

The Bristol Dual Diagnosis Strategy 2009-2014

Response to the Draft for Consultation (May – June 2009)

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Introduction

Firstly, we welcome any move towards improved provision of services to people in Bristol with a ‘dual diagnosis’ – although we are not entirely comfortable with the term itself, for reasons which should become clear later.

We also welcome many of the specific recommendations in the draft strategy, particularly those which seek to identify and respond to the needs of marginalised communities.

However we do not share some of the starting assumptions for this draft strategy, which makes detailed comment difficult. The assumptions seem to include the following.

- The current framework is appropriate, and simply needs a little adjustment.
- People have distinct areas of need which can be considered separately, even if they sometimes interact with and impact on each other.
- The problems can largely be solved by better organisation, planning and communication between the professionals.
- The necessary changes can mostly be made without the need for new funding.
- The professional services can make the necessary changes and then invite the voluntary sector to pay a role within the new framework.

In particular, we suggest that the following points should be incorporated into the strategy.

- A new framework is needed, which aims to work with people in a holistic way from the outset. Dual diagnosis is simply one part of a much larger integration of services which is required.
- We will always need to have people with specialist skills, knowledge and experience, but these specialists must work in a cooperative way with the other specialists, which means that the specialists must always work under the supervision of a generalist, holistic practitioner. Every specialist will always consider that their area is more important than other areas, and without this

larger framework, you will never be able to prevent the individual being subject to conflicting and contradictory treatments and strategies.

- The provision of services to the individual must be shaped by the needs and priorities of the individual (within the framework of funding arrangements, national strategies, etc.) and not by the needs and priorities of the organisations delivering those services. In particular, the services delivered by the voluntary sector must be given a priority determined by their importance to the individual, rather than their relevance to contracts and funding arrangements.
- The voluntary sector has a good track record at providing a holistic service to needy people, and the statutory services should seek to learn from the practices, systems and ethos of the voluntary sector as they seek to move in the direction of a holistic service.

Further Details

We are not reassured by the diagram on page 8: the sub-groups of Dual Diagnosis. This represents a complex situation in a trivial and diagnostically irrelevant fashion. If we had a test which could say clearly and with certainty whether the severity of any given individual's mental illness was low or high, we could completely restructure our entire mental health service. In practice, I am not sure I know a single mental health professional who could say what this question even means, at this abstract level. Is it the severity of how they feel about the problem, how it affects their life, how it affects the life they would like, how it affects the people around them, how it affects the choices they will have in the future, how it affects their economic stability and prospects, or something quite different? I do not know in what context the diagram was produced, but it should only be used in a context where it is helpful, and this is certainly not such a context.

In the 'Vision for the Future' on page 6 we are told that better collaboration between different agencies will ensure that no-one slips between the gap. But no amount of collaboration will ensure that no-one slips between the the gap. While you have different agencies with different agendas and different priorities and different systems, you will always find that there is a gap for people to slip through. And, if they can, some will. The answer must be, in the long term, to remove the gap.

We are also told it is the fact that 'many services... are organised and planned separately' which makes effective treatment 'problematic'. But the problem lies not with the organisation and planning of these services: it lies in the framework within which the services operate, and in the goals and priorities they are working towards.

Many of the conflicts between the different services come from a few key factors.

- A limited understanding of the theoretical framework within which they operate.
- Funding constraints and performance targets.

The theoretical framework goes back to the assumptions being made about the

nature of the person the practitioner is dealing with, their social setting, capacity, and so on. It is reasonable from a pedagogical point of view to start with the assumption that the problem being addressed is the only problem the person suffers from. But this cannot be the assumption at the end of the training: the practitioner must be equipped to work with and help an individual who is suffering in many, complex ways.

This requires a re-working of the training being given to all the professionals, and a re-thinking of assumptions and priorities. In first aid, we are taught that a problem with breathing is more important than a problem with bleeding, because it will kill you quicker. But we have one set of professionals trained to deal with breathing and another set trained to deal with bleeding. Communication between the two is not enough: they must each understand how they fit into the bigger picture.

The funding constraints and performance targets are fairly obvious: whatever my speciality, it is always faster, quicker, easier and cheaper to deal with someone who has no other significant problem. Therefore, if I have performance targets and a limited budget (and who doesn't?) I will always want the other problems to be sorted out before I play my part.

Optimising the System

There is a conceptual problem which often causes misunderstandings here. People believe intuitively that the way to optimise the performance of a system is to optimise the performance of the individual components. But, in the real world, this is hardly ever the case. If you seek to optimise each component – each service in this case – then they will each compete for resources and for their priorities to dominate. To optimise the system, you need the components to cooperate in a carefully controlled way, and for each component to operate in a sub-optimal fashion.

In other words, each specialist service (drug treatment, mental health treatment, physical health treatment and the criminal justice system, as a bare minimum) must be willing at times to operate less effectively and less efficiently than they are capable of. This is very counter-intuitive, but is well established, both in mathematics and in real-world applications.

One small example may help here. Housing Services exist in order to help people access accommodation, and to keep it once they have it. On the whole, this is good and necessary. But this morning, we have been seeking to help someone who has a flat, and who would actually be much better off if they had lost their flat a year ago. Mostly, this target works for the individual. But, sometimes, it doesn't. And you can't have a system in which people decide on a case-by-case basis whether the targets they have been set are appropriate or not.

It is our conviction that you can summarise this abstract principle from systems analysis clearly and accurately, and apply it to the area of service delivery as follows.

If we adopt an ethical approach to care, seeking to optimise the help given to each individual, we will find that the long-term result is to make the system as a whole as cost-effective as possible.

In other words, if we seek to make each person, each department and each service as cost-effective as possible, we make the system as a whole less efficient and less cost-effective. We must seek efficiency not at the level of departments and services, but at the level of the system as a whole. But because the function of the system is to help the individuals being cared for, we can optimise the system by optimising the help given to the individuals being cared for.

We currently have a system which seeks to make each part as effective as possible. The consequence of this is that the individual is often crushed by the wheels of the system which is intended to help them.

If we make the well-being of the individual the only (or main) target, then the key workers, the departments and the services will each be less efficient, but together they will be achieving much more.

A description of how this can be worked out in practice is beyond the scope of this response, but more details are available from CCM on request.

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