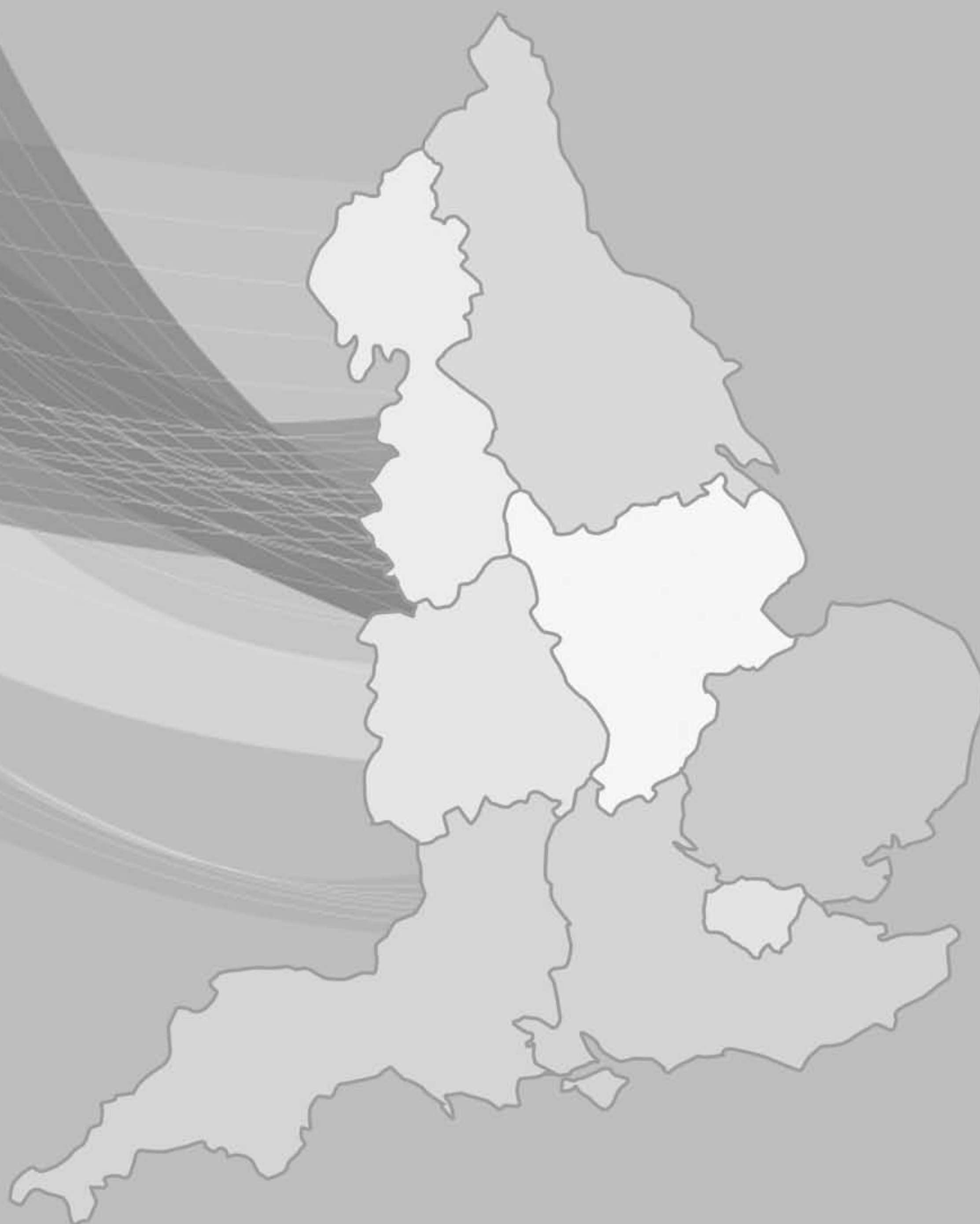
Care Services Improvement Partnership CSIP

Dual Diagnosis

Developing capable practitioners to improve services and increase positive service user experience



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For Recipient's Use	

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Background

Recent UK Policy (DH 2002 & 2006) and research (Adams 2008, Dolan & Kirwan 2001, Maslin et al 2001 and Rassool 2006) on Dual Diagnosis has identified the need to address deficits in training and development for staff providing services to individuals who experience problems with their mental health and who have co-existing substance misuse problems. This policy and research highlights the importance of creative and flexible ways to develop capabilities in the workforce and to challenge negative perceptions and stigmas often associated with this service user group. Other studies (Calderwood & Christie 2008) have stressed the need to focus on ongoing training for practitioners in both mental health and drug and alcohol fields to enable them to meet this service user group's diverse needs.

In the *Mental Health Policy Implementation Guide* (MHPIG); *Dual Diagnosis Good Practice Guide* (2002) the Department of Health (DH) state *"Flexibility and adaptation are essential skills for a workforce charged with providing treatment and care for this client group"*. Training should *"raise awareness of drugs related issues and therapeutic responses . . . increase staff confidence and reduce anxiety in relation to working with people with complex needs"*.

Over recent years there has been a significant body of research developed looking at training issues for the mental health workforce. Maslin et al (2001) found that psychiatric staff exhibited a considerable level of enthusiasm in working with co-morbid substance misuse and mental health problems. However, other research (Holland 1998, Gorry 2002, Maslin et al 2002, Rassool 2006) has also highlighted the lack of confidence and skills the mental health workforce perceive they have in dealing with substance misuse problems present in their clients.

Closing the Gap: A capability framework for working effectively with people with combined mental health and substance use problems (Dual Diagnosis) (Hughes 2006) provides a competency framework that informs the training agenda for dual diagnosis, and forms the basis for recommendations in this document.

The content of this document aims at applying to dual diagnosis, and refining, the key concepts outlined in *New Ways of Working* (DH 2005) and the *Creating Capable Teams Approach* (DH 2007) which is "intended to help local health and social care services at a multidisciplinary team level to review their skill mix and refine their learning and development needs on the basis of service user and carer need".

A number of authors (Johnson et al 1997 and Hayes et al 2003) have identified that barriers between services appear to be one of the most significant factors in preventing service users with mental health and substance misuse problems from accessing services. Other authors have noted the paradox where services, comprising of staff with higher levels of skill in dealing with complex needs, may withdraw or lose contact with service users leaving service delivery to other agencies whose staff may have lower levels of skill in dealing with mental health or substance misuse (Velleman & Baker 2008). Circumnavigating or removing these barriers and boundaries is dependent on services having knowledge of each others roles and strengths, together with a willingness to apply service criteria flexibly to include, rather than exclude, people who present with these complex needs. The challenge for services to overcome such boundaries is dependent upon assessment of individual need, shared care pathways, an evidenced skills base and operational knowledge of local services. Shared education pathways may be significant in overcoming some of these challenges and barriers, allowing practitioners opportunities to explore flexible working and develop high quality integrated care.

Introduction

The purpose of this document is to explore opportunities for building flexible partnerships with a variety of health, social care and higher education institutions to meet the training and support needs of the workforce in delivering high quality care to service users with co-existing mental health and substance misuse problems. This document uses examples of existing good practice throughout the UK to demonstrate where the challenges of flexible working have been met by creative responses. Each example summarises key points that might be applied in other practice settings to benefit service and developmental improvements.

Commissioners and policy makers may find this useful in developing strategies which are aimed at collaborative, comprehensive working to meet the need of this service user group.

Developing flexible partnerships poses several challenges:

- Ensuring learning opportunities are flexible enough to meet the needs of staff who work varied shift patterns and overcoming resource limitations which sometimes inhibit clinical staff being released to undertake training.
- Encouraging staff and challenging the attitudes of service providers who may avoid or find training difficult to access in this area because they believe that substance misuse or mental health is not part of their core business.
- Challenging service or organisational configuration and boundaries which prevent adaptation, flexible learning and ways of working to meet the needs of this service user group.
- A scarcity in the UK of evidence associated with dual diagnosis interventions and outcome measures which is sometimes seen as a lack of evidence for intervening at all.
- Recognising that whilst one-off training may be useful in the short term, a lack of continuity of support and consistency of training can pose challenges for staff in the retention of capabilities in the longer term.
- Learning to adapt skills to meet this service user groups needs involves individual and group supervision and collaborative learning and work with service users and carers.

At the centre of flexible working to meet this service user group needs is an integrated approach which the Department of Health describes as “mainstreaming” (DH 2002). The complexity of need that service users present means they often require interventions across health, social care, statutory and non-statutory boundaries. Mainstreaming requires the whole of this multi disciplinary workforce to have appropriate capabilities which are supported by a 'want to attitude' to providing comprehensive services which ensure holistic care for these service users. This document suggests a number of key development points for good practice and in doing so stresses the importance of a multifaceted approach rather than reliance on one single route to improving practitioners' capabilities.

Areas for development and exploration

1) Training which engenders networking and integrated care pathways across organisational boundaries

Integrated care pathways for this service user group benefit from networking across a variety of organisations. Many regions throughout the UK offer stand alone courses which are provided independently by health services, social care providers, service commissioners and higher education institutions. However, there is little evidence that these courses are developed in partnership or are shared between services. Flexible training opportunities are an explicit way of showing how organisations are able to blend and 'network' to explore commonalities and mutual opportunities for developing integrated care pathways. Partnerships and service level agreements (SLA's) between training organisations associated with Drug and Alcohol Action Teams (DAAT), healthcare providers, social care providers and higher education can be developed to facilitate this process of cross fertilisation.

Example Manchester collaborative:

A collaborative initiative developed and funded by the Manchester Drug and Alcohol Strategy Group (Representing the DAAT, Manchester Mental Health and Social Care NHS Trust, Manchester City Council and other health and social care providers) where core skills training has been delivered which comprises:

- Attitudes and values (hearts and minds)
- Case formulation
- Assessment of drug ,alcohol and mental health need
- Collaborative care planning

Any practitioner across the health and social care spectrum can attend. A network of Link-workers has evolved from this, many of whom are now involved in the delivery of training or the development of Link-Worker conferences.

Key Learning/Good Practice points:

- Shared commissioning of the training has prevented funding acting as a barrier to practitioners' development.
- Networking has improved the practitioner's ability to signpost to other relevant service providers to meet service users' and carers' needs.
- A shared understanding around barriers to care for service users has evolved.
- Services which represent the diverse population in the metropolitan area (including Black and Minority Ethnic and Lesbian and Gay groups) have had access to the training and taken opportunities to network and be involved in the education programme.

2) Developing protocols with Higher Education providers which identify work-based learning opportunities

Developing partnerships between treatment services and higher education institutions provides an opportunity to focus on courses which have robust links with practice. Courses of this type offer the opportunity to place an emphasis on case formulation which targets individual need and engender collaborative learning with service users and carers.

Example Nottingham University Dual Diagnosis module:

This 20 credit module, at degree level, which is accredited with Nottingham University was developed in collaboration between The University and Nottinghamshire Healthcare NHS Trust. The course content was recently re-written in line with core competencies published by CCAWI & CSIP (Hughes 2006). A core element of the course has been to increase the practice relevance of its content through active partnership with service users and carers.

Service user led sessions commence as early as possible on the second day of the course, to demonstrate that the service user perspective is central to the delivery of evidence based services. The students are also given the opportunity to explore their experiences with a service user and carer panel.

The taught component of the course runs over eight days split into two 'semester blocks', with eight weeks practice time between semesters. The eight week period in clinical practice is utilised as time for the students to begin to apply the theory they have learned in the classroom to their practice. This link between the practice based and taught elements of the course encourages the students to use reflective practice. On their return to the second semester 'clinical successes and dilemmas' are adopted from their reflective time in practice. These form the basis for discussion in care planning sessions initially with their peers and subsequently with a panel of service users and carers. This can then also form the basis for the assessed part of the course work. The aim of this element of the course is to emphasise the importance of collaborative care planning and provision in dual diagnosis.

Key Learning/Good Practice points:

- Engaging Service Users and Carers in developing and delivering training engenders a collaborative approach to working.
- Building in practice learning time aids application of theory to practice.

3) Developing regional support networks which promote open learning and shared opportunities to explore positive clinical work in dual diagnosis

Regional networks which focus on dual diagnosis provide opportunities for service providers, service users and carers to learn from each other. Such forums are invaluable in sharing learning, exploring and challenging attitudes, providing peer supervision, eliciting service user and carer perspectives and building high quality lasting collaborative relationships.

Example East Midlands Regional Dual Diagnosis Network:

This Bi-monthly forum attracts service providers, service users and carers to a meeting where learning opportunities are developed collaboratively through regular brief presentations and discussion. Examples of positive practice from across the region are shared and the forum provides an opportunity to discuss challenges and new developments in the field. It also provides an opportunity for peer support and supervision. Recent research is disseminated to inform members of new clinical evidence. The Forum is exploring opportunities for certification and accreditation for its activities.

West Midlands Dual Diagnosis Network:

This quarterly forum is open to service users, carers, professionals, commissioners and people with an interest in Dual Diagnosis. The forum has helped to draw together areas of good practice from across the West Midlands and encouraged information sharing across service boundaries. It acts as a central point for updating participants on areas of dual diagnosis development, evidence based practice and policy. The forum provides all participants with a broad view of issues related to dual diagnosis from a variety of perspectives actively encouraging service user collaboration. The forum encourages networking and communication outside of meetings between participants to allow sharing of positive approaches to clinical dilemmas.

Croydon Manager's Dual Diagnosis Forum:

This forum builds on the five day pan-London dual diagnosis training which is delivered to mixed groups of staff representing the range of agencies providing care for this service user group. The forum aims to: improve standards of care provision within agencies; enhance effective working between agencies; and promote collaborative problem-solving to the challenges encountered when multiple agencies are working with a service user with complex needs. Membership is open to anyone who is working in a supervisory role with staff that have completed the training. It includes representatives from: mental health; substance misuse (statutory and non-statutory), residential rehabilitation (mental health and substance misuse); criminal justice (probation and substance misuse criminal justice programme providers).

The forum takes place monthly and is facilitated by the dual diagnosis team. The first part of the forum focuses on updating and/or educating participants on national and local dual diagnosis developments. Members themselves and invited speakers contribute. The second focuses on case discussion, with an emphasis on considering cases that have presented difficulties to services because two or more are involved.

Key Learning/Good Practice points:

- Provides a model of multi-agency/professional working as set out in Closing the Gap (Dual Diagnosis Capability Framework) (level 3) *'To be able to work across various service and professional boundaries understanding the specific issues that someone with dual diagnosis may raise within and between teams/services. Be able to resolve conflicts in treatment decisions'*
- The forums engender sharing of good practice in a non-hierarchical environment.
- Encourages networking, peer supervision and exploration of learning across social care, healthcare, statutory and non-statutory boundaries.
- Actively encourages the participation of service users and carers emphasising a collaborative developmental process.

4) Work rotation and secondments

Organisations should explore opportunities to provide shared learning within their own practice settings. Work rotation schemes and secondments both within organisations and across organisational boundaries can be opportunities for work based learning, the development of integrated care pathways and to improve links between services. Secondments and rotational schemes have a number of vicarious benefits including:

- Career progression and succession planning;
- Empathic and supportive understanding across organisations and beyond organisational boundaries of service criteria,
- Strengths and challenges;
- Opportunities to work together to produce integrated care pathways.

Example The Experienced Nurse Rotation Scheme, Central and North West London and West London Mental Health NHS Trusts:

The scheme seeks to offer Experienced Nurses an option for career development, and as such to support their motivation to work within health services, provide health care to communities, and to develop and improve the health services that are provided. The three basic possibilities for rotation in this scheme are outlined below:

- The practitioner stays exactly where they work but would change their job in some radical way – for instance through the development of a new project.
- The practitioner works in another area part time e.g. two days a week (not necessarily desirable, but expedient)
- The practitioner negotiates a secondment.

The initial evaluation of the scheme has shown that it is an attractive way to develop for experienced nurses. Whilst this is not a dual diagnosis specific programme the concept would appear to be transferable.

Key Learning/Good Practice points:

- Encouraging skill sharing across service boundaries.
- Helping staff to understand pressures on services and explore ways to release service blocks across inter and intra agency boundaries.
- Creative pathways for personal and professional development.

5) Partnership commissioning and ownership of dual diagnosis posts

Developing posts which are commissioned across organisational boundaries can be used to ensure that clinical practice and academic learning and research are merged to mutually benefit each other.

Example Consultant Nurse and Senior Lecturer

This post in coexisting Mental Health and Substance Misuse (Dual Diagnosis) has been appointed by Avon & Wiltshire Mental Health Partnership NHS Trust in partnership with the University of the West of England.

Key Learning/Good Practice points:

- Since the appointment, pre-registration training on dual diagnosis has increased by some 900%, with a more structured programme and the opportunity for students to adapt theory to practice by 'shadowing' the Nurse Consultant.
- Developing a practical clinical response following completion of training. E.g. Clinical network meetings, local support/steering groups and 1:1 supervision.
- Developing specific roles within teams and supporting the training of Dual Diagnosis 'champions'.
- Supports a flexible understanding of service delivery which informs training need and engenders a comprehensive and systematic relationship between skill development and evidence based practice.

6) Developing Across-Service Level Agreements to share learning opportunities

It is common for service providers and commissioners to develop and provide training to their staff. However, the opportunity for 'across-service' sharing of such training is often overlooked. Developing across-service level agreements to support sharing of training not only provides an economical use of resources, but also engenders networking between organisations. This affords the opportunity for participating organisations to form new networks to share knowledge and collaborate on challenging attitudes when working with people who experience complex needs. Expert knowledge from a variety of fields is shared and supports and promotes opportunities for developing integrated care across service boundaries. The mapping of training provision in an area may help services to identify training which is appropriate to their needs and identify opportunities to share training with different organisations by developing service level agreements which 'trade' training opportunities across service boundaries. (For an example see point 1 the Manchester Collaborative).

Key Learning/Good Practice points:

- Rationalises scarce resources across the care pathways associated with substance misuse and mental health.
- Can engender an understanding of the integrated and holistic nature central to care provision for individuals with coexisting mental health and substance misuse problems.
- Can help 'healthy erosion' of boundaries which exist between services and care groups.

7) Developing an electronic web based learning package and toolkit on dual diagnosis

There is a significant move towards 'e' learning in health and social care settings. Services could develop or adopt their own 'e'-learning package which can have downloadable/printable paper tools for use in practice (E.g. brief assessment packages). This type of flexible learning has considerable advantages in that it can be accessed at any time, completed by the student/participant in part and saved for completion later and can be tailored to meet specific workforce needs. Learning of this type can provide accredited training accessible to parts of the workforce which may normally find it more difficult to access training, for example staff on night shifts.

Key Learning/Good Practice points:

- Allows staff to learn at a time which is appropriate to them and can be used by staff working unsocial shift patterns.
- Provides accessible evidence based tools for use in face to face work with service users and carers.

Next Steps

1) Mapping existing training in the UK on dual diagnosis, substance misuse and mental health against the core competencies outlined in *Closing the Gap: A capability framework for working effectively with people with combined mental health and substance use problems (Dual Diagnosis)* (Hughes 2006) could help service providers identify education opportunities which are relevant to their workforce and service user's need.

2) Agencies actively pursue opportunities for across-service training supported by service level agreements which recognise the benefits of interagency training and working.

3) Training opportunities essentially include input from service users and carers at the outset; from development to delivery, with opportunities for service users and carers to be involved in course evaluations and re-development.

4) Healthcare Provider Trusts and Universities pursue opportunities for collaboration, in particular the opportunity to jointly commission and appoint senior practitioner, lecturer, and researcher roles in dual diagnosis practice.

5) Service providers, commissioners and higher education institutions explore the development of 'e' learning toolkits on dual diagnosis to provide flexible and accredited learning opportunities for the whole workforce.

6) Service providers explore opportunities for workforce rotation schemes both within their own organisations and across service boundaries to encourage learning which is based in understanding of service provision and which meets service user needs through integrated care pathways within and across services.

7) Local and regional network groups are set up and maintained to support skills sharing amongst service providers, carers and service users.

8) Opportunities for peer support for service users are supported and facilitated.

Conclusion

There is little doubt that developing capable practitioners to deliver high quality care in dual diagnosis poses significant challenges. This document offers some 'real world' solutions to a challenging concept. We have demonstrated that there are significant skills and resources already present in a variety of semblances within services which if disseminated and shared could have a meaningful impact in developing sustainable learning and support opportunities for our workforce. A skilled and capable workforce is the key to mainstreaming care in dual diagnosis.

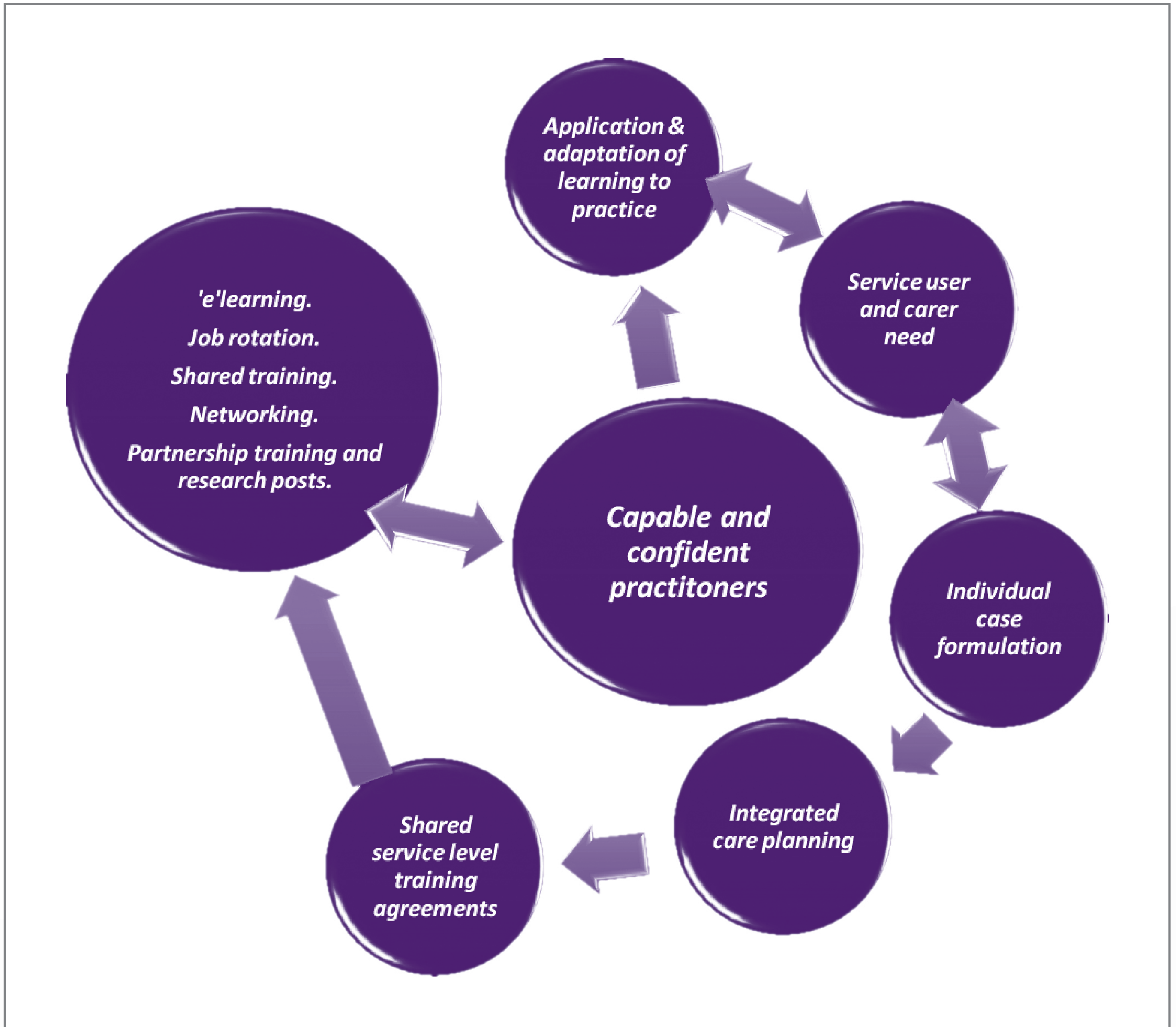
Involving service users and their carers in bringing their expertise to the table holds significant benefit in ensuring that care is based upon individual assessment of need and case formulations (Velleman & Baker 2008) which meet specific service user need, and recognises the values that provide the context for their experiences. Collaboration and effective communication between all involved can challenge and change the existing barriers to service delivery which will ultimately benefit our service users, their carers and our workforce.

Key Steps for Positive Practice

The positive practice pathway on the right illustrates how the examples of practice in this document interact to influence the confidence and capabilities of practitioners. More confident and capable practitioners can ensure application and adaptation of learning to practice which in itself can influence individualised care which meets service users' needs. Service users and carers can influence and add to learning which in turn develops improved practice.

The cyclical nature of the pathway attempts to illustrate that all parties involved in integrated care can influence good practice:

- **Commissioners** by purchasing and encouraging shared training protocols and partnership research and development posts. (Refer to points 1 & 5)
- **Services** through service user and carer involvement, the instigation of integrated care pathways, job rotation schemes, 'e' learning, shared training and supporting local and regional networks.
- **Individual practitioners** through individual assessments and case formulations, an enthusiasm to improve practice through learning and subsequent sharing of skills through training, networking and peer support.
- **Service users and carers** through their involvement in; the development and delivery of training, collaborative learning and regional support networks.


Application & adaptation of learning to practice
Service user and carer need
Individual case formulation
Integrated care planning
Shared service level training agreements
'e'learning.
Job rotation.
Shared training.
Networking.
Partnership training and research posts.
Capable and confident practitoners

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