Appendix 3A

BRIGHTON & HOVE CITY COUNCIL

SCRUTINY PANEL ON DUAL DIAGNOSIS

3:00PM 29 FEBRUARY 2008

HOVE TOWN HALL

MINUTES

Present: Councillor Watkins (Chairman); Councillors Hawkes, Taylor and Young.

Witnesses: Simon Scott (Lead Commissioner for Mental Health, Brighton & Hove City teaching Primary Care Trust); Dr Richard Ford (Executive Director, Sussex Partnership Trust); Dave Dugan (Residential Services Manager, Sussex Partnership Trust); Steve Bulbeck (Head, Single Homelessness and Social Inclusion, Brighton & Hove City Council).

PART ONE

ACTION

1 PROCEDURAL BUSINESS

1A. Declarations of Substitutes

1.1 Substitutes are not permitted on ad-hoc Scrutiny Panels.

1B. Declarations of Interest

1.2 There were none.

1C. Exclusion of Press and Public

1.3 The Committee considered whether the press and public should be excluded from the meeting during the consideration of any items contained in the agenda, having regard to the nature of the business to be transacted and the nature of the proceedings and the likelihood as to whether, if members of the press and public were present, there would be disclosure to them of confidential or exempt information as defined in Schedule 12A, Part 5A, Section 100A(4) or 100 1 of the Local Government Act

1972 (as amended).

1.4 **RESOLVED** - That the press and public be not excluded from the meeting.

2. CHAIRMAN'S COMMUNICATIONS

2.1 The Chairman noted that Dual Diagnosis (of mental health and substance misuse problems) was a serious and wide-reaching problem in Brighton & Hove, and one which might require a good deal of involvement, perhaps on an ongoing basis, from Overview & Scrutiny.

2.2 The Chairman reminded witnesses that they were entitled to have any part of their evidence considered in private session if they so wished.

3. EVIDENCE FROM WITNESSES

3.1 Witnesses at this session were: **Simon Scott**, Strategic Commissioner for Mental Health, Brighton & Hove City teaching Primary Care Trust; **Dr Richard Ford**, Executive Director Brighton & Hove Locality, Sussex partnership Trust; **Dave Dugan**, Residential Services Manager, Sussex Partnership Trust; **Steve Bulbeck**, Head of Single Homelessness and Social Inclusion, Brighton & Hove City Council.

3.2 Panel members initially asked the witnesses a series of questions, some of which were answered by a single witness, some by a combination. These responses have been recorded thematically rather than sequentially in the following minutes.

4. BACKGROUND

4.1 Mr Scott explained to the Panel that he is responsible for commissioning adult mental health and substance misuse services for Brighton & Hove City teaching Primary Care Trust (PCT) and for Brighton & Hove City Council, under "section 31" arrangements for the pooling of healthcare budgets and of commissioning responsibilities (now section 75 of the National Health Service Act 2006).

4.2 Mr Scott does not set the budget for mental health and substance misuse services, but is responsible for commissioning city services within the budget, with reference to the appropriate legislative framework and evidence of national best practice. Dedicated services for children and young people are commissioned separately (by the Children & Young People's

Trust).

4.3 City budgets for mental health and substance misuse services are approximately equivalent to spending by comparable PCTs, although there are difficulties in finding exact comparators for Brighton & Hove.

4.4 Brighton & Hove has a higher than average incidence of mental health problems: 17 - 31% higher than the national average. The City also has higher than average problematic drugs use: some 17% higher than the national average. Rates of drugs misuse and mental health problems vary considerably across the city, with some wards recording lower than average incidences and others a very high prevalence.

4.5 Dual Diagnosis of mental health and substance misuse is not just a problem in terms of the misuse of "class A" drugs (heroine, cocaine, crack cocaine etc), but is also a major issue in terms of the misuse of cannabis, alcohol and prescription drugs, particularly benzodiazepines. (Brighton & Hove has the fifth highest prescription rate for benzodiazepines in England and concomitant problems with improper use of these drugs.)

4.6 Brighton & Hove receives some additional funding from the Department of Health in recognition of the city's higher than average incidence of mental health problems. Funding of substance misuse services is linked to the perceived success of existing services, with services which are judged as effective liable to receive additional funds, and ineffective services at risk of having their funding reduced.

4.7 There is no central budget for Dual Diagnosis (of mental health and substance misuse problem); funds are allocated from the main mental health and substance misuse budgets in line with estimates of the prevalence of the problem within the city.

4.8 In an effort to accurately determine the prevalence of Dual Diagnosis and to ensure that city services reflected national best practice, a Needs Assessment was conducted (for Brighton & Hove and East Sussex) in 2002. This Needs Assessment provides the basis for current city Dual Diagnosis services. (A copy of the 2002 Needs Assessment is included in the background information section of the Dual Diagnosis file).

4.9 In compiling the Needs Assessment, PCT officers examined national guidance and published research in an attempt to determine best practice in terms of treating Dual Diagnosis. However, there is rather weak evidence for the effectiveness any particular treatment model.

4.10 Brighton & Hove currently operates a "parallel" system of treatment, in which separate mental health and substance misuse teams work with clients who have a Dual Diagnosis. This system has some major strengths, particularly in terms of encouraging the development of specialist expertise in each area of working. However, there is a real danger that, because the treatment of Dual Diagnosis is split between two services, patients run the risk of falling "between the gaps", with their needs being properly addressed by neither service.

4.11 There may also be a major problem in terms of "unmet need" in the city; that is, of people who have both severe mental health problems and problematic substance use, but who have not been formally identified as having a Dual Diagnosis.

4.12 The PCT has done some work with city GPs and with city Practice Based Commissioning Groups (i.e. groups of city GPs who have pooled responsibility for the commissioning of certain services under the NHS "Practice Based Commissioning" programme) to increase awareness of Dual Diagnosis.

GPs have expressed a desire for more responsive services with a single point of access, and have chosen to commission such a service. From April 2009 there will be a single team (run by the Sussex Partnership Trust) responsible for assessing patients with suspected drugs/alcohol/mental health issues based in each Brighton & Hove locality (i.e. West, Central and East).

4.13 In the past, people with a Dual Diagnosis have often been "bounced" around between various service providers. The PCT now has powers to "incentivise" providers to ensure that this does not happen. The single locality teams will seek to address this problem.

4.14 Once a patient is assessed as having a Dual Diagnosis, a Care Plan will be developed and agreed with the patient and with all the agencies who will be involved in that patient's care.

4.15 Richard Ford noted that mental illness was prevalent in the city as was problematic substance use, and there was inevitably a big cross-over of people with some aspects of both problems. However, the Panel might be best advised to focus more narrowly: on people with severe mental health problems and severe substance misuse issues.

4.16 Richard Ford told Panel Members that there was no absolutely typical profile of a Dual Diagnosis client, although many people with severe co-morbidity problems would suffer from schizophrenia, would misuse a wide range of substances, and would have regular mental health admissions, regular attendances at A&E, frequent episodes of homelessness and frequent encounters with the police (generally for fairly minor offences).

5. CHILDREN'S SERVICES

5.1 Richard Ford told Panel Members that there were currently separate adult and children's services for both mental health and substance misuse problems. This arrangement creates difficulties in terms of clients moving from one service to another, particularly as the age at which the services overlap is also an age at which very many people experience mental health problems and/or problematic substance use. There are therefore plans to introduce a dedicated service for 14 to 25 year olds. However, this is not currently in place.

5.2 In terms of looked-after children, there is a very strong correlation between being in care and having birth parents with problematic drugs or alcohol use issues. A service has been commissioned with 28 intensive treatment places intended for families at risk of having their children taken into care. However, this service is not currently set up to deal with problematic substance users who have concurrent mental health problems.

5.3 Panel members also asked whether, within the process of drawing up a patient's care plan, there was a protocol which would ensure that the relevant authorities were informed of any dependant children (of the patient being assessed) who might be considered to be at-risk. **GR**

5.4 The Panel was also informed that there needs to be closer working between adult services and the Children & Young People's Trust, as effective preventative works needs to start with school-age children. Witnesses thought that Panel members would be well-advised to pay attention to this area.

Public Health information on substance misuse which specifically targets young people has seen a reduction in funding in the past few years. This is an area that needs addressing.

5.5 A Panel Member noted that she was encouraged by young people's ability to talk openly and sensibly about mental health issues, and felt that young people would be receptive to

preventative healthcare messages, provided they were couched in the right terms.

6. FUNDING

6.1 In answer to questions about funding, Panel members were told that Dual Diagnosis could either be defined quite narrowly or very broadly (either as people with both severe mental illness *and* severe substance misuse issues, or as people with some combination of mental health and substance misuse problem). In terms of the first definition, funding was unlikely to be a major issue as people with a Dual diagnosis of severe mental health and drugs misuse problems are typically a very high priority for treatment and support.

However, in terms of the second definition, funding is certainly an issue, as current services are not successful in identifying or supporting everyone with a mental illness or with problematic substance use issues (for instance, only an estimated one third of intravenous drugs users are currently supported by substance misuse services). Some of this failure to reach out to all potential clients is doubtless due to insufficient funding. GR?

Dual diagnosis involving alcohol presents much more acute funding problems, as treatment for alcohol related problems is poorly funded nationally, with Brighton & Hove expenditure being significantly lower than comparators. There are some plans to increase funding for these services, but it is unlikely that such plans will mean that services are properly funded.

There are also plans to fund a dedicated Dual Diagnosis post at the level of Nurse Consultant.

7. HOUSING

7.1 Richard Ford noted that there was a major problem with housing and tenancy support services for people with Dual Diagnosis. Clients were regularly discharged into unsuitable accommodation which impacted upon their chances of recovery. The problem was not so much a paucity of good accommodation for people with mental health problems, but rather that this type of supported housing was not generally set up to deal with clients who also had substance misuse issues.

7.2 Dave Dugan noted that the Sussex Partnership Trust employed a placement officer whose role it was to place mental health service users in appropriate supported accommodation, but that there were simply not enough places available, despite there

being a considerable amount of supported housing in the city. There is therefore an urgent need to work closely with housing providers to ensure that the accommodation they offer is appropriate for the clients who need to be placed in a supported environment.

7.3 Panel members were told that there were very real difficulties in housing people with Dual Diagnosis, as clients are often confrontational and are typically unable to obey tenancy rules. Housing numbers of people with a Dual Diagnosis together is problematic, as the presence of other substance misusers tends to encourage individuals to use. Having a number of active users with severe mental health problems in one place can also impact on the local community, who can in turn put pressure on housing providers to better control their tenants. Providers may respond to such pressures by evicting active users.

7.4 There is currently no supported accommodation in Brighton & Hove for non-abstinent or non-minimising substance misusers with mental health problems. The West Pier Project is the nearest thing the city has to this type of facility.

7.5 In answer to a question as to whether people in hostel accommodation were permitted to take drugs, Steve Bulbeck told Panel members that whilst there was certainly a need for some accommodation that imposed a rule of abstinence, the complex needs of many clients were such that abstinence was not a realistic option. Brighton & Hove City Council was therefore committed to working with housing providers to ensure that the available accommodation met actual client need: that is, for providers to recognise that they could and should not insist on total abstinence.

7.6 Richard Ford noted that abstinence was very rarely a short term option for people with Dual Diagnosis, as few such clients could cope with the kind of rule-based regime necessary to ensure abstinence. Key to achieving good outcomes for people with Dual Diagnosis was not imposing unrealistic targets or expectations.

7.7 Dave Dugan told Panel members that Brighton & Hove needed a number of small residential units with a flexible approach to dealing with Dual Diagnosis clients.

7.8 Panel members were told that there were some very good partnerships between the NHS and Adult Social Care and the Registered Social Landlords who provide much of the city's supported accommodation. However, there is certainly a good

deal more that could be done to make these partnerships more effective. This may not involve a great deal of additional expenditure, but rather using existing supported accommodation in a way which better reflects need in the city.

7.9 Simon Scott noted that the budget for mental health and substance misuse services could be re-profiled to provide additional funds for supported housing if clear benefits to such a move could be shown. However, the current financial climate is one in which major cuts have been made to the Supporting People budget (although attempts have been made to protect working age mental health services).

8. PARTNERSHIPS

8.1 In terms of integrated working between partners, the Panel was told that some partnerships work well, including most partnerships between Brighton & Hove City Council Adult Social Care services and NHS services for city residents.

However, integration between NHS services and those dealing with employment and housing is much less effective. There is currently a major Government initiative to extend the availability of psychological therapies, and this will have a specific focus on helping people with mental health problems to find and maintain employment.

The Panel heard that much more needs to be done in terms of co-ordinating mental health and housing support services.

9. SUPPORT SERVICES

9.1 Richard Ford said that having a single point of referral for mental health and substance misuse issues would improve outcomes. However, ensuring that formerly disparate working cultures coalesce effectively will almost certainly take a good deal of time.

9.2 Richard Ford stated that an important challenge is to get people with Dual Diagnosis to engage more with support and treatment services. Traditionally, such clients tend not to engage well with services, or with primary care. However, this is not an "invisible" group: people with Dual Diagnosis are generally well known to the NHS, to Adult Social Care and to the police due to their chaotic lifestyles.

9.3 Richard Ford said that it was important for mental health professionals to gain skills in dealing with substance misuse issues.

This was ultimately preferable to joint working between mental health and substance misuse professionals.

9.4 Simon Scott noted that money might not always be best spent directly addressing the needs of people with severe Dual Diagnoses. There was considerable opportunity to "spend to save" by funding preventative measures in an attempt to shape the culture of Brighton & Hove away from the kind of widespread problematic drugs and alcohol use that was bound to cause many people major problems at a later date.

9.5 The Panel was told that carers and supporting families had not, in the past, been accorded a major say in developing services for people with a Dual Diagnosis. However, it was now recognised that carers have an important role to play and the PCT is working to improve the situation. Measures will include ensuring that carers are not excluded on the basis of patient confidentiality without good reason. The PCT also plans to encourage carers to get more involved with the commissioning of services.

9.6 In answer to a question regarding Care Plans, Panel Members were told that there was some co-working between partners when developing Care Plans. However, a Care Plan which could be made available to housing support agencies would be very useful. There has been some attempt to develop such a plan, although progress has been slow.

9.7 If members wished to learn more about Care Plans it was recommended that they call Dr Rick Clarke, a consultant psychiatrist with Sussex Partnership Trust's Assertive Outreach Team, to give evidence.

10. OTHER ISSUES

10.1 In response to questions about Dual Diagnosis and prison services, Panel members were told that people with severe Dual Diagnosis should not typically enter the prison system, but would rather be diverted to mental health care. In both the prison system and secure mental health accommodation, substance misuse issues were relatively straightforward to treat, as access to drugs/alcohol could be restricted (although not with absolute assurance). However, there would be a very high incidence of relapses once people were discharged into the community.

10.2 The Chairman noted that he would seek to have the Panel's final report presented to the boards of Brighton & Hove City teaching Primary Care Trust and the Sussex Partnership Trust as well as to

the Brighton & Hove City Council executive.

The meeting concluded at 5:00 pm

Signed Chairman

Dated this day of 2008