Many substance users also have mental health problems, and find it difficult to access services. Collaborative working brought services for both problems together

**Partnership working in dual diagnosis**

**In this article...**

- Prevalence and problems of dual diagnosis
- Identifying and filling gaps in services
- Integrating practice between statutory and voluntary sectors

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Many mental health clients have problems with drug and alcohol use. This article describes how a collaborative project at Leicestershire Partnership Trust is addressing the needs of clients with dual diagnosis. It outlines the aims of the project, the successes and the challenges, and provides guidance on setting up a collaborative service.

Dual diagnosis refers to mental health clients who also have problems with alcohol and non-prescribed drugs. It is complex. Historically, clients have only been able to access either a mental health service or a substance use service, so many fall between services (Department of Health, 2002).

Access to voluntary service drug treatment is on the basis of self-referral, with people walking in and asking for help (Box 1). This means that every day brings new clients requiring a number of interventions. People who attend drug services come from all walks of life; many work full time, while others are on benefits or come via the criminal justice route and rely on voluntary sector organisations for help. Many present initially to third sector organisations.

According to Drake et al (2001), the best way to provide an effective service for people with dual diagnosis is through shared skills and practice. Hughes (2006) also recommends an integrated approach, where mental health and substance misuse problems are addressed at the same time, in one setting, by one team. This article demonstrates how integrating practices between NHS services and third sector organisations can improve care and engagement for people with dual diagnosis.

**Background**

One third of mental health service have a dual diagnosis, as do up to 50% of substance misuse service users and 70% of prisoners (Mental Health Network, 2009).

In 2008, national clinical director for mental health Louis Appleby said: “The management of people with dual diagnosis remains an area of concern, and one of high priority for mental health policy and within clinical policy” (Department of Health, 2009a).

DH guidance recommends integrated practice when working with dual diagnosis clients (DH, 2009b; 2007; 2002), yet many services are commissioned separately and have little integration (DH, 2007).

The DH (2002) set out a broad framework for identifying which services would be likely to be best placed to meet the needs of different client groups. With the prevalence of dual diagnosis having doubled in the last 15 years (MHN, 2009), different approaches are needed to engage individuals with treatment. Each local area is required to build on this framework and ensure that care pathways are in place to facilitate transitions between services. Persuading clients to engage with services, and ensuring they receive the right treatment are priorities.

**Developing the service**

Baseline is a voluntary organisation drop-in service offering help to stimulant users. It was set up to provide an open-access service for advice, information and treatment interventions for problematic stimulant users.

Staff identified gaps in services after noting that many clients also had mental health problems and were struggling to access psychiatric services. There was also a lack of clarity about roles and responsibilities of the staff and services.

This prompted staff to consider whether service users’ needs could be better met by working with mental health services and offering joint needs assessments. It was essential that the new service had a number of criteria in place (see 5 key points), with the aim of offering:

- Open access for advice, information, harm reduction and drop-in;
- Access to structured treatments;
- Outreach services;
- Complementary therapies;
- Crisis intervention;
- Washing and laundry facilities;
- Snacks, cooking and nutrition;
- Housing, benefits and debt advice;
- Social and relaxation facilities.

Missing from this list was mental health intervention. Baseline staff requested assistance from mental health services for clients with mental health problems accessing the drop-in service.

It was crucial that the service would be local and keep them in mainstream services (DH, 2009). Baseline was developed to meet the needs of people using stimulants because a needs-led assessment had identified the gap; however, this client group had unmet mental health needs. We agreed...
needs assessments

5 key points
When setting up an integrated service:

1. Have terms of reference for the practitioner role
2. Develop an ethos of harm minimisation and drug reduction
3. Ensure staff can share practice to learn from each other
4. Enable clients to see all professionals in one appointment
5. Undertake shared risk and needs assessments

with Baseline that this need could be met by a mental health practitioner attending one day a week.

With information-sharing protocols in place, teams could discuss clients and work towards the best outcomes for each individual. The service also provided a one-stop shop. Some service users find it difficult to enter mental health service premises, so attending a drop-in service, and being seen by a mental health professional there enables them to engage with mental health services in familiar and unthreatening surroundings.

When developing strategies around dual diagnosis, the National Mental Health Development Unit (2008) recommends engaging all parties in meeting clients' needs, and working collaboratively to achieve this. To meet local needs, it is vital to know the local population and be able to engage them. In terms of staffing, it was crucial the worker was a qualified mental health practitioner who could make decisions and carry out assessments. This role was carried out with clinical supervision, provided by a nurse consultant in dual diagnosis.

The project was piloted for six months. The nurse consultant was available one morning a week; it was important to offer the service on a set day so clients would know when it was available, and could book an appointment if they preferred. A total of 47 clients saw the nurse consultant for a variety of reasons (Box 2).

Mental health practitioner role
The practitioner's role is to assess clients and refer them to other services. They also provide advice to staff and telephone support to clients, and work alongside voluntary sector workers, sharing and delivering skills. This collaborative working also helped him to develop skills in issues around substance use.

Most clients were unaware of how or where to access mental health services, so the nurse consultant provided ongoing support and informal training to drug/alcohol workers on mental health issues, regardless of whether they were related to substance use. This was done on an informal basis, with staff talking to him about aspects of a client's presentation they were concerned about, or symptoms being presented. This also enabled the nurse consultant to learn more about substance use and its effects on his usual client group.

Discussion
The nurse consultant collated evidence on the number of clients seen and referred to services. Clients gave verbal feedback, which were positive and demonstrated that integrated working helped them to access the services they needed. Client comments included: “I found it really helpful. The mental health practitioner knew exactly how I felt and didn’t laugh like my mates do.”

Baseline reported increased confidence in staff around working with clients who had mental health problems, as they knew they could access services for clients they were concerned about. The nurse consultant said it had increased his awareness of the impact of substance use on mental health, and given him greater understanding of individuals' needs related to substance use.

It is vital that initiative such as this are sustainable and have measurable outcomes. The main challenge associated with the initiative was staffing - the service went from one mental health practitioner attending every week to four different ones rotating, which changed the cohesive approach. Other challenges included allaying the fears of voluntary sector workers around mental health and addressing the mental health practitioners' own issues towards substance users. This was done on an informal basis but both groups of staff would have benefited from training.

Conclusion
In the long term, roles need to be commissioned in line with local policy and be part of clear, robust care pathways. There also need to be distinct roles and responsibilities for each organisation.

The pilot project was a success and has been rolled out to the wider mental health organisation, offering support to members of other teams who visit Baseline.

Advice and assessment is provided on a weekly basis. The service now includes an early interventions team for younger adults. More teams now provide staff for the drop-in clinic, including crisis, assertive outreach, inpatient settings and community mental health teams. This allows our workforce to develop their skills, as well as being able to support dual diagnosis clients who would otherwise find it difficult to access services. NT

References


Department of Health (2007) Dual Diagnosis in Mental Health Inpatient and Day Hospital Settings. London: DH. tinyurl.com/day-hospital


