brief interventions and referral	Hazardous, harmful and dependent drinkers	Includes: Primary healthcare services A&E Social services Homelessness services General hospital wards Police settings Prison service	Includes: Alcohol advice and information Targeted screening and assessment for those exceeding government alcohol limits Simple brief interventions for hazardous and harmful drinkers Referral for those requiring specialised alcohol treatment Partnership with specialised alcohol treatment services	A wide range of agencies, the main focus of which is not alcohol treatment. GPs, nurses or trained non-medical practitioners	Reduction of alcohol consumption (abstinence or moderation goal)	Brief interventions are effective in reducing alcohol consumption among hazardous and harmful drinkers at low-risk levels Effects of brief interventions last for up to 2 years after intervention and perhaps as long as 4 years There is no evidence that opportunistic brief interventions are effective among people with more severe alcohol problems and

Tiers of Intervention	Typical Service User	Point of Access/Settings	Involves/Interventions	Carried out by	Outcome for the Service User	Effectiveness
		Education services				levels of dependence *Review of the Effectiveness of Treatment for Alcohol Problems* (2006)
Tier 2: Open access, non-care planned, alcohol-specific interventions	Harmful and dependent drinkers	Includes: Specialist alcohol services Primary healthcare services Acute hospitals Psychiatric services Social services Domestic abuse agencies	Includes: Alcohol-specific information, advice and support Extended brief interventions and brief treatment to reduce alcohol –related harm Alcohol-specific assessment and referral of those requiring more structured alcohol treatment Partnership with staff from Tier 3 and 4 provision or	Competent alcohol workers	Improvement in health and reduction of alcohol consumption (abstinence or moderation goal)	There is mixed evidence on whether extended brief interventions in healthcare settings add anything to the effects of simple brief interventions There is some evidence that extended brief intervention is effective among male hazardous or harmful drinkers in the contemplation stage of change *Review of the Effectiveness of*

Tiers of Intervention	Typical Service User	Point of Access/Settings	Involves/Interventions	Carried out by	Outcome for the Service User	Effectiveness
		Homelessness services Probation services Prison services Occupational health services	joint care of individuals attending other services providing Tier 1 interventions Triage assessment			*Treatment for Alcohol Problems* (2006)
Tier 3: Community-based, structured, care-planned alcohol treatment	Dependent drinkers	Includes: Specialist alcohol treatment services (in the community or within a hospital site) Outreach services Primary healthcare services	Includes: Comprehensive substance misuse assessment Care planning and review for all those in structured treatment Community care assessment and case management of alcohol misusers Evidence-based prescribing interventions in the context of a package of care, including community-based medically assisted detoxification Evidence-based psychosocial therapies	Competent drug and alcohol specialist practitioners	Reduction of alcohol dependence Improvement in alcohol related social problems	The community reinforcement approach is an effective treatment modality, particularly relevant to service users with severe alcohol dependence. It is particularly effective with socially unstable and isolated service users with a poor prognosis for traditional forms of treatment Social behaviour and network therapy is an effective treatment for alcohol problems Behavioural self-control training is the most effective treatment available for service users considered

Tiers of Intervention	Typical Service User	Point of Access/Settings	Involves/Interventions	Carried out by	Outcome for the Service User	Effectiveness
			within a care plan to address alcohol misuse and co-existing conditions such as depression where appropriate Structured day programmes and care-planned day care Liaison services with other services			suitable for a moderation goal Coping and skills training is an effective treatment among moderately dependent drinkers *Review of the Effectiveness of Treatment for Alcohol Problems* (2006)
Tier 4: Alcohol specialist inpatient treatment and residential rehabilitation	Severely dependent drinkers	Includes: Specialist statutory, independent or voluntary sector inpatient facilities For medically assisted detoxification Residential rehabilitation units for alcohol misuse	Includes: Comprehensive substance misuse assessment Care planning and review for all inpatients residential structured treatment Evidence-based prescribing interventions in the context of a package of care, including medically assisted detoxification in inpatient or residential care Psychosocial therapies to address alcohol misuse Provision of information,	Alcohol specialist in specialist setting	Reduction of alcohol dependence Improvement in alcohol related health problems	

Tiers of Intervention	Typical Service User	Point of Access/Settings	Involves/Interventions	Carried out by	Outcome for the Service User	Effectiveness
			advice and training to others delivering Tier 1, 2 and 3 services			

Substance Misuse

Figure 4 Best Practice Review Substance Misuse: The Four Tiers of Intervention

Tiers of Intervention	Typical Service User	Point of Access/Settings	Involves/Interventions	Carried out by
Tier 1: Non-substance misuse specific services requiring interface with drug and alcohol treatment	Wide range of clients including drug and alcohol misusers	Includes: General healthcare settings Social care Education settings Criminal justice settings Drug treatment is not the main focus for any of the above	Includes: Drug and alcohol screening, assessment and referral mechanisms to drug treatment services from generic, health, social care, housing and criminal justice services Management of drug misusers in generic health, social care and criminal justice settings (e.g. police custody) Health promotion advice and information Hepatitis B vaccination programmes for drug misusers and their families	Wide range of professionals including: Medical services Social workers Teachers Community pharmacists Probation officers Homeless person units All need to be sufficiently trained to deal with drug misusers
Tier 2: Open access drug and alcohol treatment services	Wide range of drug and alcohol misusers referred from a variety of	Includes: Primary care settings Outreach Pharmacy settings	Includes: Drug-related information and advice Triage assessment and referral for structured drug treatment Interventions to reduce harm and risk	Competent drug and alcohol specialist workers

Tiers of Intervention	Typical Service User	Point of Access/Settings	Involves/Interventions	Carried out by
	sources including self-referral	Criminal justice settings Tier 2 interventions may be delivered separately from Tier 3 but will often be delivered in the same setting and by the same staff as Tier 3 interventions	due of infections for active drug users eg needle exchanges Brief psychosocial interventions for drug and alcohol misuse Brief interventions for specific target groups including high-risk and other priority groups Drug-related support for clients seeking abstinence Drug-related support for clients who have left care-planned structured treatment Outreach services engaging clients into treatment	
Tier 3: Structured community-based drug treatment services	Drug and alcohol misusers in structured programme of care	Includes: Specialist drug services within their own premises, the community or hospital Outreach Primary care settings Pharmacies Prison settings	Includes: Comprehensive drug misuse assessment Care planning, co-ordination and review for all in structured treatment Community care assessment and case management for drug misusers Harm reduction	Competent drug and alcohol specialist workers

Tiers of Intervention	Typical Service User	Point of Access/Settings	Involves/Interventions	Carried out by
			Prescribing interventions Psychosocial interventions Liaison services for acute medical and psychiatric health services and for social care services	
Tier 4: Residential services for drug and alcohol misusers	Drug and alcohol misusers with a high level of presenting need	Includes: Dedicated inpatient or residential substance misuse units or wards Those with co-existing medical needs may be being services in the setting of those medical needs Prison detoxification units	Includes: Inpatient specialist drug and alcohol assessment, stabilisation and detoxification/assisted withdrawal services Inpatient detoxification/assisted withdrawal provision directly attached to residential rehabilitation units	Medical staff with specialised substance misuse competency

Mental Health

The NSF Mental Health 1999 set the scene for major investment in mental health services and there are now many Policy Implementation Guides for mental Health. The 'stepped care model' is referred to in, NICE Guidance on Treatment of Depression and in the Improving Access to Psychological Therapies programme. This stepped care model can be utilised across mental health care systems and provides a cross reference point for alcohol and substance misuse interventions.

Figure 5 Best Practice Review Mental Health: Stepped care model

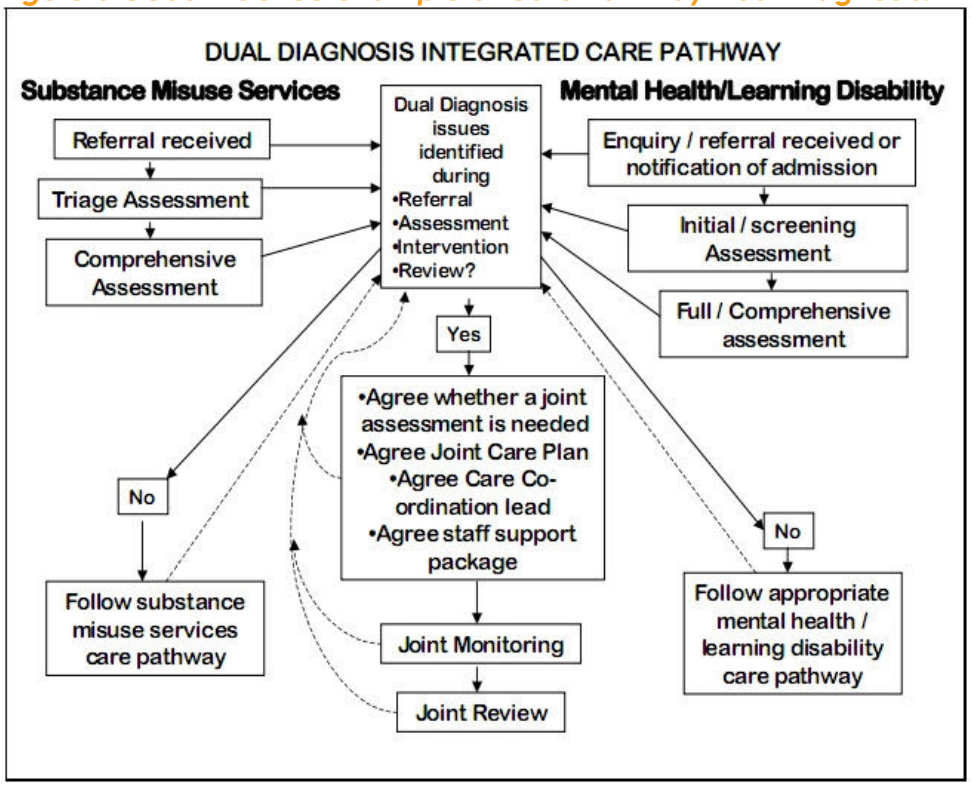
Step	Point of Access	Level of Mental Health Problem	Involves/Intervention	Carried out by
Step 1	Primary care and general hospital setting	Recognition (either the patient refuses treatment or the health professional thinks they will recover without treatment)	Watchful waiting	GP Practice nurse
Step2	Primary care setting	Mild	Guided self-help Computerised CBT Brief psychological interventions	Primary care team Primary care mental health worker
Step 3	Primary care setting	Moderate to severe	Medication Brief psychological intervention Social support	Primary care team Primary care mental health worker
Step 4	Specialist mental health setting	Treatment-resistant Recurrent Atypical and psychotic depression Those at significant risk	Medication Complex psychological interventions Combined treatments	Mental health specialists including crisis teams

Step 5	Specialist mental health setting	Risk to life Severe self-neglect	Medication Combined treatments ECT	Inpatient care teams Crisis teams

Dual Diagnosis

As the care and treatment of a Dual Diagnosis, or co morbidity of substance misuse (including alcohol) and mental health problems is the combination of best practice from the relevant services the figure 6 below is suggested as a mechanism for ensuring that the 'shared care' 'Integrated approach is achieved. Discussion of this model of care can be found at 'Model of Care' section. Although this diagram references only substance misuse for Halton and St Helens' purposes this should be read to include alcohol too.

Figure 6 Good Practice example of Care Pathway Dual Diagnosis.



(Source Dual Diagnosis A multi – agency strategy for County Durham and Darlington -2005)

This pathway would ensure that any service user who had been referred directly to any service would not 'fall through the net'.

For the avoidance of doubt, the principles of integrated care as drawn in figure 6 can be applied both in primary and secondary care and include alcohol and substances. With the development of the single point of access where, comprehensive multi-disciplinary assessments occur, the expectation would be that the majority of service users requiring a coordinated approach to their care are identified much earlier in the care system.

Within the Halton and St. Helens Dual Diagnosis Model, mental health services either primary care or secondary care would take a lead in ensuring that the service user had both their substance and mental health care needs met.

WHERE ARE WE NOW?

LOCAL CONTEXT

This section describes the local commissioning, and provider arrangements
outlines the demographics of the Halton and St Helens footprint.

Overview

At the time of writing this strategy, a number of initiatives were taking place in parallel. Notably the development of a 'single point of access' into mental health services and the development of an Alcohol Strategy. The Mental Health Strategy itself is now due for a review.

Commissioning

Halton and St. Helens Primary Care Trust has recently evolved from the merger of Halton Primary Care Trust and St Helens Primary Care Trust. It currently operates in a complex commissioning context: there are two Local Authorities (Halton Borough Council and St Helens Council), there are two Drug and Alcohol Action Teams (DAAT) and two Local Implementation Teams (LITs mental health). Currently these organisations are responsible for the commissioning of Mental Health, Alcohol, and Substance Misuse Service Services.

Dual Diagnosis provision is a combination of these services led by mental health.

Providers of Service

A range of agencies currently provide dual diagnosis services, across the two localities. Service provision would appear to be variable across the two localities with different service availability, range, and choice.

From the information obtained, from the self -report questionnaires, and subsequent interviews with staff. Greater clarity is required regarding the outcomes services are commissioned to deliver.

A distinction between the tiers of service, service delivery, and outcomes would assist providers and commissioners manage the gaps in service provision.

Insufficient data regarding Halton services required a 'best guess' approach to determining the current care pathway.

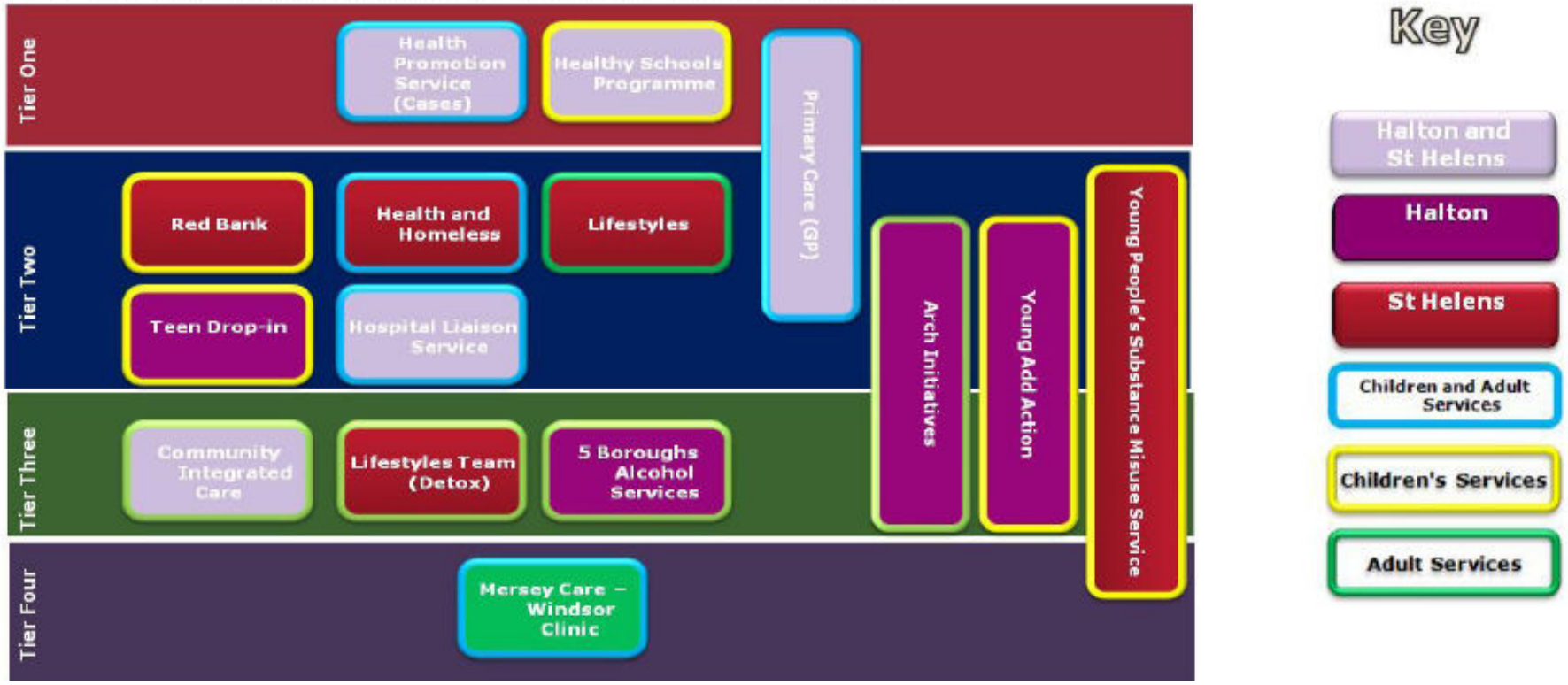
An existing pathway is present in Halton but requires a review in light of this document.

Residential Care recovery is available via the respective Local Authority Community Care Funding Panels.

A more detailed view of alcohol services is provided in the Alcohol Strategy and is reproduced here for convenience.

Figure 7 Alcohol Services by locality

- Tier 1 interventions: Alcohol related information and advice; screening; simple brief interventions (up to 4 interventions) and referral
- Tier 2 interventions: Open access, non care planned alcohol specific interventions and extended brief interventions
- Tier 3 interventions: Community based, structured, care planned alcohol treatment
- Tier 4 interventions: Alcohol specialist in-patient and residential detox



(Source Halton And St. Helens Alcohol Strategy 2008 p17)

The above diagram demonstrates that Halton services include Arch and Young Add Action across Tiers 2 and 3, an Alcohol service provided by the mental health trust for Tier 3 and Teen Drop In providing a Tier 2 service. This compares to St Helens that have a Young Peoples Substance Misuse service provided across Tiers 2, 3 and 4. Lifestyles provide a service to Tiers 2 and 3. Red Bank provide a service to Tier 2. Services shared across Halton and St Helens include; Primary Care, (Tier 1&2. Health Promotion (Tier 1) and Community Integrated Care (Tier 3). This does not indicate the capacity of these services within each of the localities.

DEMOGRAPHICS

In this section brief details of population and deprivation are given. This is followed by an examination of prevalence issues. A more detailed account of Halton and St. Helens demographics may be found in the respective Joint Strategic Needs Assessments.

Population

The total population is 297k composed of 119.5k in Halton and 177.5k in St Helens

The population of Halton is projected to increase by 6% to 126,500 by 2021. An increase of 43% of the 65 plus age group is estimated to grow from 16,400 in 2006 to 23,500 in 2021.

The Population of St Helens is currently 177,500 and is projected to increase by 1% up to 2015. St Helens mirrors the national trend. Like Halton will see an increase in the 65 plus population. By 2015 1:5 people will be over 65 years old.

The ONS mid year estimates for 2007 however, show that there is a significant difference in the 15-64 year populations. St Helens estimated as 116.9k and Halton as 80.2k[24]

Deprivation

Deprivation is linked to an increase in the prevalence of some mental health problems[25] The Index of Multiple Deprivation 2007 (IMD 2007) measures deprivation in small areas (known as super output areas), and consists of seven "domains" relating to income, employment, health and disability, education and training, housing and services, the living environment, and crime.

Twenty three percent of the LSOAs in St. Helens are in the top 10% most deprived areas in England and 27% for Halton. However, some areas are ranked as much less deprived. For both Halton and St. Helens 8% of their LSOAs are in the top 25% least deprived areas. The respective Joint Strategic Needs Assessments and Local Authority data will give information that is more detailed.

Prevalence Estimates

[24] ONS Table 9 Mid-2007 Population Estimates: Quinary age groups and sex for local authorities in the United Kingdom.

[25] Amongst many studies, Meltzer H, Gill B, Pettigrew M and Hinds K (1996) **"The prevalence of psychiatric morbidity among adults living in private households: OPCS surveys of psychiatric morbidity in Great Britain"** Report 1 HMSO London: HMSO

According to the ONS, 1 in 6 of adults experience some sort of neurotic disorder, the most prevalent type being mixed anxiety and depression. This is described as a "catch all" category which includes people with significant neurotic psychopathology who could not be coded into any of the other five neurotic disorders. Estimates of life time prevalence range from 1 in 6 to 1 in 4.

At the time of writing, an audit of primary care services was under way in the locality. This audit is to establish the actual number of people within GP practices who would have a substance or alcohol problem co existing with an emotional or psychological difficulty.

Halton and St. Helens Prevalence Summary

1. **Alcohol dependence + any neurotic disorder in general population**

We predict that there are 590 people with moderate/severe alcohol dependence and one or more neurotic disorders. The neurotic disorders are listed below:

- Mixed anxiety and depressive disorder
- Generalised anxiety disorder
- Depressive episode
- All Phobias
- Obsessive compulsive disorder
- Panic disorder

2. **Any drug dependence + any neurotic disorder in general population**

In total it is estimated that 3096 people in Halton and St. Helens have one or more neurotic disorder/s and any drug dependence.

To arrive at the this figures in 1 and 2 above we used data from the psychiatric morbidity survey, Tobacco, alcohol and drugs use and mental health report (2000) and the ONS population estimates for Halton and St. Helen's.

To the informed reader these figures may appear the wrong way around.
For the avoidance of doubt however, 590 cases (an individual may have more than one disorder –see previous paragraph) will experience a moderate to severe **alcohol dependence. Whereas 3096 cases will experience a drug dependence. In this context, drug dependence refers to 'any drug'.**

These figures were calculated as follows:
4% of men with any neurotic disorder had moderate/severe alcohol dependence and 0% for women (see http://www.statistics.gov.uk/downloads/theme_health/Tobacco_etc_v2.pdf page 66). Halton and St Helen's male neurotic disorder population is 14,756. And so 4% of 14756 is **590**.

There is estimated to be 12% of males with any neurotic disorder who have ***any*** drug dependence (inc. cannabis, amphetamines, crack, cocaine, ecstasy, tranquillisers and opiates) and 6% for females (see page 70 of Tobacco report).

Applied to Halton and St Helen's male neurotic population this equals 0.12 x 14,756=**1771** and for female neurotics 0.06*22,097=**1326.** So the total for males and females equals **3096** as documented.

3. Substance misuse + mental health disorder in substance abuse population

The prevalence rates of mental health disorder in drug and alcohol services from the COSMIC study (Weaver et al. 2003) and the number of referrals (116 in 6 months) in Halton and St. Helens were used to estimate the number of co-morbid cases.

Estimated Number of Mental Health Cases in Halton and St. Helens PCT's SMS Service April 08 to October 08 (6 month period)

Disorder	Number of cases
Psychotic disorder	13
Personality disorder	61
Depression and/or anxiety disorder	112
Severe depression	45
Mild depression	67
Severe anxiety	32

Note: one person can be present in multiple disorder categories above.

4. Dual diagnosis in Adult CMHT and Inpatient services population

Assuming there is a similar level of referrals over time, the Adult CMHTs can expect between 17 and 32 patients with dual diagnosis every six months. Adult Inpatient units can expect between 48 and 95 dual diagnosis patients every six months.

The total number of referrals used to arrive at these figures was sourced from Halton and St. Helen's own activity data. The prevalence rates are taken from DH policy guidance.

Current Demand

The information available to date includes:

The numbers recorded in treatment for St. Helens 01/07/2007 to 30/06/2008 is 1025

The numbers recorded in treatment for Halton 01/07/2007 to 30/06/2008 is 709

Those in Alcohol treatment in Halton and St. Helen at November 2008 are No in treatment – 588
New Presentation – 41
No in Treatment YTD – 989

This equates to 2723 people who are or, have been treated for a substance abuse problem in the last year.

Commissioner feedback included the fact that 96 people were in treatment (Drugs Service) 20 of whom were in contact with mental health service the remaining 76 were considered to have anxiety and depressive problems but 73 were not in contact with any mental health service

Mental Health data informs us that

1. Halton and St Helens GPs have registered 2324 people with a severe and enduring mental health problem (Primary Care Trust Data)

From Tony Ryans & Associates: Case Load Audit of 5 Boroughs Partnership NHS Trust (5BP) report July 2007

2. Halton >65 population 606 people receiving a service from 5BP
3. Halton 16-64 population 1314 people receiving a service from 5BP

Total Halton 1920 people

4. St Helens >65 popn 1422 people receiving a service from 5BP
5. St Helens 16-64 popn people receiving a service from 5BP
6. Total St Helens 3367 people

Open cases to 5BP as at 20/01/09 5BP data
Halton = 4504
St Helens = 4700
Total 9204 people

This data would benefit from further analysis to begin to determine trends and a 'mostly likely' figure of actual incidence of Dual Diagnosis.

There would be some merit in determining prevalence or expected demand range against actual activity. This would highlight the success of the care pathway in identification, assessment, and treatment of those with co morbidity.

Performance

This section will consider the relationship between this strategy and substance misuse targets. The section will compare the performance of Halton and St Helens in relation to 'statistical near neighbours'.

The tables below show the relevant statistical neighbours as per CIPFA Model further information regarding this model can be found at: www.cipfastats.net

Figure 8 Statistical Neighbours of Halton UA

Position	Neighbour Authorities	Statistical Distance	Corresponding PCT
1	Stockton-on-Tees	0.05	North Tees Primary Care Trust
2	Middlesbrough	0.08	Middlesbrough Primary Care Trust
3	Telford & Wrekin	0.08	Telford and Wrekin Primary Care Trust
4	Hartlepool	0.10	Hartlepool Primary Care Trust
5	Darlington	0.11	Darlington Primary Care Trust

Figure 9 Statistical Neighbours of St. Helens LA

Position	Neighbour Authorities	Statistical Distance	Corresponding PCT
1	Rotherham	0.04	Rotherham Primary Care Trust
2	Wakefield	0.06	Wakefield District Primary Care Trust
3	Barnsley	0.07	Barnsley Primary Care Trust
4	Wigan	0.08	Ashton, Leigh and Wigan Primary Care Trust
5	Doncaster	0.09	Doncaster Primary Care Trust

Source: CIPFA Nearest Neighbours Model http://www.cipfastats.net/

The data in the tables below are derived from the HCC annual health check 2007/8. The HCC get the data from the National Treatment Agency.

Figure 10 An assessment of the 12 week retention rate for Financial Year 2007/2008 in comparison with the 12 week retention rate for Financial Year2006/2007

PCT	%
Ashton, Leigh and Wigan Primary Care Trust	92.2
Doncaster Primary Care Trust	101.0
Telford and Wrekin Primary Care Trust	103.8
Halton and St Helens Primary Care Trust	**105.0**
Middlesbrough Primary Care Trust	106.3
Wakefield District Primary Care Trust	107.1
Hartlepool Primary Care Trust	109.3
North Tees Teaching Primary Care Trust	111.0
Rotherham Primary Care Trust	113.9
Barnsley Primary Care Trust	115.9
Darlington Primary Care Trust	119.2
Comparator Average	108.0
England Average	104.4

Source: HCC http://www.healthcarecommission.org.uk/publicationslibrary.cfm?fde_id=9590

The above table compares the 12 week retention rate of service users in the years 2006 / 07 to 2007 / 08

Measuring the percentage of drug misusers who were retained in treatment for 12 weeks or more, focuses on the effectiveness of the local treatment system in engaging drug users and minimising early drop out.

Evidence suggests that drug treatment is more likely to be effective if clients are retained in treatment for 12 weeks or more, resulting in reduced drug use, reduced morbidity and mortality associated with misuse, reduced crime and improved health and social functioning. Benefits include substantial

financial savings in both the criminal justice system through reduced offending and in the NHS through reduction in blood-borne diseases amongst drug misusers.[26]

This table tells us that Halton and St. Helens perform less well than their statistical neighbours (ranked 8 out of 11) but better than the England average. It also shows us that Halton and St Helens are keeping more drug users in sustained treatment (12 weeks+) than they were the previous year in 2006/7 (but all of the neighbours did better than the previous year except for Ashton PCT.)

Figure 11 The actual number of drug misusers accessing treatment divided by the planned number of drug misusers accessing treatment

PCT	%
Rotherham Primary Care Trust	107.6
Middlesbrough Primary Care Trust	125.0
Halton and St Helens Primary Care Trust	**131.7**
North Tees Teaching Primary Care Trust	132.4
Ashton, Leigh and Wigan Primary Care Trust	132.4
Wakefield District Primary Care Trust	134.4
Doncaster Primary Care Trust	134.6
Telford and Wrekin Primary Care Trust	141.1
Darlington Primary Care Trust	146.3
Barnsley Primary Care Trust	148.1
Hartlepool Primary Care Trust	165.7
Comparator Average	136.8
England Average	125.8

Source: HCC http://www.healthcarecommission.org.uk/publicationslibrary.cfm?fde_id=9590

The above table shows that all of Halton and St Helen's statistical neighbours outperformed their local PCT plan for how many drug misusers they would have in treatment. Halton and St . Helens outperformed less than the comparator average but more than the England average.[27]

[26]http://www.healthcarecommission.org.uk/guidanceforhealthcarestaff/nhsstaff/annualhealthcheck/annualhealthcheck2007/08/qualityofs/drugmisuserssustainedintreatment.cfm

[27]http://www.healthcarecommission.org.uk/guidanceforhealthcarestaff/nhsstaff/annualhealthcheck/annualhealthcheck2007/08/qualityofs/drugmisusersintreatment.cfm

STAKEHOLDER FEEDBACK

In this section stakeholder, views are recorded. Stakeholders in the Dual Diagnosis strategy cover a wide range of organisations and individuals. This includes; alcohol and drug misuse services alongside mental health services. These services are statutory and non – statutory in origin.

The key themes included the following.

Defining Dual Diagnosis: Most people when considering dual diagnosis as a topic immediately refer to the relative low prevalence, high cost, high risk, high complexity, highly dependent poly drug users with psychosis requiring multi-agency interventions. However, almost without exception, most went on to say...

Alcohol is greater concern than substance misuse: In terms of volume and impact upon the whole community alcohol was perceived to be a far greater issue. Alcohol impacted upon all age bands, economic classes, it has significant impact upon the criminal justice, public health and treatment agendas.

Shared Care: there were issues about the roles, responsibilities between statutory and 3rd Sector agencies. Services providers often work in silos: sometimes by choice, on other occasions out of necessity due to exclusion criteria (e.g., some mental health services refusing to work with individuals who were still drinking). All stakeholders acknowledged the need to 'share' the care for individuals both in the formal sense and in a more informal mutually supportive manner. In some areas clear protocol existed with clear structures of accountability in others this was not the case. In all cases appropriately qualified individuals needed to be engaged to ensure appropriate governance

Clarity in Commissioning intentions: the flip side of the shared care approach was the articulation that each service should have a clearly defined role and purpose and that these should be explicitly agreed in advance with commissioners. Currently due to a desire to collaborate (i.e., share the care) some services are providing support that they were never commissioned to do, or conversely they are not providing services due to the explicit documentation in their service level agreements or contracts. In both instances the gap in service provision is masked: where there is a gap in service provision it should be provided for by appropriately funded and commissioned services. Commissioners contended in response that there was not a lack of clarity regarding their intentions and expectations, rather there was on occasions a lack of providers 'hearing' what was being articulated.

Efficient and effective commissioning: in support of the above point stakeholders expressed a view that DAAT commissioning and Mental Health commissioning could be brought together or ***aligned***. This would maximise resources, attain best value, and address eligibility criteria. Performance management could also be unified across the commissioning process with providers being clear what key performance indicators were being measured. (see also alcohol strategy where this is also an issue)

Single point of Access: awareness of the emerging single point of access for mental health services is variable across the localities and consequently different practices of referral and routes into services persist. This results in too great a variation in who gets (or doesn't get) accepted into services, and for a perception that many people remain in the service of first contact regardless of whether that was the most appropriate one.

Crisis Access: A frequent comment from those who work in primary care services was that there is a need for an alcohol and substance misuse crisis service. Too often other agencies criteria for access will not intervene at the point of greatest need, resulting in an escalation of issues and risks.

Pathway gaps: For those who do access services there are not sufficiently robust care pathways for service users to navigate. Service offerings and therefore their outcomes vary significantly between services. The greatest articulated gap appears to be that between primary and secondary care services (between tiers two and three).

Pathway blocks: Even where there are defined pathways to access services there is too often a wait between referral and intervention. This is most notable in brief interventions in primary care that 'open up' deeper issues for individuals but then they have to wait up to 4 months to have their needs addressed in a distressed state. Similarly, there are still reported waiting issues in accessing detoxification and rehabilitation support resulting in a further deterioration in individuals, including on occasions fatalities. Tier 4 services are reported hard to access both in psychiatric and general hospital services.

Variation in provision and providers in each locality: Dual Diagnosis practitioners operate within St Helens CMHTs and recent appointments have been made to Halton CMHTs.. Stakeholders also debated the role and function of this role it was felt that this role should be more of a consultative function and a support to other workers and agencies, rather than 'hold a case load'. This was perceived to be a misuse of their expertise as they would soon become ineffective due to under capacity. In other words they would spend all their time working with single individuals they would not be able to tackle the wider partnership and interface issues needed to deliver seamless care.

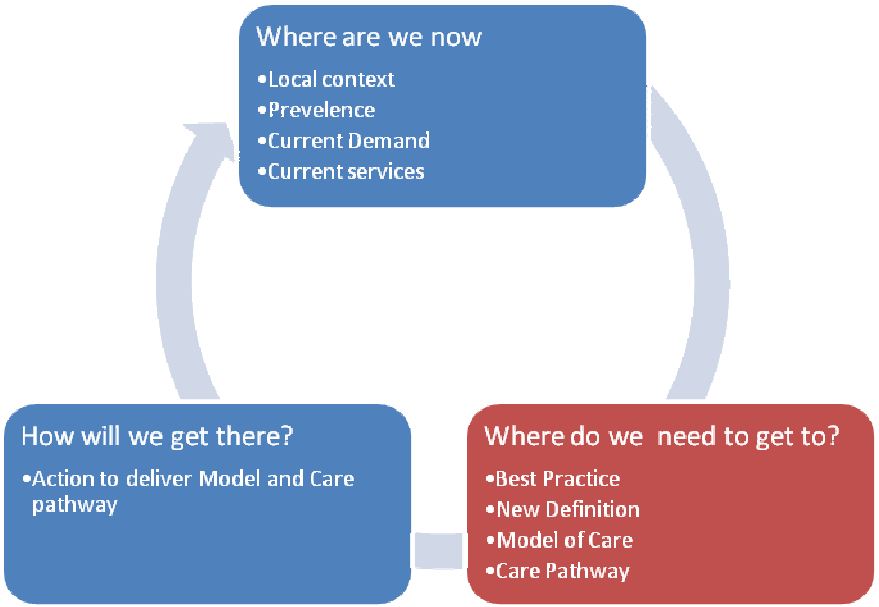
The Arch service operates in Halton and is based at Ashley House. Young Addaction and the 5 Bouroughs Partnership Alcohol services also operate in Halton. The Lighthouse project services St Helen's. CIC provide different services to the different localities. There was an articulation that a single consistent pathway(s) should be developed in both areas – even if the agencies that provide it are different.

Specialist verses generic?; Despite specialist dual diagnosis practitioners being funded, there was a strongly held view that give +75% of service users in secondary mental healthcare had some form of alcohol or substance misuse issue, then shouldn't all staff have addiction training as a core skill?

Need for more training: Whether, generic or specialist there was a clearly articulated view that greater addiction training was required for all staff grades tailored to the tier of care in which they operate.

Governance: The complexity of the client group's needs, the range of agencies concerned and the demographic and geographic issues there is a perception of a lack of leadership at a strategic level. The process of developing this strategy has been welcomed but stakeholders have expressed the view that clearer roles and responsibilities need to be established between the DAAT, the LIT, public health and the criminal justice system. More 'joined up' commissioning for all age groups is required and the consensus appears to be for this to be led by the PCT.

WHERE WE NEED TO GET TO!



MODEL OF CARE & CARE PATHWAY

In this section, a model of care is defined. This has been influenced strongly by the views of stakeholders and all the previous sections.

Key Features of Model

As stated above in the Stakeholder feedback emphasis on Integrated and shared care was a key theme

Shared Care

> Shared care is the joint participation of specialists and GPs [and other agencies as appropriate] in the planned delivery of care for patients with a drug misuse problem, informed by an enhanced information exchange beyond routine discharge and referral letters. It may involve the day-to-day management by the GP of the patient's medical needs in relation to his or her drug misuse. Such arrangements would make explicit which clinician was responsible for different aspects of the patient's treatment and care. These may include prescribing substitute drugs in appropriate circumstances".[28]

> Medical practitioners should not prescribe in isolation but should seek to liaise with other professionals who will be able to help with factors contributing to an individual's drug misuse. A multidisciplinary approach to treatment is therefore essential."[29]

Integrated Care

Integrated care is an approach that aims to **combine** and **co-ordinate** all the services required to meet the assessed needs of the individual.
It requires:

- treatment, care and support to be person-centred, inclusive and holistic to address the wide ranging needs of drug and alcohol users;
- the service response to be needs-led and not limited by organisational or administrative practices; and
- collaborative working between agencies and service providers at each stage in the progress of the individual in treatment, from initial assessment onwards

People who have drug or alcohol misuse problems will, in many cases, have a range of other difficulties in their lives including problems with housing, family relationships, employment, offending behaviour and debt. This means that a wide range of interventions and a range of organisations will need to be involved to assist any individual with substance misuse problems.

[28] Dept of Health 1995 and *Drug Misuse and Dependence: Guidelines on Clinical management*. Department of Health 1999)

[29] Drug Misuse and Dependence – Guidelines on Clinical Management 1999

An integrated care approach founded on co-operation and collaboration between all relevant providers will have a number of benefits for individual service users. It should:

- Promote early assessment and intervention: ensuring that services are accessible and appropriate to the service user's needs.
- Remove barriers to progressing towards recovery: supporting the service user to identify and achieve their own goals whilst acknowledging their own beliefs and culture.
- Provide consistent, co-ordinated and comprehensive care: ensuring that all care providers are working towards a shared aim and minimising unnecessary duplication of activity.
- Ensure a comprehensive and timely response: making sure that all the needs of the service user, physical, psychological and social, are considered and addressed appropriately.

The **overarching aim** of integrated care is to support drug or alcohol users to overcome their drug or alcohol problem and their associated health and social difficulties by providing effective, co-ordinated and timely treatment and care.[30]

As this strategy is also about individuals who experience mental health problems as well as drug or alcohol difficulties it is even more important to ensure that a 'shared care' 'integrated approach' is the foundation upon which we develop services and our approach to service delivery.

The main problem is in determining the referral pathway. When the severity of both mental illness and substance misuse is high, then shared care working between mental health and addiction teams might be the best solution. If the substance misuse and mental health issues are of a moderate nature then the agency first attended may be able to deal with both issues. However, the agency would need to be well supported and staff appropriately trained.

Figure 12 Allocation of care by need

[30] (2008) *Integrated Care for Drug or Alcohol Users: Principles and Practice Update* 2008 Available from http://openscotland.gov.uk/Publications

	Low degree of mental illness	High degree of mental illness
Low level of substance use	Mainstream or addiction service Anxiety spectrum disorders Depressive disorders Moderate severity personality disorders	Mainstream service only Korsakoff's psychosis and dementia Severe personality disorder Obsessive-compulsive disorder
High level of substance use	Addiction service only Withdrawal states including delirium Wernicke's encephalopathy Residual psychoses	Mainstream and addiction services Schizophrenia Bipolar affective disorder Post-traumatic stress disorder

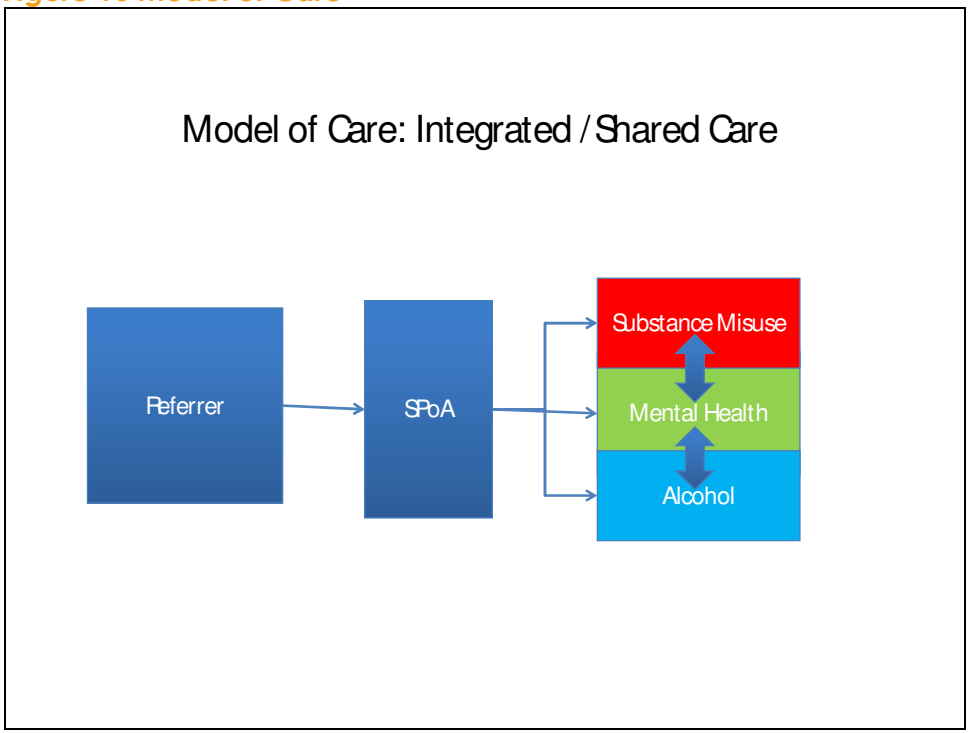
Table 13d: Example of possible allocation of care by diagnostic group

(Adapted from Department of Health (2002))

(source NTA for substance misuse –Review of effectiveness of treatment for alcohol problems Raistrick et al –DH 2006 p158)

The above table depicts a model for allocation of care. People with a low degree of mental illness can be supported by primary care. Whereas a high degree of mental illness must be supported by secondary care services.
This can mean a high number of people with mild /moderate dual diagnosis issue receive their care within primary care services and this is an area that requires further development in order to support primary care practitioners

Figure 13 Model of Care



(adapted from National Treatment Agency for Substance Misuse – Review of the effectiveness of treatment for alcohol problems (DH 2006) Raistrick D et al. Service models p157)

The above figure depicts the proposed model. Here referrers including self- referral are made through a single point of access. At this point a multi-disciplinary assessment is carried out. This will ensure that, the individual is assisted to engage, with all the relevant elements of service. As can be seen in the diagram mental health services overlap with both substance

and alcohol services, so indicating an integrated and shared care approach.

Commissioning integrated care pathways

An integrated care pathway (ICP) describes the nature and anticipated course of treatment for a particular client and a predetermined plan of treatment. A system of care should be dynamic and able to respond to changing individual needs over time. It should also be able to provide access to a range of services and interventions that meet an individual's needs in a comprehensive way. Previous consultation has shown that the majority of respondents found that the ICPs set out in Models of Care 2002 had been useful to them in their work. ICPs should be developed for drug and alcohol misusers for the following reasons:

- Drug and alcohol misusers often have multiple problems that require effective co-ordination of treatment.
- Several specialist and generic service providers may be involved in the care of a drug and alcohol misuser simultaneously or consecutively.
- A drug and alcohol misuser may have continuing and evolving care needs requiring referral to services providing different tiers of intervention over time.
- ICPs ensure consistency and parity of approach nationally (i.e. a drug misuser accessing a particular treatment intervention should receive the same response wherever they access care)
- ICPs ensure that access to care is not based on individual clinical decisions or historical arrangements.

Elements of integrated care pathways

Commissioners should ensure that each drug and alcohol treatment intervention should have an ICP. This should be agreed with and between local providers, and built into service specifications and service level agreements.

Integrated care pathways should contain the following elements:

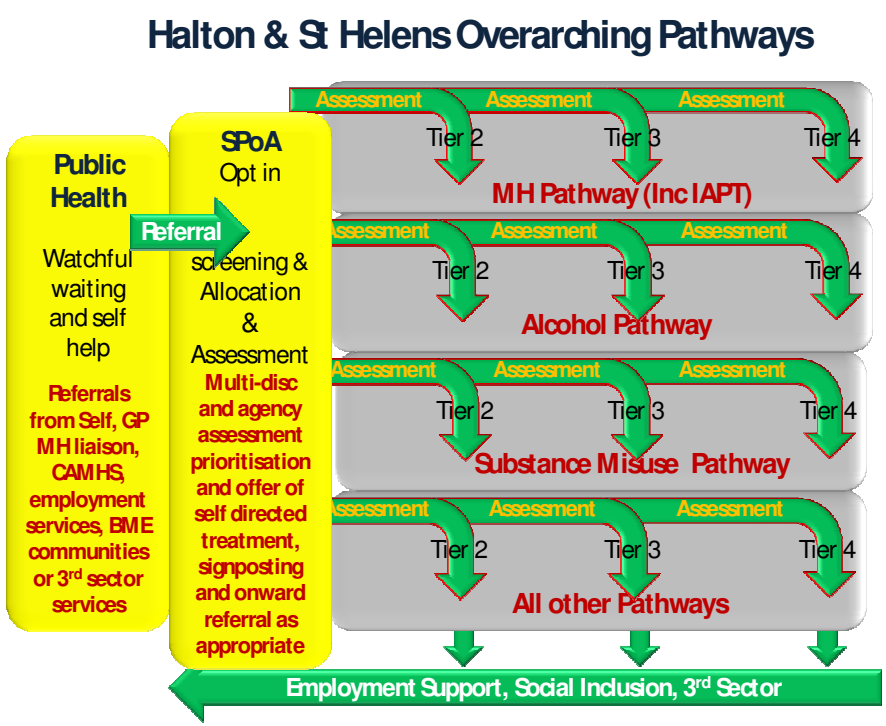
- A definition of the treatment interventions provided
- Aims and objectives of the treatment interventions
- A definition of the client group served
- Eligibility criteria (including priority groups)
- Exclusions criteria or contraindications
- A referral pathway
- Screening and assessment processes
- Development of agreed treatment goals
- A description of the treatment process or phases
- Co-ordination of care
- Departure planning, aftercare and support
- Onward referral pathways
- The range of services with which the interventions interface.[31]

[31] National Treatment Agency for Substance Misuse. (2006) *Models of Care for Treatment of Adult Drug Misusers: Update 2006*

Care Pathway

With the above in mind and taking into account the views of stakeholders, the following is the proposed care pathway

Figure 14 Overarching Care Pathway



The above diagram adds some detail to the 'Model of Care Diagram'. This shows that following a referral and assessment that there are a range of service options in various pathways of care at different levels of need to meet the individuals' needs for care and treatment. The expectation would be that Mental Health Services from either primary care or secondary care services would take a lead depending on the severity of the mental health issue.

NHS Contracting have developed a specific care pathway for alcohol services and this can be found at http://www.pcc.nhs.uk/204.php

The proposed role of Advanced Practitioner in Primary Care would be critical to the success of this model. The Advanced Practitioner would carry out a similar role to that of the Dual Diagnosis Worker in Secondary Care.

It is envisaged that these roles would provide support and supervision/consultation to staff across both the statutory and non - statutory services. They would take responsibility for ensuring appropriate protocols were in place and that compliance to these was ensured. The remit of the AP would be to ensure that the interface between primary and secondary care was clear and those individuals moving from one area of care to another did so with minimal disruption to their care. A primary role would be co-working with colleagues. It is not envisaged that these role would manage a case - load.

The above diagram now shows the specific care pathway for Dual Diagnosis.

Mental Health Services will lead this and from the Tier 3 point onwards be care coordinated from the secondary care mental health service. Access to Tier 4 services – inpatient detoxification will be via the crisis resolution and home treatment team in accordance with their role and function to ascertain that inpatient care is the only safe option and best meets the individual care needs. It is anticipated that this will be agreed in conjunction with the Dual Diagnosis Worker and Care Coordinator.

Figure 15 Halton and St Helens Dual Diagnosis Care Pathway

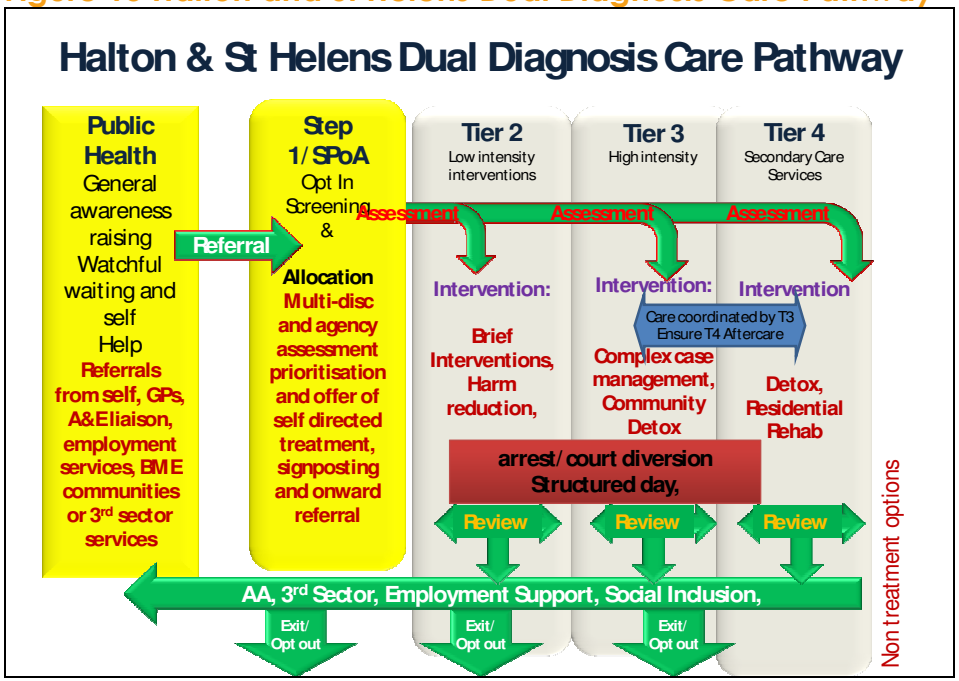
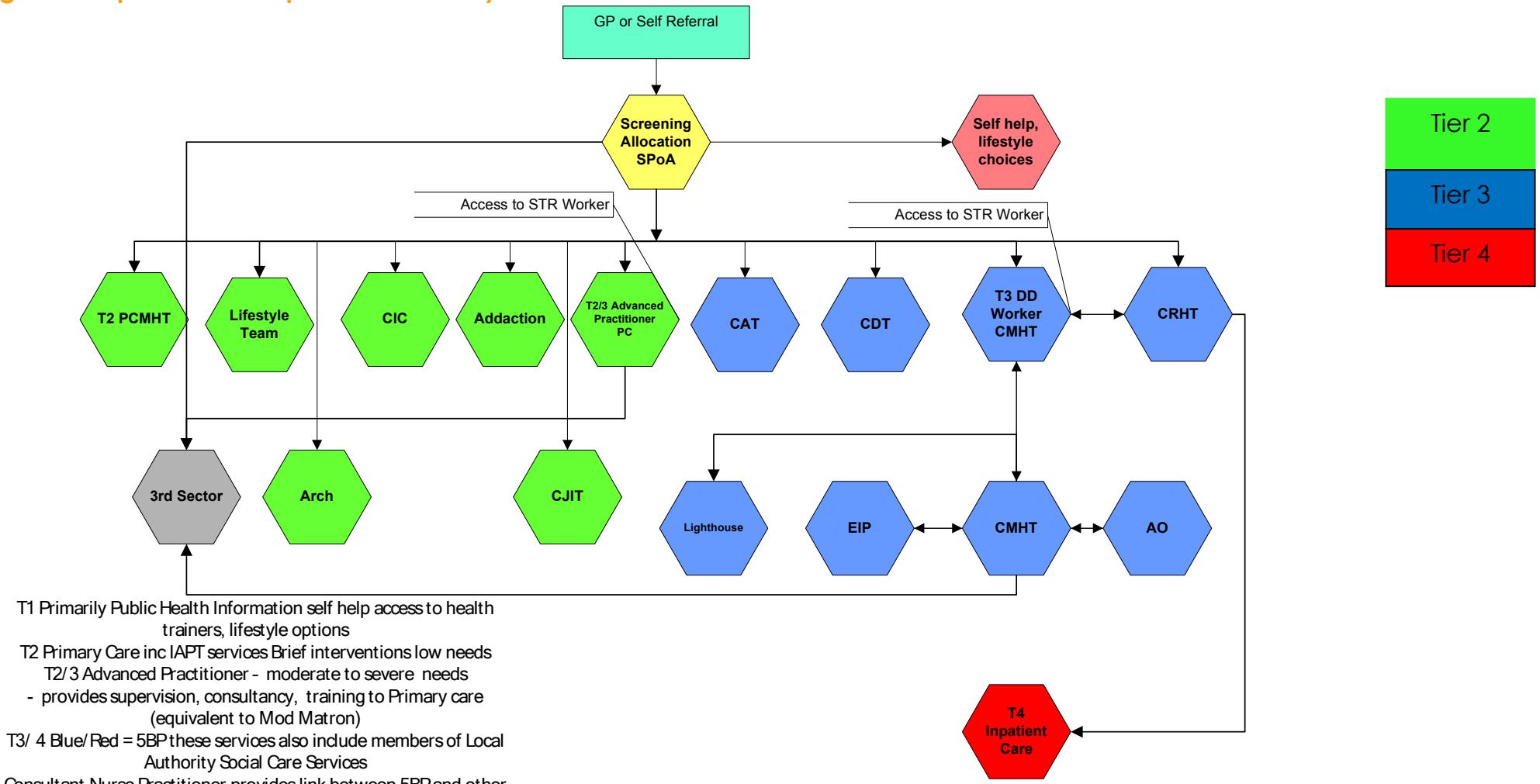


Figure 16 Operational Map – Care Pathway



T1 Primarily Public Health Information self help access to health trainers, lifestyle options
T2 Primary Care inc IAPT services Brief interventions low needs
T2/3 Advanced Practitioner - moderate to severe needs - provides supervision, consultancy, training to Primary care (equivalent to Mod Matron)
T3/ 4 Blue/Red = 5BP these services also include members of Local Authority Social Care Services
Consultant Nurse Practitioner provides link between 5BP and other services
T3 DD Worker
Moderate to severe need plus SMI.
(as Adv Prat but in 2° Care)
All inpatient services via CRHT inc Detox
3rd Sector includes structured day services

The diagram above shows how this model of care might look utilising current services and organisations.

The aim with this model of care and operational map is to highlight the need for one care pathway across the Halton and St Helens footprint. However, there may be different providers of service. The intention is to ensure equitable services across the localities. This may mean extending the remit of some service to include both Halton and St Helens.

The following features will underpin commissioning intentions and the further development of a 'whole systems approach' to commissioning dual diagnosis services

- A broad spectrum of provision which is primary and community focused.
- Access locally to a complete range of primary and secondary services
- Improved pathway of care between services irrespective of provider
- Non reliance on inpatient care
- Integrated pathways where these can improve outcomes.
- Jointly commissioned services by Primary Care Trust/Local Authority
- Broad range of providers giving service user choice
- Service Users and Carers pro-actively involved in the commissioning planning delivery and quality control of services.
- A focus on prevention and promotion of health and well being
- Development of a broader range of social prescribing
- Avoidance of large institutional settings
- Services and their delivery will be based on individual assessment of need.
- A needs led service irrespective of age, or disability

In order to implement an equitable service across the locality ensuring that each locality has access to the complete range of primary and secondary services (Tier 1 to 4) a review of contracted services will be necessary. The aim of the review will be to ensure that a 'whole systems approach' is being commissioned that ensures consistency, continuity, and collaboration.

Summary

This section has identified the proposed model of care to be adopted based on a 'shared care – integrated approach' It has stated the basic principal of Dual Diagnosis Care being led by Mental Health Services whether this is in Primary or Secondary Care. To facilitate this, the role of Advanced Practitioner will be developed and work in conjunction with Dual diagnosis Workers in Secondary Care.

Figure 32/33 shows a Care Pathway that is aimed at ensuring an equitable, and integrated approach is delivered.

This section further identifies a number of features of the model that will underpin commissioning intentions to develop a 'whole systems approach' to 'Dual Diagnosis'

CONCLUSION - COMMISSIONING INTENTIONS

This strategy has set out the definition of Dual Diagnosis to be adopted. This definition embraces the principle of inclusion. That is, those who need a service will be offered care and treatment and that eligibility criteria will not stand in the way of accessing care.

The model of care to be adopted is based on best practice and the principle of 'mainstreaming'. This model is based on the practice of 'integrated and shared care.' The care pathway to be adopted seeks to reinforce the practice of integration. Mental Health will take a lead in the coordination of care for those experiencing both a mental health problem and a substance misuse dependency. To facilitate this role of Advanced Practitioner in Primary care will be developed and a review of the role of Dual Diagnosis Worker in secondary care will be undertaken.

Demand

Based on our analysis within Halton and St Helens Primary Care Trust footprint there is projected to be, be 36,900 cases of neurotic disorder (one individual may have more than one type of neurotic disorder). Of this identified population, 590 cases are likely to be moderate to severe alcohol dependence.

The analysis further identifies a projected 3096 cases of neurotic disorder and some form of drug dependence.

Adult CMHTs can expect between 17 and 32 patients with dual diagnosis every six months. Adult Inpatient units can expect between 48 and 95 dual diagnosis patients every six months.

Halton and St. Helens reported 116 appropriate referrals to their SMS teams. The figures in the table below are calculated using the 116 referral figure and the prevalence rates from the COSMIC study (Weaver et al 2002).

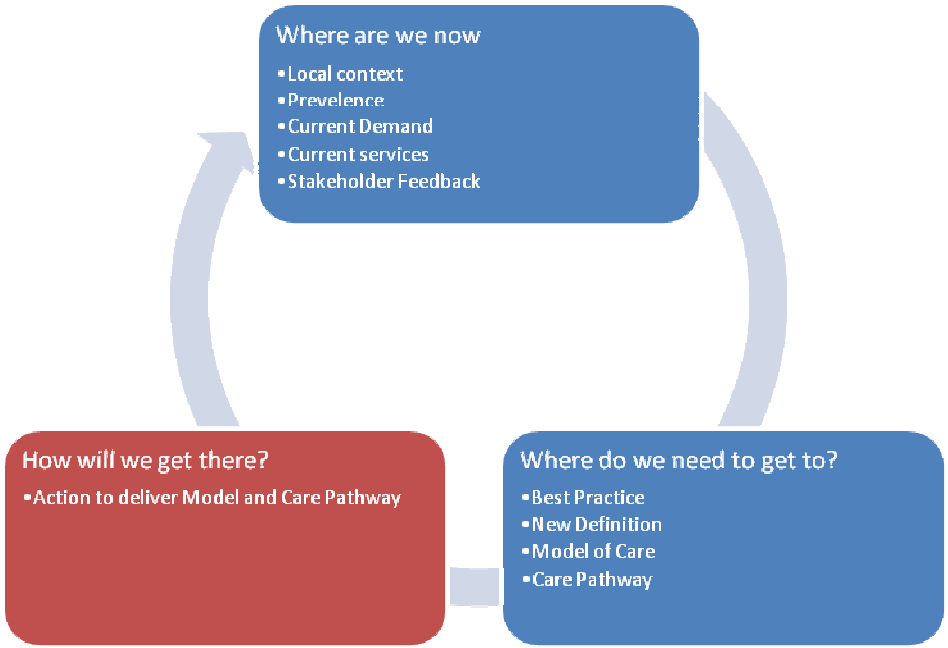
Estimated Number of Mental Health Cases in Halton and St. Helens PCT's SMS Service April 08 to October 08 (6 months period)

Disorder	Number of cases
Psychotic disorder	13
Personality disorder	61
Depression and/or anxiety disorder	112
Severe depression	45
Mild depression	67
Severe anxiety	32

In this strategy document, we have used reported data in relation to the demand and estimates have been calculated accordingly. It must be noted however, that stakeholder feedback suggested that the majority people experiencing a mental health problem had an alcohol or drug problem. This may be due to individuals 'self-medicating' and that many people with a drug or alcohol problem also had a mental health issue.

A range of actions is now necessary to implement this strategy. A detailed account of these actions follows.

HOW WE GET THERE



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This section sets out the action now necessary to implement this strategy.

Each of these actions is set out within a template that describes the initiative to deliver the model.

Actions

The first of these actions will be to review the current commissioning mechanisms. Stakeholder feedback supported a move to a more aligned commissioning process. The proposal is to develop a joint commissioning board that will commission services that implement integrated care pathways for people who have both mental health and substance misuse (including alcohol) issues.

This would facilitate a coordinated approach to commissioning with a lead commissioner identified. A 'best value' approach will then be facilitated.

A performance management process equitable across Halton & St Helens with core key performance indicators and outcome measures to be delivered identified for each tier of service and provider.

Establishing the model of care and single care pathway will bring benefits to both service users and providers clearly establishing role and function This would demonstrate clarity of entry and exit points within services.

As part of this care pathway development, the implementation of the single point of entry to services will facilitate good assessment and care / treatment options being identified.

The development of a work force plan is integral to this strategy to ensure that all staff at all levels have the appropriate skills and qualification to deliver the care and treatment required. This work force plan will also include training, advice and support for primary care staff to ensure appropriate governance regarding 'shared care'

This workforce plan will also take account of the need to develop the role of Advanced Practitioner in primary care and the review of the role of Dual Diagnosis worker in secondary care and the role of Support, Time and Recovery (STaR) workers in primary care to develop an individual's capacity for adopting various strategies in relation to 'social problem solving'

The development of service specifications in line with the new NHS standard contract will be developed as part of this process. Attention will be given to eligibility criteria and interface issues between services, Tiers of service delivery, between organisations and between primary and secondary care. The principle adopted will be 'criteria for inclusion'.

Further reflection is required to ensure that all individuals have access to crisis services when required, irrespective of their dependence on substances.

The development of a specific dual diagnosis service user forum in Halton based on the model already in place in St Helens, will be undertaken.

The development of a Provider forum will be established to promote integrated working between providers, to assist identify blockages and barriers to service delivery. It will, also,

provide commissioners with the opportunity to discuss gaps in service and identify ways in which these may be filled.

As the Model of Care is developed and care pathway implemented commissioning will be based on the priorities identified to meet capacity and capability of delivering the model and care pathway.

To ensure that this strategy is complemented and a 'strategic fit' it is recommended that the current Mental Health Strategy be reviewed as soon as practicable.

An implementation plan to deliver this strategy will now be required.

INITIATIVES TO DELIVER THE NEW MODEL #1

Initiative Title **Review current commissioning process and mechanisms with a view to developing a joint commissioning group for mental health, alcohol, and substance misuse services.**
Rationale (including evidence base) Current commissioning is via several commissioning groups and sources of revenue. This leads to duplication and a lack of coordination A Dual Diagnosis commissioning group would facilitate a coordinated approach and achieve 'best value' across primary and secondary care This is in line with new contracting guidance
Current position There are two Local Authorities Two DAATs one Primary Care Trust. Two Local Implementation Teams, One Mental Health Provider Trust and numerous 3rd sector providers. Revenue sources are: Alcohol, Substance Misuse, Mental Health plus education, public health and other social care sources
Commissioner Issues Develop a project group which includes all commissioning partners including PCT, PbCs, Local Authorities Develop a strategic action plan Develop an implementation plan
Provider Issues Providers need to recognise the authority and position of commissioning organisations
Financial impact

The review will necessitate commissioners devoting time to undertake the review.
Cost will be in terms of organisational / individual time.
The review may identify some efficiency savings.

Timescale

Primary Care Trust and Local Authority Commissioners identify Dual Diagnosis Commissioning Group - September 2009
Agree Strategic Plan for change - October 2009
Implementation of Change - March 2010

Links to WCC

1. Lead the NHS
2. Work collaboratively with community partners to commission services that optimise health gains and reduction in health inequalities
5. Manage knowledge and undertake robust regular needs assessments – develop a full understanding of current and future local health needs
10. Manage the local health system
11. Make sound financial investments to ensure sustainable developments and value for money

Also new contract guidance suggests a coordinated approach to commissioning is the preferred option.

Links to other local strategies and initiatives

Mental Health Strategy
Alcohol Strategy
Substance Misuse
Ambition for Health

Expected Outcomes

Reduction in the possible duplication of services commissioned by current substance misuse and mental health commissioning Boards.
Increased collaborative and integrated working between services.
Early intervention for people with dual diagnosis, especially those currently receiving care in primary care services only.
Clear and easily accessible care pathways.

Agreement on cordinated use of resources
How this will benefit service users and their carers By collaborative coordinated commissioning, more service users will benefit from accessing the appropriate interventions. As services will be better coordinated the 'patient journey' will become clearer and smoother interface between organisations and services will develop. This should result in a better service user experience.

INITIATIVES TO DELIVER THE NEW MODEL #2

Initiative Title **Develop a performance management process which is robust, equitable, and consistent across Halton & St. Helens footprint**
Rationale (including evidence base) The development of core key performance indicators and outcome measures applicable to all providers. This will enable commissioners to actively compare providers and ensure delivery of outcomes commissioned. – This is a value for money issue alongside promoting improvement and innovation.
Current position There would appear to be a lack of coordinated KPI and outcome measures across the locality therefore no base line
Commissioner Issues Development of core KPI and outcome measures applicable to all services This links to the new contract development. This is core data for the contract. The core KPI and Outcome measures will need to be implemented and enacted.
Provider Issues Ability to provide data on request Development of data improvement plan Development of quality improvement plan Development of data sets, performance management as set by commissioners. This is part of the new contract development and key to its success.
Financial impact The development will necessitate commissioners and providers both statutory and non-statutory devoting time to undertake the development work Cost will be in terms of organisational / individual time. Costs in developing framework and agreeing implementation Time of individuals to agree and implement a reporting framework. Cost of any IT solutions to implementing reporting framework

Timescale

Development of project group - September 09
Identify Core KPI and Outcome measure - January 2010
Develop reporting mechanism - February 2010
Go live - April 2010
This links to new contract development

Links to WCC

1. Lead the NHS
2. Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities
6. Prioritise Investment according to local need and service requirement
8. Promote and specify continuous improvement
   Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality outcomes
11. Make sound financial investments

Links to other local strategies and initiatives

This links to the all the Primary Care Trusts key activities – primarily contracting and performance management

Expected Outcomes

Agreed joint key performance indicators and outcomes for dual diagnosis service users, their carers and families.
Integrated performance management of services for people with dual diagnosis
Robust data collection
Improved service user and carer outcomes

How this will benefit service users and their carers

It ensures quality care and outcomes, best value process will enable more service users to benefit from appropriate and timely interventions. It will also hold services to account. One of the measures will be the data received from the Patient Survey so the service user's voice will be clearly captured and reflected in the performance management of services.
The data will enable service users to make informed choices where there are comparable services and interventions suited to their needs

INITIATIVES TO DELIVER THE NEW MODEL #3

Initiative Title **Establish the model of care and care pathway including the single point of access.**
Rationale (including evidence base) This would facilitate better access to services and interventions, avoid duplication. This would give clarity to commissioners, providers and most importantly service users and their carers as to the expected 'patient journey' Each organisation and discipline would understand their role and function and that of others Deliver a better service user experience
Current position There would appear to be an unclear alcohol pathway. There are identified barriers to accessing mental health services There is a lack of capacity and capability at some levels of service
Commissioner Issues Develop a project group Develop project plan Develop an implementation plan
Provider Issues Providers statutory and non statutory will be required to engage with commissioners to ensure best outcomes are delivered to service users. Providers will be required to engage in service redesign and modernisation processes.
Financial impact Commissioners and providers will need to ensure sufficient time and appropriate staff are enabled to undertake this work. Therefore, initial costs will be in terms of organisational and individual time. Implementing the model and care pathway will necessitate a review of commissioned services and reviews of individual contracts. Service redesign and modernisation process are likely to have financial implications It may be that providers are required to extend their current service delivery across both Halton and St Helens.

Further capacity may also be required at tiers 2 and 3
The implementation of the Advanced Practitioner role will incur significant costs. Funding for these roles have been allocated within Mental Health Development Funding

Timescale

Development of Project Group - September 09
Development of Project Plan - December 09
Development of Implementation Plan - February 10
Pilot Model and Care Pathway - April – June 10
Implementation of Model and Care Pathway - September 10

Links to WCC

1. Lead the NHS
2. Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities
4. Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service redesign and resource utilisation
7. Stimulate the market
8. Promote Improvement and Innovation
10. Manage the local health system
3. Engage with public and patients

Links to other local strategies and initiatives

This Model of Care will primarily link to the following strategies and services:
Public Health, Alcohol, Mental Health, Substance Misuse

Expected Outcomes

Clear and accessible care pathways that make sense to referrers and service users and carers.
Early interventions in primary care that are coordinated and integrated which will offer help and support at the earliest opportunity to those experiencing both mental health and substance misuse problems.
Agreed protocols between mental health and substance misuse services that eliminate the blockages to people receiving integrated care.
A holistic assessment that focuses on the needs of the individual rather than just the diagnosis and facilitates help for identified health and social care problems.

How this will benefit service users and their carers

The proposed new model of care and care pathway will facilitate easier access and integration of service. This will ensure a better service user experience. Service users in future will experience one comprehensive assessment of their needs. This will facilitate an integrated care package from the start of their treatment. This avoids silo service delivery and will shorten the overall duration of interventions for many people.

INITIATIVES TO DELIVER THE NEW MODEL #4

Initiative Title

Development of Workforce Plan

Rationale (including evidence base)

Explain the need and the objective of change

Ensure a staff compliment that is equipped and supported to deliver high quality care.

Ensure that all staff across both health and social care are equipped to deliver; advice and brief interventions at first point of contact.

Ensure key staff are qualified and meet the minimum standards required to be commissioned to undertake 'shared care' responsibilities.

Ensure sufficient capacity and capability are employed to deliver high quality care

Develop new role of Advanced Practitioner within Primary Care

Develop role of STaR workers in primary care

Review role and function of Dual Diagnosis Workers

Ensure a robust recruitment and retention plan is in place

Current position

Inequalities in service provision exist across the two localities

Capacity gaps exist at Tiers 2 and 3

After care services are required.

Access to Mental Health Services are an area for development particularly in regard to Common Mental Health Problems

Improved access to Crisis Services is required.

Commissioner Issues

Commissioners will need to be assured that appropriate governance, capacity and systems are in place to support

staff
Commissioners will need to be assured that appropriate protocols and interface between providers is robust.
Commissioners will require evidence that where appropriate providers comply to NHSLA standards
Commissioners will require assurance that all staff are appropriately qualified to deliver the care and treatment required.
Commissioners will need to assure themselves that an appropriate whole systems model of care is delivered giving attention to social as well as health issues

Provider Issues

To work with commissioners to facilitate the above
Work force issues are predominantly the ultimate responsibility of the provider of service, therefore a close working relationship with all providers will be necessary to ensure the above assurances to commissioners are achieved
Ensuring staff are aware of other organisations and individuals roles.

Financial impact

The development of the workforce plan will be the single most revenue intensive development
The development of Advanced Practitioner role A4C band 7
Development of Star role in Primary Care A4C band 3
Training of all Primary Care, Social Care, Police, Probation and other front line staff in advice and brief interventions.

Timescale

Development of Project Group - September 10
Development of Project Plan - November 10
Implementation of Plan and recruitment process - January 10
Implementation of training package - January 10
Review of Recruitment and training progress - June 10
The training of staff will be an ongoing

Links to WCC

1. Locally lead the NHS
2. Work with community partners
4. Collaborate with Clinicians
   Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service redesign and resource utilisation
6. Priorities investment
7. Stimulate the market
   Effectively stimulate the market to meet demand and secure required clinical and health and well being outcomes
8. Promote improvement and innovation
   Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration
10. Manage the local health system
11. Make sound financial investments
    Make sound financial investments to ensure sustainable developments and value for money.

Links to other local strategies and initiatives

This will primarily link to the following strategies and services:
Public Health, Primary Care, Alcohol, Mental Health, Substance Misuse

Expected Outcomes

Increased communication and shared training between services.
Increased knowledge and skills in primary care to work with people with dual diagnosis problems.
Access to dual diagnosis advice and support for primary care staff
Close Primary / secondary mental health care interface working
A network of practitioners who can successfully work together for the benefit of the service user, their carers / family when required.

How this will benefit service users and their carer

This initiative will enable more frontline staff provide advice and brief interventions so impacting on the demand of related services. Service users will therefore access advice and brief interventions quicker. There will be increased capacity and expertise within the care pathway and so will have a positive impact on waiting times and an improved service user experience.

A 'whole systems' workforce plan will ensure that the right staff in the right numbers are available in the right places to deliver the appropriate interventions. This should result in shorter waiting times, duration of intervention may be less as the principle of early intervention is that if treated early this will prevent the individual's problems becoming longterm.

INITIATIVES TO DELIVER THE NEW MODEL #5

Initiative Title **The development of service specifications in line with the new NHS standard contract will be developed as part of this process attention will be given to eligibility criteria and interface issues between services, Tiers of service delivery, between organisations and between primary and secondary care. The principle adopted will be 'criteria for inclusion'**
Rationale (including evidence base) Explain the need and the objective of change Develop clear KPI and outcome measures for each service Develop clear kpi and outcome measures for each TIER of Service delivery and mechanism for data capture and measurement Ensure all service users have access to a crisis service when they need it Address new contract issues **Links to Initiative 1** **Links to initiative 2**
Current position Primary Care Trust commissioners are preparing new contracts DAAT Commissioners will have a review programme for contracts Local Authority will have a review programme for contract The processes are not coordinated and have different performance management structures.
Commissioner Issues Develop project group Develop project plan Identification of contracts, and service specification to review. Prioritise review process Develop Implementation plan Impact assessment and sustainability of changes to service specifications. **Links to Initiative 1** **Links to initiative 2**

Coordination of contracting and service specification development.

Provider Issues

Engage with commissioners to facilitate best outcomes
Providers will need to undertake impact assessment of changes to service specifications.
Development of data quality improvement plan
Development of quality improvement plan

Financial impact

The review of service specifications may impact upon:
Eligibility criteria; leading to more people accessing services leading to impact on capacity of services.
Ways of working; changes in interface with other organisations, job descriptions, new posts

Timescale

Development of project group - September 09
Development of Project Plan - October 09
Commencement of implementation of Plan - November 09
Review of progress - January 2010
Complete review and all service specifications in place - February 2010
Sign off for new contracts - February 2010

Links to WCC

1. Lead the NHS
2. Work collaboratively with community partners to commission services t hat optimise health gains and reductions in health inequalities
4. Collaborate with Clinicians
   Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service redesign and resource utilisation
8. Promote Improvement and Innovation
   Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration
10. Manage the local health system
11 Make sound financial investments

Links to other local strategies and initiatives

This will primarily link to the following strategies and services:
Public Health, Primary Care, Alcohol, Mental Health, Substance Misuse

Expected Outcomes Clear, specific and robust service specifications for all services working with people with dual diagnosis problems People are not excluded from services, based on particular diagnoses and that care pathways are developed for all those requiring services. Local services are flexible, coordinated and responsive to identified dual diagnosis issues.
How this will benefit service users and their carers This initiative will improve access, improve quality so improving the service user experience. Service specifications will be developed on the principle of 'criteria for inclusion' this will result in more people being able to access services and so reducing barriers to access. This should also have an impact on waiting times and service users remaining in inappropriate services due to inaccessible interventions. This will impact on the service delivery in terms of organisations and services working together more so delivering an integrated service.

INITIATIVES TO DELIVER THE NEW MODEL #6

Initiative Title **The development of a specific Dual Diagnosis service user peer group support forum in Halton.**
Rationale (including evidence base) Meaningful engagement with service users and their carers, Development of mutual support and self help.
Current position Currently no service
Commissioner Issues Facilitate Providers develop forum
Provider Issues Develop service and support
Financial impact Finances will be required to cover cost of venue, refreshments, any literature and publicity materials, time of staff to support the group.
Timescale Identify staff to facilitate set up and initial organisation - October 09 Identification of Venue - November 09 Identification of Service Users and Carers - December 09 Start Group - January 10
Links to WCC 1. Lead the NHS 2. Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities 3. Proactively seek to build continuous and meaningful engagement with the public patients to shape services and improve health 10. Manage the local health system

Links to other local strategies and initiatives

This will primarily link to the following strategies and services:
Public Health, Primary Care, Alcohol, Mental Health, Substance Misuse plus Management of Long Term Condition

Expected Outcomes

An opportunity for peer support groups across both Halton and St Helens.
Increase service user and carer involvement mechanisms across Halton and St Helens.
Increase equity across the PCT footprint

How this will benefit service users and their carers

Facilitate engagement and give a voice and support to service users and their carers. It will assist in the shaping and development of new services.
Service users engaging in this forum will benefit from informal peer support, being able to discuss their difficulties with people who have experienced similar problems in a non-threatening environment.

INITIATIVES TO DELIVER THE NEW MODEL #7

Initiative Title **The development of a Dual Diagnosis Provider forum**
Rationale (including evidence base) To promote integrated working between providers, to assist identify blockages and barriers to service delivery. Provide commissioners with the opportunity to discuss gaps in service and identify ways in which these may be filled
Current position Currently Local Authority manage a broad provider forum not dual diagnosis specific
Commissioner Issues Develop Forum Engage with providers
Provider Issues Engage with the process
Financial impact The financial impact will be on the time of commissioners from Primary Care Trust, Local Authorities, and DAATs to organise and run forum. Some costs may be incurred in providing venue and refreshments
Timescale Identification of lead commissioner - October 09 Identification and invitations to providers - November 09 Identification of agenda and 1st meeting January 10
Links to WCC 1. Lead the NHS 2. Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities 3. Proactively seek to build continuous and meaningful engagement with the public patients to shape services and improve health 5. Manage knowledge and undertake robust and regular needs assessment that establish a full understanding of current and future health needs and requirements 6. Prioritise investments according to local needs and service requirements

7. Effectively stimulate the market to meet demand and secure required clinical and health and well being outcomes 10. Manage the local health system
Links to other local strategies and initiatives This will primarily link to the following strategies and services: Public Health, Primary Care, Alcohol, Mental Health, Substance Misuse, Management of Long Term Conditions
Expected Outcomes Regular meetings of service providers to discuss any blockages and delays between services and identify which systems are working well. An opportunity for providers to hear the views and experiences of service users. A forum where commissioners can work with providers to continuously improve services across the care pathway
How this will benefit service users and their carers Ensure continuous improvement in service development. Providers should be supported at the forum by elected service user representatives. The provider forum will assist in the smooth working between organisations and services reducing blockages and barriers and identifying problem areas sooner and bringing a collective approach to problem solving and meeting service user needs.

INITIATIVES TO DELIVER THE NEW MODEL #8

Initiative Title **Mental Health Strategy to be reviewed**
Rationale (including evidence base) The aim of this will be to ensure that an up to date Mental Health Strategy is a 'Strategic Fit' with all other related Strategies and plans
Current position Current Mental Health Strategy is now out of date
Commissioner Issues Develop a Project Group Develop Project Plan Develop Implementation Plan
Provider Issues Engage with the process
Financial impact Organisational and individual time will be required to complete the review and update the strategy
Timescale Develop project group - October 09 Develop Project Plan - November 09 Develop Implementation Plan - December 09
Links to WCC 1. Lead the NHS 2. Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities 3. Proactively seek to build continuous and meaningful engagement with the public patients to shape services and improve health 5. Manage knowledge and undertake robust and regular needs assessment that establish a full understanding of current and future health needs and requirements 6. Priorities investments according to local needs and service requirements

7. Effectively stimulate the market to meet demand and secure required clinical health and well being outcomes
10. Manage the local health system

Links to other local strategies and initiatives

This will primarily link to the following strategies and services:
Public Health, Primary Care, Alcohol, Mental Health, Substance Misuse, Management of Long Term Conditions

Expected Outcomes

Increased understanding of mental health commissioning plans across primary, secondary and tertiary care and the context for delivering services to people with dual diagnosis.
Ensuring a closer 'fit' between any mental health commissioning strategy, substance misuse strategy and alcohol strategy for people with dual diagnosis problems

How this will benefit service users and their carers

The development of an up to date Mental Health Strategy will facilitate the progress of a 'whole systems approach to commissioning and the provision of services. So leading, to a better service user experience, and patient journey. An up to date Mental Health Strategy will take account of New Ways of working, and recent policy and guidance. This will impact on; how services are managed, and delivered. The outcome of which, will improve access, reduce waiting times and provide a vehicle for partnership working. Service Users and their Carers will be critical informants to the development of the strategy.

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RESOURCES

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