**APPENDIX 2**

Altogether healthier

County Durham Health and Wellbeing Board

# Dual Needs in County Durham - A Strategy for Action

## 2015-2017

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## 1. Introduction

People who experience problems associated with learning disability and/or mental illness (including dementia) and a concurrent problematic substance misuse issue (drugs and/or alcohol) are at increased risk of serious poor physical health outcomes. Use of drugs and alcohol also increases the chance of unstable housing or homelessness, social isolation and stigma, disrupted family relationships, unemployment and imprisonment. People with dual needs often have very complex needs, and the provision of effective treatment and support may require input from a range of health and social care providers. Although guidance refers to diagnosis it is vital that our focus is on the needs of people with dual issues and the needs of their families and carers.

Dual needs refers to an individual with needs arising out of one or more of the following as well experiencing a substance misuse issue (drugs and/or alcohol):

- Mental and behavioural disorders;
- Dementia;
- Learning disability.

This strategy aims to raise awareness, challenge stigma and promote good practice by supporting individuals and families through integrated care pathways, ensuring they have access to coordinated and responsive services to meet their complex and changing needs.

Assessing which is a primary and secondary need may be possible but, all too often this approach can be a barrier to accessing treatment. It is important that the needs of the individual are placed first, and treating concurrent issues together should be the treatment of choice. The emerging evidence suggests components of 'An Integrated Treatment Approach' have better outcomes for individuals and families.

This Dual Needs Strategy will set out the vision and values for local service provision and be the focal point for collaboration between all key stakeholders who will work to address the varying needs of individuals and families using a comprehensive and flexible approach. This strategy will reflect recommendations from national policy guidance and best practice to ensure prevention, early intervention, care and recovery of those with co-existing needs.

The scope of this strategy is all age and mirrors that of 'No Health Without Mental Health' (UK Government, 2012) and sets out ways to help individuals, families, providers and commissioner's to work together to respond to complex and changing needs of individuals living with dual needs.

## 2. Dual Needs Strategy Vision and Objectives

**The Vision**:
'Improve the mental and physical health of people with dual needs through improved care and support to individuals, their families and carers'.

**Key Objectives**
Prevention

Objective 1: Reduce stigma and discrimination towards people who experience dual needs by raising awareness amongst the general public, workplaces and other settings.

Objective 2: Develop a multiagency workforce able to support people with dual needs, their carers and families.

Objective 3: Define and collate data on people with dual needs and use to identify gaps ensuring a seamless pathway of support.

Objective 4: Improve access to support services including housing, employment, financial and relationship support.

Early identification and intervention

Objective 5: Develop capacity within the voluntary and community sector increasing opportunities for early intervention.

Objective 6: Improve access to family support and interventions for children at the earliest opportunity.

Objective 7: Increase early identification through screening and improved response to dual needs.

Objective 8: Improve the physical health of people with dual needs.

Improve the care of people with dual needs

Objective 9: Ensure ease of access to services through referral pathways and clear joint working arrangements including agreement of the Lead Professional role.

Objective 10**:** Adopt a 'whole family approach' when offering interventions including support for carers and pathways for parental dual needs.

Recovery

Objective 11: Promote long term recovery and empowerment of the individual by developing community projects including mentoring and a visible recovery community.

Objective 12: Develop a person centred recovery approach when agreeing care/interventions which includes involvement of individuals, families and carers to ensure services are coordinated and responsive to their needs (including children within the family).

To achieve these objectives the strategy will work towards:

**Developing partnerships across agencies** which promote integrated care to ensure positive outcomes for service users, carers and families;

**Adopt a whole family approach** and ensure interventions are available at the earliest opportunities for the individual their partner, carers and children;

**Improve the commissioning of specialist services** to develop integrated dual needs approach;

**Agree local care pathways** which comprehensively address complex needs reflecting multi agency health and social care;

## 3. National Policy Drivers

This strategy has been guided by the following policy and guidance documents.

Department of Health (2002) published 'Dual Diagnosis Good Practice Guide', providing a framework to help strengthen services. This guidance advises services to view dual diagnosis as 'usual rather than exceptional' and outlines the need to ensure that mainstream service providers are prepared and equipped to work with Dual Diagnosis.

'Dual Diagnosis in mental health inpatient and day hospital settings' (Department of Health, 2006) provides guidance on assessment and clinical management of patients with mental illness primarily being cared for in psychiatric inpatient or day care settings who also use or misuse alcohol and/or illicit or other drugs. However, some issues will be of relevance to community services, such as community mental health teams and to other settings, for example prisons. It covers organisational and management issues to help mental health services manage service users who also use alcohol or drugs.

A key recommendation is that the assessment and management of substance misuse are core competences required by clinical staff in mental health services. It encourages integration of substance misuse expertise and related training into mental health service provision. It provides suggestions and guidance to front-line staff and managers to help them provide the most effective therapeutic environments, and advocates closer working relationships between mental health services and the police.

The Bradley Report (2009) was commissioned by the Ministry of Justice following an independent review of the experience of people with mental ill-health and people with learning disabilities in the criminal justice system. The aim is to divert individuals away from the criminal justice system and into services to support their recovery. One of the 82 recommendations for change was improved services for prisoners who have dual needs of mental health and substance misuse and suggests that these services be developed.

The Ministry of Justice and Department of Health produced 'Guidance for the management of dual diagnosis in prisons' (2009) recognised that the prevalence of substance misuse and mental ill-health in the prison population is high. Specific guidance was produced for use by all services within prisons, including primary care, mental health and substance misuse services.

In 2009 Department of Health published 'Valuing People Now: a new three year strategy for people with learning disabilities'. The strategy continues the vision of 'Valuing People: a new strategy for the 21st Century' (2001), that all people with a learning disability have the right to independent living, social inclusion and choice and control over their lives. People with learning disabilities have poorer health and are more likely to die at a younger age than the general population. A key objective of 'Valuing People Now' is that all people with learning disabilities receive the health care they need. Although the strategy does not refer specifically to dual needs, it identifies the priority for inclusion of those groups who are most often excluded from society, this includes people with more complex needs and offenders in custody and in the community.

Lord Patel was commissioned to chair the Prison Drug Treatment Strategy Review Group to review drug treatment and interventions for people in prison, people moving between prisons and the continuity of care for people on release from prison. The Patel Report was published in 2010. It acknowledges that dual needs have become far more common in both the community and prisons.

Over the last few years recovery has become a key concept in substance misuse services. The UK Government Drug Strategy (2010), states that it has 'recovery at its heart'. This new approach offers support for people to choose recovery as an achievable route out of dependency. The Government has made clear their determination to break the cycle of dependence on drugs and alcohol. Although it does not specifically refer to dual needs, it emphasises that services should work together to enable recovery.

In November 2010, a national refresh of the 2008 carers strategy was announced 'Recognised, valued and supported: Next steps for the carers strategy', which includes health, education, social care and employment for carers. The refresh built on the previous national strategy, reaffirming the support for the vision and outcomes for carers in the previous strategy but also making new commitments to carers. The strategy refresh identified the following four priority areas:

- Identification and recognition. Supporting those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset, both in designing local care provision and in planning individual care packages;
- Realising and releasing potential. Enabling those with caring responsibilities to fulfil their educational and employment potential;
- A life outside caring. Personalised support, both for carers and for those they support, enabling them to have a family and community life;
- Supporting carers to stay healthy so that they remain mentally and physically well.

The Social Care Institute for Excellence (SCIE) has produced a guide 'Families that have alcohol and mental health problems: A template for partnership working' and an Ofsted report, 'What about the children?' which outlines key messages that adult services should implement to ensure the needs of young people within the family are considered.

In February 2011 the Government introduced its new strategy for mental health 'No Health without Mental Health'. The strategy stresses the interconnections between mental health, housing, employment, the criminal justice system and substance misuse provision. It outlines six objectives to improve the mental health and wellbeing of the nation and improve outcomes through high quality services.

The six objectives are:

- More people will have good mental health.
- More people with mental health problems will recover.
- More people with mental health problems will have good physical health.
- More people will have a positive experience of care and support.
- Fewer people will suffer avoidable harm.
- Fewer people will experience stigma and discrimination.

Additionally the Government launched the National Improving Access to Psychological Therapies (IAPT) programme which represented a significant investment in improving access to talking therapies. 'Talking therapies: a four year plan of action' outlined the Government's commitment to expanding access to psychological therapies in the four years from April 2011. The programme aims to ensure every adult who requires it should have access to psychological therapies to treat anxiety disorders or depression. The 'Four Year Plan' will see the IAPT provision extended to older people, children and young people, people with long term health conditions, people with medically unexplained symptoms and people with severe mental illness.

The UK Governments Alcohol Strategy was published in 2012 and cites dual diagnosis as a key issue. It acknowledges the clear association between having a mental illness and increased risk of alcohol dependence. It states that promoting good mental health in children and adults can help prevent alcohol misuse.

'Transforming Care: A national response to Winterbourne View Hospital' was published by Department of Health in 2012. This is the final report of the review of events at Winterbourne View, a private hospital in South Gloucestershire, where patients with learning disabilities and autism were subject to sustained abuse, ill- treatment and neglect. These events triggered a wider review of care across England for people with challenging behaviours. The report sets out a programme of actions to transform care and support for people with learning disabilities or autism who also have mental health conditions or challenging behaviours. These include actions to transform the way services are commissioned and delivered so that people with challenging behaviours no longer live inappropriately in hospitals but receive care based on their individual needs. Although the report does not specifically refer to dual diagnosis there are lessons to be learnt regarding the planning and delivery of care and the need to strengthen adult safeguarding arrangements.

Preventing Suicide in England: A cross government outcomes strategy to save lives (2012) focusses on six main areas for action:

- Reduce the risk of suicide in key high risk groups
- Tailor approached to improve mental health in specific groups
- Reduce access to the means of suicide
- Provide better information and support to those bereaved or affected by suicide.
- Support the media delivering sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring

The National Institute of Clinical Excellence (NICE) produce evidence-based guidance, advice and quality standards for health, public health and social care practitioners to implement within their area of work thus improving health and wellbeing. Appendix 2 details examples of guidance and quality standards that should be implemented when working with individuals with mental ill-health, learning disabilities, behavioural disorders and substance misuse.

'Drug Misuse and Dependence, UK Guidelines on Clinical Management' (2007) concluded that 'there is still a need for more collaborative planning, delivery and accountability of services for people with co-morbidity, including those with mild to moderate mental ill-health, early traumatic experiences and personality traits and disorders'. It expressed concern about lack of specified core competencies, inadequate assessment and co-ordination of services, and only limited progress on the development of integrated care.

## 4. Local Policy Drivers

As well as national policy and strategy it is important that key linkages are made to local policies and strategies including:

- The County Durham Alcohol Harm Reduction Strategy 2015 - 2017
- County Durham Drug Strategy 2014 - 2017
- County Durham Joint Health and Wellbeing Strategy 2014-2017
- County Durham Public Mental Health Strategy 2013-2017
- Safe Durham Reducing Reoffending Strategy 2011-2014
- County Durham and Darlington Dementia Strategy 2014-2016
- Safe Durham Partnership Plan 2014-17
- Joint Protocol for Tackling Anti Social Behaviour where Mental Health is an issue (2013)

## 5. Dual Needs County Durham Profile

There is limited data available at both national and local level in relation to rates of dual needs. The data which is available does not provide a picture of dual needs over a period of time however does provide information for specific contributing factors at a County Durham level compared to North East and England.

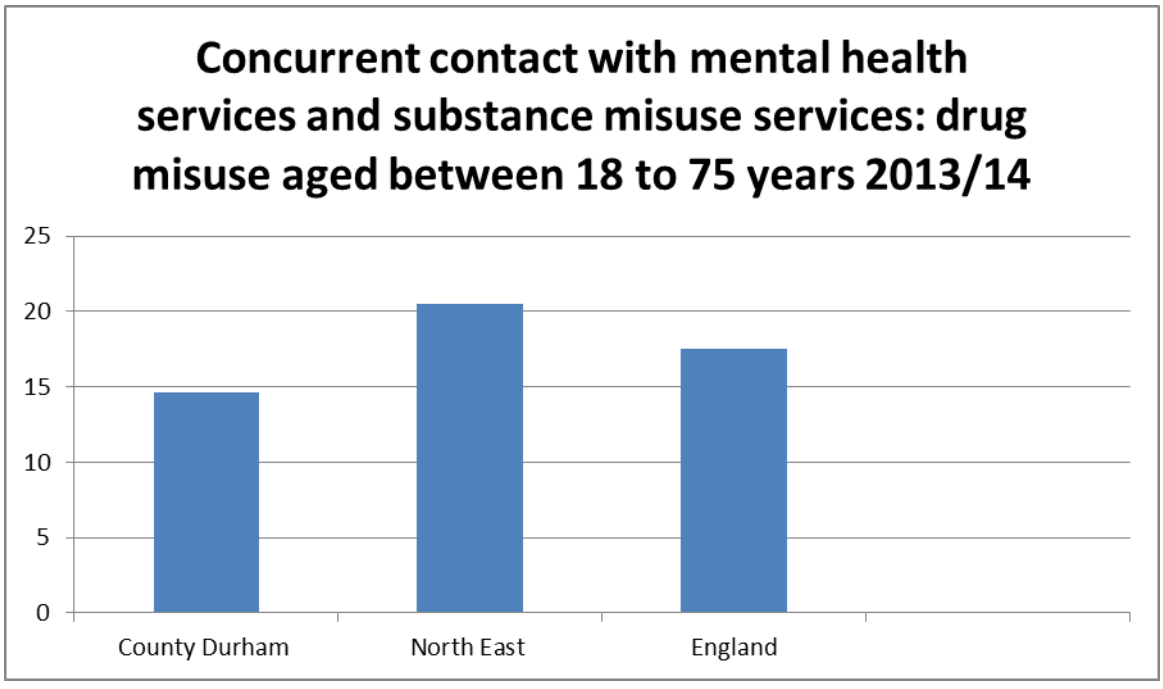
Although direct indicators of dual needs are currently largely unavailable mental ill-health is very common among those in treatment for drug use.

Graph 1 shows the proportion of people aged from 18 to 75 years who, when assessed for drug treatment, were receiving treatment from mental health services for reasons other than substance misuse, as a proportion of all individuals in specialist drug misuse services.

The measure is indicative of levels of co-existing mental ill-health in the drug treatment population. However, it should not be regarded as a comprehensive measure of dual needs as it only captures whether a person is receiving mental health treatment at a given point in time.

County Durham has a lower proportion of people with concurrent contact with mental health services and substance misuse: drug services aged between 18 to 75 years during 2013/14 compared to North East and England estimates.

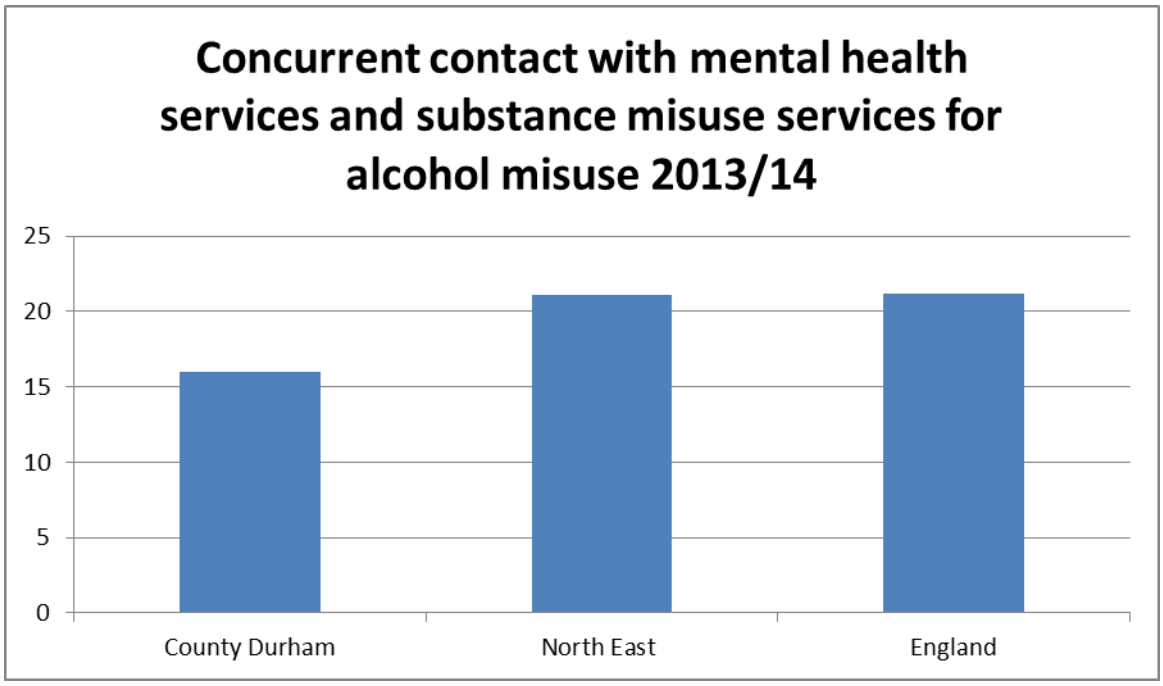
**Graph1**: Concurrent contact with mental health services and substance misuse services (Drug services) for those aged 18 to 75 years 1st April 2013 to 31st March 14.



Graph 2: shows the number of individuals who received treatment at a specialist alcohol misuse service and were currently in receipt of treatment from mental health services for a reason other than substance misuse at the time of assessment, as a proportion of all individuals in specialist alcohol misuse services.

County Durham has a lower proportion of people with concurrent contact with mental health services and substance misuse, alcohol services aged between 18 to 75 years during 2013/14 compared to North East and England estimates.

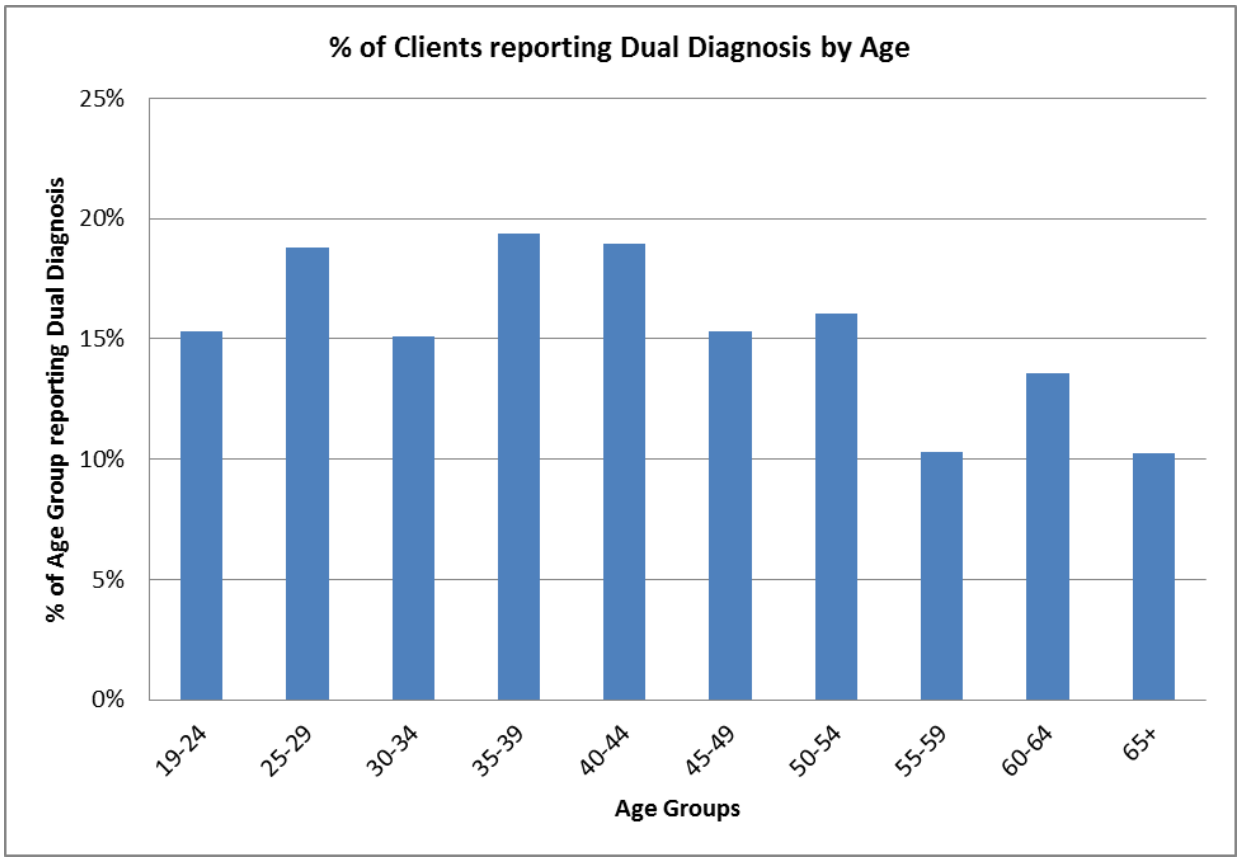
**Graph 2**: Concurrent contact with mental health services and substance misuse for alcohol misuse aged between 18 to 75 years 1st April 2013 to 31st March 20 2014.




**County Durham Community Alcohol Service (CAS)**
From 1st April 2013 to 31st March 2014, 1666 Individuals have been recorded as accessing treatment with the Community Alcohol Service in County Durham.

Of the 1666 individuals accessing CAS, 266 (16.0%) have reported dual needs. The gender split for reported dual needs within the Community Alcohol Service is 62.8% male and 37.2% female.

**Graph 3:** Percentage of clients reporting dual diagnosis into CAS by age 1st April 2013 to 31st March 2014.



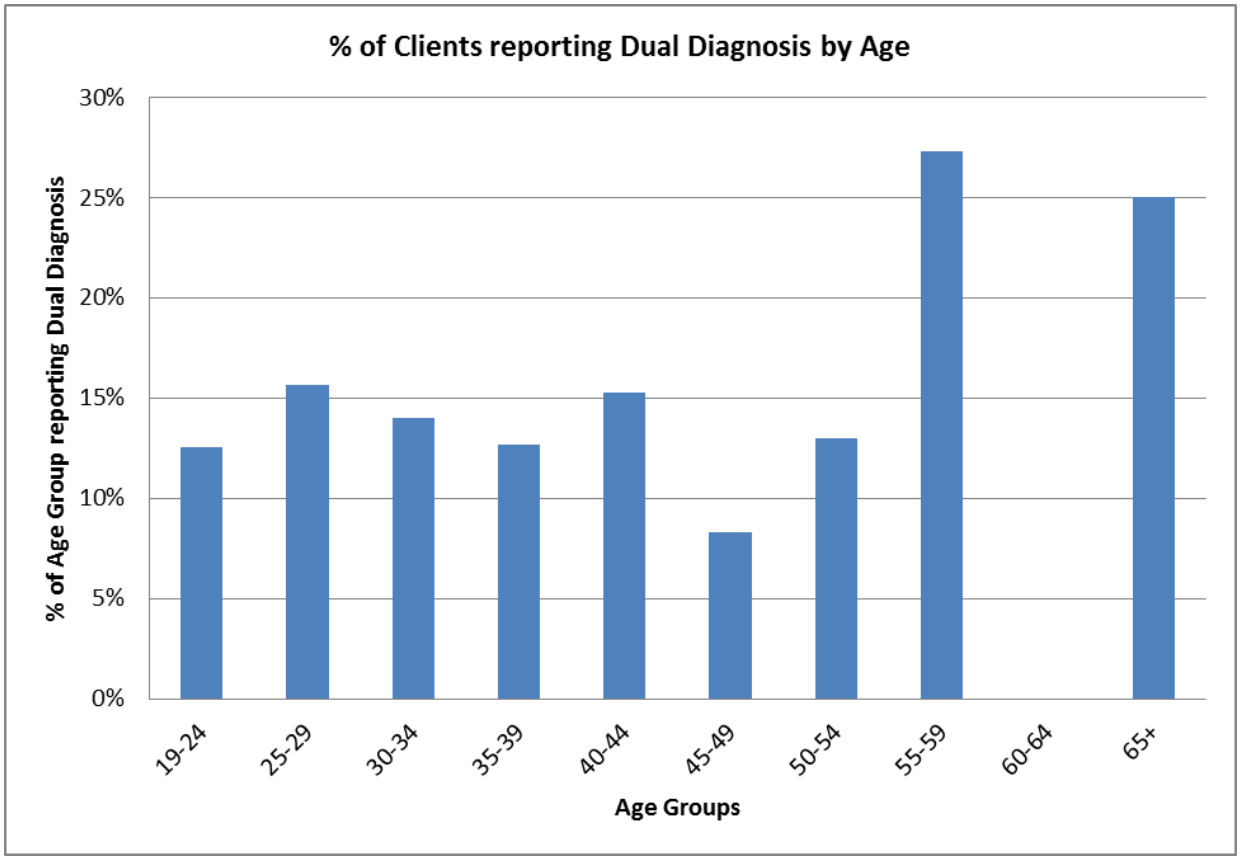
**County Durham Drug Service (CDS)**
From 1st April 2013 to 31st March 2014, 1981 Individuals have been recorded as accessing treatment with the Community Drug Service in County Durham.

Of the 1981 individuals accessing CDS, 271 (13.7%) have reported dual needs. The gender split for reported dual needs within the Community Drug Service is 67.9% male and 32.1% female.

Graph 4 shows that within age bands of 55-59 and 65+ years have a high percentage reported having dual needs.

- Within age band 55-59, 3 out of every 11 clients reported having dual needs.
- For individuals aged 65 and over, 1out of every 4 clients reported having dual needs.

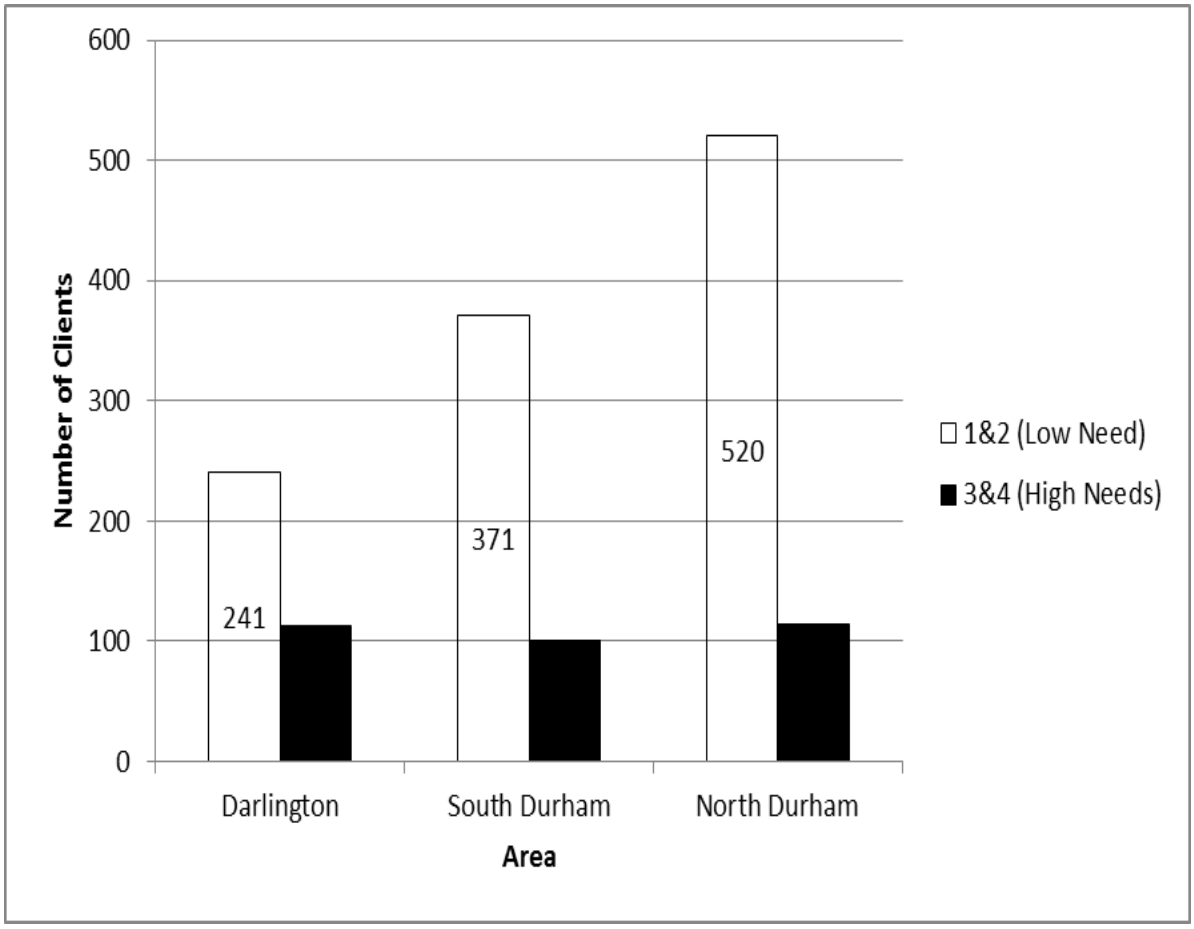
**Graph 4:** Percentage of clients reporting dual diagnosis to CDS by age (1st April 2013 to 31st March 2014)



**Adult mental health services (Durham and Darlington)**
Graph 5 shows the number of service users in adult inpatient and community mental health teams in Tees, Esk and Wear Valleys NHS Foundation Trust (TEWVFT) who have dual needs.

White indicates low level needs that are managed by staff within the individual clinical settings, accessing community substance misuse services for advice and support if necessary. Black indicates service users with higher level dual needs which require support and intervention from community substance misuse services as well as other community services depending on the level of complexity.

**Graph 5:** Individuals engaged with TEWV Mental Health Trust with dual needs 1st April 2012 to 31st March 2013



**People with a personality Disorder**
There is no local prevalence data for people with personality disorder. Service users with a Personality Disorder can be care coordinated within Community Mental Health Services. Research indicates that prevalence of personality disorder in clients attending substance misuse services is higher than expected. Proposals to improve provision within mainstream mental health services for those with personality disorder are compatible with this strategy and will reduce people with dual needs being excluded from mental health services.

**Dementia**
Dementia presents a significant and urgent challenge to health and social care in County Durham in terms of both numbers of people affected and costs.
It is a clinical syndrome characterised by a widespread loss of mental function, including memory loss, language impairment, disorientation, change in personality, self-neglect and behaviour which is out of character. One of the main causes of disability in later life, it has a huge impact on capacity for independent living.

Projections suggested that an estimated 6,153 people affected in 2011 could almost double to 10,951 by 2030 (POPPI, 2011). Typical of the situation across the country, the observed prevalence in GP surgeries, in other words the number of people registered with dementia, (around 3,000 in County Durham) is around half the expected prevalence. This has implications in terms of lack of treatment, care and unmet need.

There is limited local data available about people with dementia who are also engaged in substance misuse services. People with learning disabilities have an increased risk of developing dementia and usually develop the condition at a younger age. This is particularly true of people with Down's syndrome, one in three of whom will develop dementia in their 50s (The Rising Costs of dementia in the UK, Alzheimer's Society, 2007).

**Criminal Justice System**
Within County Durham and Darlington Constabulary records between 1st April 2012 and 31st March 2013 show 841 reported incidents who had mental ill-health and alcohol jointly identified and 193 that had mental ill-health and drugs jointly identified.

During 2012, there were around 16,400 detentions in County Durham custody suites. The 2013 Durham Police Custody Needs Assessment found that an arrest for a drug offence was a significant (independent) predictor of whether a person sees a Custody Care Practitioner or a Forensic Medical Examiner.

People in prison are more likely than the general population to have a mental illness. Some 90% of all prisoners are estimated to have a diagnosable mental illness (including personality disorder) and/or substance misuse. The Prison Reform Trust Bromley Briefing (2010) reports that 75% of all prisoners have a dual diagnosis. In prison 72% of men and 70% of women suffer from two or more mental illnesses compared to 5% of men and 2% of women in the general population.

A Prison Health Needs Assessment in County Durham (2009) identified that prison officers cited drug and alcohol problems as the most pressing health need of prisoners. However the risk assessments are based on self-report in an environment which may be conducive to under reporting of health problems which carry a stigma. Furthermore, detainees are often admitted under the influence of drugs and/or alcohol, making identifying other health problems problematic.

Between 1st April 2012 and 31st March 2013 there were 37 offenders identified as having dual needs in the Durham Tees Valley Probation Trust living in County Durham and Darlington. This is approximately 2% of the overall caseload and is likely to be an under-recording.

**Veterans**
Mental illness in serving and ex-service personnel is similar to the general population, with depression, anxiety and alcohol misuse being the most common problems. In particular those who leave services early and are young are up to three times more likely to take their own life than the general population.

**Self-harm**
Substance misuse has been identified as a significant factor in some incidents of self-harm, particularly in relation to use of alcohol. Self-harm is an expression of personal distress. It can result from a wide range of psychiatric, psychological, social and physical problems and self-harm can be a risk for subsequent suicide.

The directly standardised rate for emergency hospital admissions for self- harm in County Durham 1st April 2012 to 31st March 2013 was significantly worse than the England average.
Data is available by Clinical Commissioning Group area compared to England rate:

- Durham, Dales, Easington and Sedgefield Clinical Commissioning Group 316 hospital admissions for self harm per 100,000 population.
- North Durham Clinical Commissioning Group 217 hospital admissions for self harm per 100,000 population.
- England 191 hospital admissions for self harm per 100,000 population.

**Suicide**
Substance misuse increases the risk of suicide attempt and death by suicide. The risk associated for mixed intravenous drug use is greater than that for alcohol misuse.

A suicide audit undertaken in County Durham for the period 2005-2012 found that 81% of those who took their own life were male, with a peak age of 40-49 years. 62.8% were divorced, 32.3% lived alone and 30% were found to be unemployed. A significant number of those who took their own life were found to have diagnosed mental health problems (58.9%). Furthermore, 30% were recorded as alcohol dependent, 13% were recorded as users of illicit drugs and 39.2% had a history of self-harm.

**Eating disorders**
There is no local prevalence data for eating disorders. Figures from NICE suggest that 1.6 million people in the UK are affected by an eating disorder. Health & Social Care Information Centre (HSCIC) data show that hospitals recorded 2,290 eating disorder admissions in the 12 months to June 2012; a 16% increase on the previous 12 month period. Women accounted for 91% (2,080) of all eating disorder admissions, compared to 88% (1,740) in the previous 12 months. Regionally, the highest number of eating disorder admissions by population size occurred in the North East at 5.8 per 100,000 (150 admissions).

Eating disorder*s* often co-exist or co-present alongside mental ill-health or substance misuse. Individuals with an eating disorder are highly vulnerable in developing substance misuse issues. The national Eating Disorder Association identifies self harming behaviour, drug addiction, alcohol abuse and tranquilliser addiction as being consequences of an eating disorder.

**Lesbian, gay, bisexual and transgender community (LGBT)**
The National Lesbian, Gay, Bi-sexual (LGB) Drug & Alcohol Database for England reports high levels of binge drinking amongst this community and a quarter of the sample showing signs of alcohol or drug dependency. Currently local data on dual needs in the LGBT community is not systematically collected.

**Voluntary Sector**
There are a wide range of services within the voluntary sector, across County Durham that provide services to people with Dual Diagnosis. Services are available to people with dual needs, ranging from counselling, group therapy, activities, training and one to one support. Additionally from the range of supported accommodation provision within County Durham between April 2012- March 2013, 147 clients recorded with dual needs were supported.

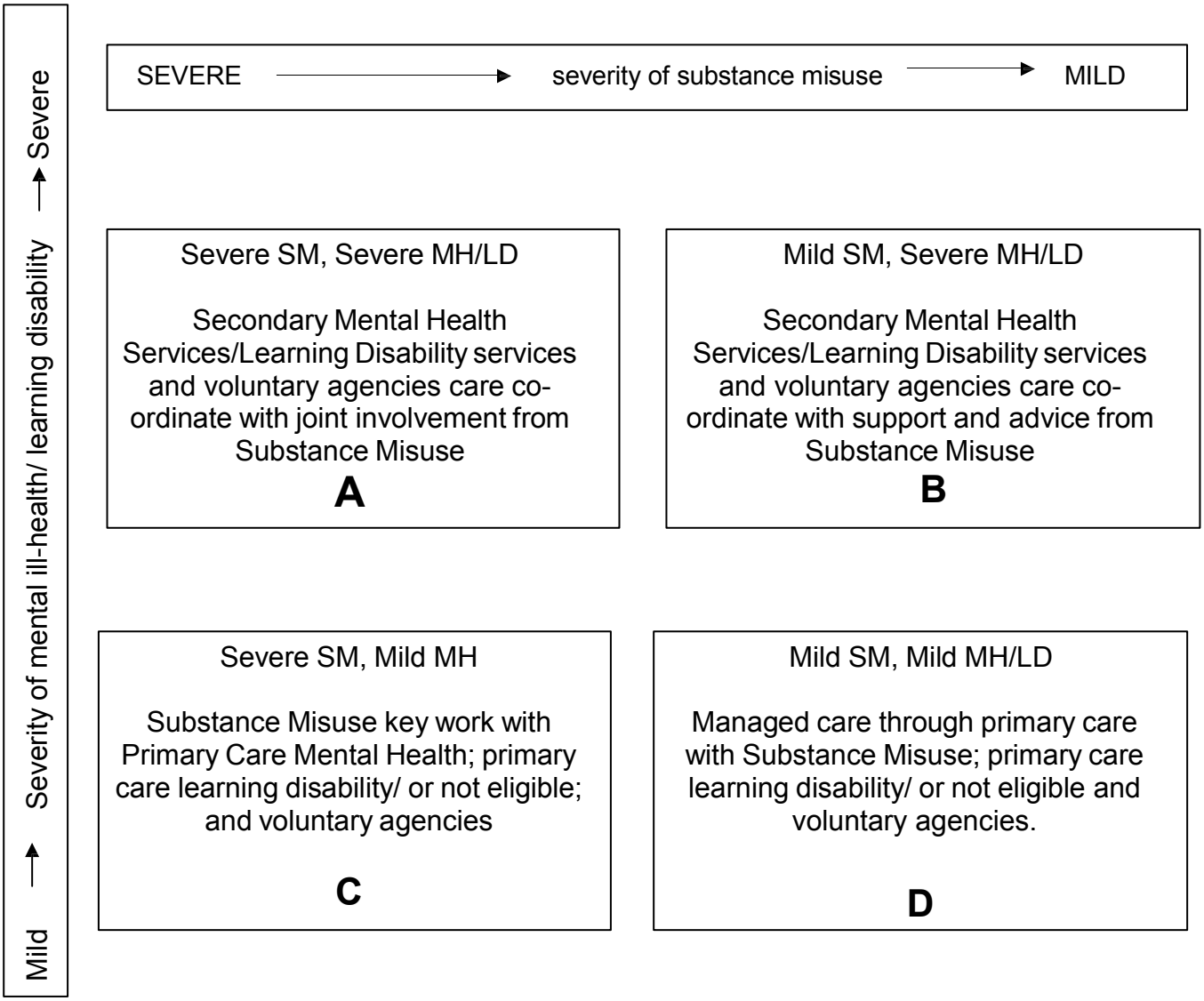
**Carers**
In County Durham there are over 57,000 carers. Durham County Carers Support has over 11,000 carers registered for support.

'Liberty from Addiction' support families living with substance misuse in County Durham. Between 1st January 2013 to 31st March 2013 the service supported 35 carers looking after a family member with a both a mental ill-health and substance misuse and 19 carers looking after a family member with both a learning disability and substance misuse.

## 7. A needs led service provision framework

This framework provides guidance for coordinating the care of individuals based upon severity of users need rather than diagnosis. An individual's most prevalent need determines which agency takes the lead in a joint care plan. **A commitment has been made that any individual whose first contact with services is supported and safely handed over to the appropriate lead agency rather than simply signposting to other services.**

**Collaborative dual needs working matrix**



## 8. Where are we now?

The County Durham Protocol for Working Together (April 2012) provides a framework that sets out the expectation by all agencies that their staff will work collaboratively in the direct provision of services to individuals (including both adults and children) and family units. Adults and children should be assessed for services in a holistic manner and not in isolation from their family or social context. The protocol is applicable to all health, social care, educational and community statutory, private and voluntary sector services and organisations working in County Durham with children, adults and all vulnerable members of society.

### Examples of good practice in County Durham

- A dedicated Dual Diagnosis posts exist within Tees Esk & Wear Valleys NHS Foundation Trust (TEWVFT) along with a local practitioner network who meet four times a year.
- Significant investment into recovery orientated substance misuse and mental health services.
- Care and recovery co-ordination between mental health and substance misuse is now well established.
- Liaison and Diversion service is available within Durham Constabulary. This service will assess and offer support to all individuals coming into contact with criminal justice system.

### Service models

Those with dual needs report that they receive services delivered in a 'serial' or 'parallel' way. 'Serial' refers to the person having to resolve their substance misuse before mental health services become involved. 'Parallel' refers to mental health and/or learning disability and substance use services providing care at the same time, yet not collaborating effectively. The Collaborative Dual Needs working matrix refers to services working together, each bringing their specialised skills to implementing a single plan of care and providing mutual staff support. Services within County Durham are committed to working in a collaborative model.

### Culture

There is currently a paradigm shift towards recovery orientated drug, alcohol and mental health services. Individuals with dual needs sometimes experience anxiety and difficulties when accessing recovery orientated treatment settings such as self-help groups and there is a risk that people with a dual needs miss out on essential elements of care. It is therefore necessary that the needs of people, their families and carers are taken into account whenever recovery orientated treatment services are developed. Staff experience, beliefs and values are challenged in a way that ensures an individual's needs are central to care and support and that this delivery is flexible.

Dual Diagnosis policy and guidelines (Department of Health, 2002; NIMHE, 2007) promote the development of local and regional networks as an important part of good practice for people with dual needs, their families and carers and that strong collaborative working between agencies and opportunities for shared learning and networking is required.

The value that the independent, voluntary and community sector bring are crucial in developing a Dual Needs network. There is much to be gained from collaboration, sharing of resources and ideas as well as the opportunity to participate in peer support programmes.

## 9. Commissioning arrangements

As a result of the Health and Social Care Act (2012), the commissioning arrangements have changed significantly. It is therefore critical that joint commissioning opportunities and pathway design is undertaken collaboratively between commissioners and providers. County Durham Mental Health and Learning Disability Joint Commissioning Group is established to progress implementation of County Durham Mental Health Framework which includes the Dual Needs Strategy.

## 10. User & carer involvement

Service users, their families and carers have a lot to contribute to service development, including peer support and staff training. This strategy will work towards strengthening this relationship creating opportunities for meaningful engagement.

## 11. Equality and diversity

Services recognise that some groups with diverse needs have problems with certain addictions and can experience difficulties in accessing treatment services. Over recent years access to services has been greatly improved e.g. by women only clinics or initiatives that work with Black and Minority Ethnic (BME) or lesbian, gay, bisexual, and transgender community (LGBT) communities.

Commissioners and providers continue to stay committed to fair and equal access for all its diverse populations regardless of:

- age,
- gender,
- sexual orientation,
- race,
- gender reassignment,
- religion and belief,
- disability,
- marriage and civil partnership; and
- pregnancy and maternity

## 12. Governance - Strategic framework performance measures

The performance management framework aligns to the priorities identified within No Health Without Mental Health (2012). The Dual Needs Strategy is accountable to the County Durham Mental Health Partnership Board (appendix 3). The Dual Needs Strategy Implementation Group will develop and monitor a local action plan and is accountable to the No Health Without Mental Health implementation group. Any key issues will be

escalated to the County Durham Mental Health Partnership Board/County Durham Learning Disability/Mental Health Joint Commissioning Group

Progress on delivery of the strategic objectives and action plan will also be reported to the Health and Wellbeing Board.

A performance framework is under development. In year one of strategy implementation process measures will be used to ensure there is a better understanding of the level of need. Key performance indicators will include:

- Numbers of people in substance misuse treatment services recorded with dual needs.
- Numbers of people in acute mental health services recorded with needs.
- Number of people in community based mental health services recorded with dual needs.
- Number of people in older people mental health services recorded with dual needs.
- Number of people in primary care recorded with dual needs.
- Number of people accessing learning disability services with substance misuse.
- Number of offenders (both community and prison) who are recorded as having dual needs.
- Number of carers (including young carers) receiving a carers assessment in relation to caring for an individual with dual needs.
- Numbers of staff trained in working with individuals with dual needs their families and carers.
- Numbers of clients who haven't had a formal diagnosis but are experiencing dual needs.

# Appendix 1

## Glossary of terms/Abbreviations

| | |
|---|---|
| A&E or ED | Accident and Emergency Department or Emergency Department of a hospital |
| BME | Black and Minority Ethnic |
| CAMHS | Child and Adolescent Mental Health Service |
| Clinical Commissioning Groups (CCGs) | Groups of GP practices, including other health professionals who will commission the majority of NHS services for patients |
| CMHT | Community Mental Health Teams |
| CPA | Care Programme Approach |
| CSIP | Care Services Improvement Partnership |
| DART | Drug and Alcohol Recovery Teams |
| DCC | Durham County Council |
| Diagnosis | The identification of the nature of an illness or other problem by examination of the symptoms. |
| DoH | Department of Health |
| GP | General practitioner also known as family doctors who provide primary care |
| HSCIC | Health and Social Care Information Centre |
| Joint Strategic Needs Assessment (JSNA) | Health and Social Care Act 2012 states the purpose of the JSNA is a statistical profile used to improve the health and wellbeing of the local community and reduce inequalities for all ages |
| Learning Disability | Learning disability is defined as a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence) with a reduced ability to cope independently (impaired social functioning) which started before adulthood with a lasting effect on development. This definition encompasses people with a broad range of disabilities, including mild, moderate, severe and profound learning disabilities. |
| LGBT | Lesbian, gay, bisexual and transgender |

| | |
|---|---|
| Mental and Behavioural Disorders | Mental and behavioural disorders includes all mental disorders, dementia, eating disorders, personality disorders, autism, aspergers and conduct disorders. |
| NICE | National Institute of Clinical Excellence |
| NIMHE | National Institute for Mental Health in England |
| POPPIE | The patient information system used by Adult Community Substance Misuse Services in County Durham. |
| SCIE | Social Care Institute for Excellence |
| Self-harm | Self-harm is when somebody intentionally damages or injures their body. It is a way of coping with or expressing overwhelming emotional distress. |
| Substance Misuse | Substance misuse is defined as intoxication by, or regular excessive consumption of and/or dependence on psychoactive substances, leading to social, psychological, physical or legal problems. It includes problematic use of both legal (including alcohol) and illegal drugs.(NICE 2007) |
| TEWV NHS FT | Tees Esk and Wear Valleys NHS Foundation Trust |

## Appendix 2

NICE guidance used to inform this strategy:-

CG 16 – Self Harm
CG 26 – Post-traumatic stress disorder (PTSD)
CG 51 – Drug misuse: Psychosocial interventions
CG 52 – Drug misuse: opioid detoxification
CG 115 – Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence
CG 100 – Alcohol- use disorders: Diagnosis and clinical management of alcohol related physical complications
CG 120 – Psychosis with coexisting substance misuse
CG 133 – Self harm (longer term management)
CG 78 – Borderline Personality Disorder: Treatment and management
CG 77 – Anti social Personality Disorder: treatment, management and prevention.

Appendix 3

# County Durham Mental Health Partnership Board Governance Structure