CONTINUUM OF CARE FOCUS GROUP

Please keep your reply within this page

Dual Diagnosis Ireland

Thinking of your remit and of the target group you deal with

1. What aspects of the National Drugs Strategy are working well?

The only interaction we have is with people who have been failed by the system. So unfortunately we do not have visibility of what is working well. It is encouraging to see supervised injection centres being proposed.

2. Are there gaps in the strategy and how should they be addressed?

In operational terms, gaps in funding, training, care pathways, inter agency working, person centredness. In addition to increased funding suggest the following

The 'no wrong door' principle[1]

Every door in the health care system should be the 'right' door to access treatment. Clarifies that the responsibility of providing care addressing a range of health and social needs is the responsibility of the care provider/service where the client presents. It requires the care provider/service to provide care and/or facilitate access to service delivery that falls beyond their specific focus. It removes the onus of negotiating different services and providers from the client and thereby aims to reduce the incidence of people 'falling through the cracks' of a complex service delivery system. Mental health, substance abuse and living life becomes every one's business.

The person centered principle[2]

When it comes to issues to do with values, meanings and relationships, clients are the most knowledgeable and informed, and are the real experts Give primacy to issues to do with power and relationships, with contexts and meanings, with values and priorities. Thus care providers/services become less concerned with fitting people into packages of rigid services and more about seeing them as people.

Recognise that models such as medical, recovery, Minnesota, bio psycho social, psychotherapeutic, consecutive, parallel, integrated etc. are useful but not all encompassing.

The family count principle[3]

Where client allows, actively involve family in treatment.

Where client does not allow, treat family as separate client needing support and help in their own right. Share family insights (with their consent) with client treating team to enable broader understanding of client issues. (Note this approach works in existing Irish organisations such as Headway)

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[1] A range of areas in England, Australia and Canada have adopted this principle. See http://mhcc.org.au/media/14048/no-wrong-door-project-overview.pdf for one example. A pilot project is taking place in North Tipperary. See http://www.dualdiagnosis.ie/wp-content/uploads/2011/05/No-wrong-Door-Proposal-Tippeary.pdf

[2] Person centered care is a cornerstone of vision for change. Additionally Patrick Bracken (West Cork, Psychiatrist) and Philip Thomas, Postpsychiatry. Mental Health in a Postmodern World argues that models should be subsidiary to understanding the person.

[3]SAMSHA, Evaluating your programme, Integrated treatment for co-occurring disorders https://store.samhsa.gov/shin/content/SMA08-4367/EvaluatingYourProgram-ITC.pdf

Is the service helping principle?[4]
Routine, regular and systematic feedback (quantitative and qualitative) is captured from all clients of a service, edited and published in the organisation's annual report and used to improve the service

The "Do not" principles
Do not create a super specialism or specific patient treatment role for dual diagnosis treatments
Do not argue about what is primary problem
Do not use a "No motivation, no service argument" Tailor support to client's stage of readiness.
Do not assume abstinence is the only goal
Do not create an environment where staff refuse to accept responsibility for complex cases and are risk adverse

3. What are the priorities for the future?

Short term priorities- for implementation within 6 months

Recruit 2 counsellors with addiction expertise to every MH team in all locations
Accepting the worldwide shortage and difficulties of recruiting psychiatric personnel, recruit 2 counsellors with addiction expertise to every MH team straight away. The clinical governance structures in Donegal, where addiction and MH services are integrated can be adapted for each MH team as necessary.

Establish extent of problem
Create an information register for people refused service using existing IT systems. Ensure both MH and addiction service providers provide input into the system.

MH dual diagnosis service pathway
Ensure this new HSE clinical programme delivers clear service user referral pathways with specific targets for clients to receive services. For complex and high risk clients, consider provision of national 24 telephone help line for health care professionals to ring to accelerate support for such clients.

Medium term

MHC quality framework
This applies to approved acute centres only due to a lacuna in the statutory instrument implementing the MH legislation. The Ombudsman is requesting a new statutory instrument to extend the framework to community based centres. If legally possible, request the procedures covering discharge/non admittance/transfer of patients to MH facilities be extended to cover transfer of patients to addiction facilities. This will reduce the incidence of patients being discharged from MH facilities due to substance abuse with no acceptance into other treatment facilities.

[4] Ibid

Upskill Staff and change cultural attitudes
Upskill all MH GP's, counsellors and staff involved in addictions treatments to have following basic skills.

a. Agreed common framework, policy and processes between primary care, MH and addiction services for screening and assessment
b. Motivational Interviewing skills
c. Cognitive behavioural therapy (CBT)
d. Harm reduction
e. Contingency management

All health care professionals are trained separately and at undergraduate level have very little interaction with each other. Aim to change professional training so different health care professionals study together with increased learning time on mental health and addiction issues. (MH and addiction alone economic cost is €6 billion and are therefore worthy of increased time and funding.)
Above all though the current stigma towards MH and addiction needs to be addressed as research indicates people with a dual diagnosis experience adverse bias from health care providers.

Use of technology
Ensure next "Light house" project of EHealth Ireland priorities electronic health record for substance abuse and mental health to allow disparate computer systems to talk each other.

Voice of families and service users to be heard.
There already exists a website "patient opinion" which allows people to tell their stories and services to respond. At least one MH service has already signed up for this. Provide funding to allow all services report on their outcomes and support responding to stories on this website.
Additionally ensure representation of service users with addictions on new HSE MH peer support panel.

Implement the Public Health Alcohol Bill
Research indicates the measures contained in this bill has most impact on younger and problem drinkers.

Access to 24/7 crisis supports
Provide alternatives to accident and emergency departments. North Kildare MH services provide 24 hour support and this should be rolled out nationally to cover people with both a MH and addiction problem.

Mental health environment screening
Current approaches by government agencies frequently discourage positive mental health. For example: Loss of entire social welfare if person works one hour per day 5 days a week. But having structured daily routine can be very important to recovery so this provision actively works against mental health recovery. A whole systems approach is necessary. Some countries use a tool such as the MWIA assessment to assess the impact of new government policies and decisions.