

Good practice: briefing

Service without substance

Addressing the gaps in service provision for street homeless people with a dual diagnosis

Summary

In 2004, *The national service framework*¹ stated that 'dual diagnosis should be viewed as the most challenging clinical problem that we face'. This is still pertinent, as supporting people with a dual diagnosis continues to present a major challenge for front-line housing and health services. The co-existence of mental health needs and addiction is difficult to treat. Few services exist that are able to provide the holistic approach that dual diagnosis requires. As a result, many service users fall through gaps in service provision, preventing them from getting the help they need and perpetuating homelessness.

There is a pressing need to understand the role of housing exclusion in the lives of dually diagnosed people and encompass a housing dimension in any strategic response to improving dual diagnosis services. Both dual diagnosis and street homelessness require cross-sector co-operation to achieve successful interventions.

- There is evidence that dual diagnosis is prevalent among street homeless people. It is difficult to treat and few specialist services exist.
- Street homeless people with a dual diagnosis can face two-fold discrimination in attempting to access suitable accommodation. There is little specialist hostel provision, and emergency and supported accommodation providers often operate a drug-free policy. There is a general lack of suitable move-on accommodation, particularly for people leaving residential drug and alcohol rehabilitation services, and few providers of specialist mental health supported housing will accept referrals for service users with a dual diagnosis.
- Funding systems are still confined to specific treatments that address single needs only, resulting in gaps in service provision for those with a dual diagnosis.
- Mental health and drug/alcohol services operate separately from each other, and have different philosophies and There is little co-ordination of services and there are few formal systems for multi-agency working. Lack of communication between services has led to duplication of assessments and complex referral systems. In addition, many agencies are operating without the skills and resources to provide appropriate help for service users with a dual diagnosis.
- Services are inflexible, difficult to access, and operate with lengthy waiting lists. Existing models do not meet the needs of many street homeless people.

¹ Appleby, *The national service framework for mental health – five years on*, Department of Health, 2004.

Defining dual diagnosis

The term 'dual diagnosis' refers to the co-existence of a broad range of mental health and substance use problems, although individuals rarely receive a formal diagnosis of both. The term 'dual' can be misleading because most people who are dually diagnosed also have multiple and complex needs. The nature of the relationship between substance use and mental health needs is complex and can take a number of forms, making dual diagnosis difficult to identify and treat. Furthermore, service users are frequently only diagnosed when both their mental health and substance use problems are deemed to be 'severe'.

Strategic context

The economic, social and personal costs of dual diagnosis are significant. Therefore, a number of research and policy developments have been made, and it has become a rapidly expanding area of debate for innovative good practice development.

In the late 1990s, addressing the needs of people with a dual diagnosis became a national priority for the Government. In 1999, the Department of Health published *The national service framework for mental health*², which highlighted the need for stronger links between drug/alcohol services and community mental health services. It argued that consideration must be given to the potential role of substance use in all assessments of individuals with mental health problems. In 2001, a toolkit for the commissioning and delivery of services for patients with a dual diagnosis was also published.³

In 2002, the National Treatment Agency for Substance Abuse wrote *Models of care*, a national framework for the commissioning and provision of an integrated drug treatment system.⁴ It contains guidance for the care of dually diagnosed people, emphasising the need to develop close working relationships between mental health and drug/alcohol services, as well as social care and criminal justice agencies. *Models of care* and the 2006 updated version⁵ are however, set against the National Drugs Strategy⁶, which focuses on expanding criminal justice interventions, but does

not specifically outline provision for people with a dual diagnosis.

In 2002, the Department of Health published a good practice guide for joint commissioning and joint planning in the field of dual diagnosis.⁷ The guide argues for the 'mainstreaming' of dual diagnosis provision by placing the primary responsibility for treatment with mental health services, thereby reducing the number of people who are shunted between, or excluded from, services. The guidelines recommend that drug and alcohol, and mental health services should provide specialist support to each other through integrated treatment pathways, with systems for joint working defined within the strategic planning process. The guide also highlights the need to train sufficient numbers of staff working within mental health and assertive outreach teams. Local Implementation Teams and Drug Action Teams are responsible for implementing these guidelines. However, in 2004, *The national service framework*⁸ identified little improvement in these areas and a lack of compliance with the guidelines.

The increased strategic interest in social exclusion and multiple and complex needs, as outlined in several government documents⁹, underpinned the introduction of a planning and commissioning framework for services related to the health needs of people who are homeless, or living in temporary or insecure accommodation.¹⁰ The framework provides guidelines for the joint planning and commissioning of health, social care and housing services, with the aim of co-ordinating service delivery, addressing current gaps in service provision and improving the health and housing outcomes for vulnerable adults. It also places an expectation on local authorities to outline clear service pathways in the revised homelessness strategies in 2008.

Mental health and drug/alcohol services

Failure of healthcare

There are relatively few specialist or integrated dual diagnosis services in operation, and some common gaps in mainstream provision exist. The inequalities

2 Department of Health, *The national service framework for mental health: modern standards and service models*, 1999.

3 The Sainsbury Centre for Mental Health, *Substance misuse and mental health co-morbidity (dual diagnosis): standards for mental health services' health advisory service*, 2001.

4 National Treatment Agency for Substance Misuse, *Models of care for treatment of adult drug misusers*, 2002.

5 National Treatment Agency for Substance Misuse, *Models of care for treatment of adult drug misusers: update 2006*.

6 Home Office, *Updated drugs strategy*, 2002.

7 Department of Health, *Mental health policy implementation guide: dual diagnosis good practice guide*, 2002.

8 Appleby, *The national service framework for mental health – five years on*, Department of Health, 2004.

9 HM Government, *Reaching out: an action plan on social exclusion*, 2006; Office of the Deputy Prime Minister, *Sustainable communities: settled homes; changing lives. A strategy for tackling homelessness*, 2005; Department of Health, *Our health, our care, our say: a new direction for commissioning services*, 2006.

10 Communities and Local Government, *Framework for planning and commissioning of services related to health needs of people who are homeless or living in temporary or insecure accommodation*, 2007.

experienced by street homeless people in accessing healthcare services are further compounded by this lack of suitable dual diagnosis healthcare provision.

Many services are commissioned on a short-term basis and insecurity in funding creates competition and cost-cutting among providers. This has a major impact upon standards, long-term development, staff recruitment and retention, and partnership working. Organisations are forced to mould their services around the requirements of funding streams, rather than respond to local need. Commissioning services in this way limits the opportunity to develop provision strategically across all sectors, while funding-related targets focus on meeting funding objectives rather than outcomes for service users. Mental health and substance use needs are often placed into separate budget pools resulting in a partial, if any, service for people with a dual diagnosis. Service users can end up being diverted from one service to another, with no one accepting responsibility for addressing their needs.

A catch-22

Many service users with a dual diagnosis who continue to use alcohol or substances experience significant problems in attempting to access mental health services. Many primary care practitioners will not refer continuing drug or alcohol users to psychiatric services, and service users face a lengthy wait before receiving a psychiatric assessment. The required abstinence from substance use before getting an assessment is not a viable option for many street homeless people. Mental health and drug/alcohol misuse services must broaden their focus by assessing and responding to both sets of needs.

A multi-faceted problem without a multi-agency solution

In some areas, dual diagnosis teams have been developed, but for most areas, resources are limited so they cannot fund specialist agencies and practitioners. Specific dual diagnosis strategies have also been developed by some primary care trusts, yet in many cases these are no longer 'live' documents. Where multi-agency working does exist, it often lacks formal structure. There are few operational protocols and those that do exist are not widely promoted or implemented. The lack of communication between services is a major problem and there is little joint working. There also appears to be a lack of co-ordination between psychiatric services themselves, and high staff turnover compounds this issue.

For any successful intervention with dually diagnosed service users, continuity of care is vital. Yet pressure to increase service take-up, especially in drug and

alcohol services, often results in inadequate care. Many dually diagnosed street homeless people end up involved with a number of health and support agencies, in both the voluntary and statutory sectors. Lack of communication and formal protocols between agencies, can result in multiple assessments, complex referral systems and fragmented support. This can lead service users to disengage with services altogether.

Housing and homelessness services

Stable housing is the linchpin for increased mental stability, health and well-being. Lives without housing are characterised by vulnerability and higher levels of mental illness. Housing is a vital aspect of any healthcare plan¹¹ and understanding the impact of housing exclusion in the lives of street homeless people with a dual diagnosis is crucial if real changes to service provision are to be made.

Temporary accommodation is usually unsuitable

The co-existence of mental health needs and drug/alcohol dependency often affects a person's ability to access suitable accommodation. The majority of emergency and supported housing providers operate policies that require service users to be drug-free. There is little specialised hostel provision for people with a dual diagnosis and exclusions from hostels are common, particularly where drug use is blamed for challenging behaviour. People who have been excluded from accommodation several times are often expelled from other care services. In addition, some residential environments have a negative impact upon mental health. Overcrowded hostels that offer little privacy can exacerbate existing mental distress or contribute to the development of mental health needs. At the same time, the recent refurbishment of some hostels operating with structured support programmes can provide an environment that is over-stimulating for people with severe mental health issues. Non-compliance with support plans and house rules are also often cited as reasons for exclusion from accommodation, rendering many direct access and emergency-based services ill-equipped to respond effectively to the needs of street homeless people with a dual diagnosis.

Lack of move-on accommodation

The shortage of appropriate emergency housing is further compounded by a lack of suitable move-on accommodation. Providers of specialist mental health supported housing often operate drug-free referral policies. For those undergoing residential drug and alcohol rehabilitation treatment, it is often impossible to find suitable move-on accommodation at the end

11 Lozier, J, 'Housing is Health Care' in FEANTSA, *Health and homelessness: looking at the full picture*, 2006.

of their programme. Many are, at best, placed in inappropriate accommodation, often in undesirable areas with poor access to the local infrastructure. They are left without support, leading to tenancy breakdown and eviction. Where referrals to specialist accommodation projects are accepted, health and support agencies previously involved with the service user frequently withdraw contact. Project workers can then be left trying to salvage tenancies and re-engage individuals with services.

Conclusion

Existing models of healthcare provision cannot meet the complex needs of street homeless people

with a dual diagnosis. Current provision is inflexible and difficult to access, operating with lengthy waiting lists and, in the case of mental health services, with limited resources. Structural changes to mental health and drug/alcohol use services must be made so that effective provision for dual diagnosis is included. Both dual diagnosis and street homelessness require a co-ordinated and integrated approach to service delivery. Barriers to appropriate and secure housing, and mental health assessment and interventions must be removed. Services must take a harm-reduction approach and involve end-to-end support. Housing plays a vital role in addressing health inequalities, and action must be taken to encompass a housing dimension.

Recommendations

- Improving services for dually diagnosed people must become a priority for local and national Government. A nationally driven, systematic approach to supporting people with a dual diagnosis is needed. This requires increased resources and a national strategy to impose cross-sector co-operation.
- Complexities in funding must be tackled. Budgets must be pooled across a range of services according to local need. Provision of cross-cutting targets across organisations would encourage services inclusive of street homeless people with a dual diagnosis. Local Area Agreements would also provide an opportunity to tackle these complexities.
- Formal partnerships must be created between drug and alcohol, mental health, and housing and homelessness services. Clear multi-agency protocols should be developed in consultation with all stakeholders. These need to be widely promoted, maintained and reviewed by all participating organisations.
- Services must be flexible in order to meet the complex needs of street homeless people with a dual diagnosis. They must provide integrated treatment and support pathways with end-to-end provision.
- The assessment and referral process must be co-ordinated to ensure that a holistic approach to need is taken. The development of joint assessments between drug/alcohol and mental health services would reduce the number of assessments and ensure that consideration is given to all needs.
- There must be an increase in the number of specialist dual diagnosis teams and personnel. These teams need to formally engage with, and provide support to, all agencies working across sectors. High-quality training in mental health and dual diagnosis must be developed and maintained across the breadth of relevant services.
- The availability of appropriate accommodation for service users with a dual diagnosis must be increased. A variety of accommodation types must be made available, ranging from abstinence-based accommodation, to housing that accepts continuing drug and alcohol users.
- Housing must be central to drug and alcohol, mental health, and dual diagnosis strategies. Housing and homelessness service providers must be involved in the development and implementation of these strategies.

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