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The Matrix Model of dual diagnosis service delivery

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The Matrix Model is essentially a strategy for managing dual diagnosis across a range of agencies. It is a way of implementing partnership working across services and commissioning structures. The Matrix Model was born out of hard experience at the coalface of dual diagnosis treatment at a tier four service in Bristol. A very common experience, which many may recognize, was that clients with complex mental health and addiction needs were being sent from 'pillar to post' in their treatment. Things needed to change. Here is a method of how things can change. Briefly, professionals in the drug/alcohol and mental health fields co-locate, working with clients in each other's workspaces. In doing this, they create nodes of integration. These nodes of integration link through parallel-working to create a matrix. Outcome and key recommendation is that professionals in the drug/alcohol and mental health fields co-locate in each other's agencies, adopting an assertive outreach approach to working with dual diagnosis/complex-needs clients.

Keywords: co-locating, complex needs, dual diagnosis, interagency, Matrix Model

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Introduction

The purpose of this paper is to introduce the Matrix Model of dual diagnosis service delivery. The Matrix Model is a dual diagnosis integrated practice model. The client group it is aimed at are those clients suffering from problematic substance use/

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dependence and mental health issues, including disorders and illness, either formally diagnosed or not.

The Department of Health officially advocates integrated working. 'More severe or complex substance use will require specialist interventions e.g. for opiate dependence, the management of severe cannabis dependence or for drug or alcohol use in the context of more complex problems. In these cases, integrated, joint or coordinated working with substance misuse services is likely to be required' (Department of Health 2006).

Background

The Matrix Model was born out of hard experience at the coalface of dual diagnosis treatment in a drug and alcohol non-statutory service in Bristol. A common experience was that clients with complex mental health and addiction needs were being sent from 'pillar to post' for treatment.

One day, a thought occurred to us. Why not invite the local Community Mental Health Team (CMHT) in to see their client while they are in treatment for addiction? This was the start of some great working relationships with the mental health services. From the initial invitation to mental health professionals to have a one-to-one with us and their client within our drug and alcohol treatment agency, we went to having full-blown Care Planning Approach (CPA) planning meetings and treatment planning, with all stakeholders crammed into the staff room.

The author acknowledges that many other agencies and services have being doing this for years. What was surprising was the discovery that no one had formulized this as a model, and that this kind of working did not fit into the serial, parallel or integrated models of dual diagnosis service delivery. Thus the Matrix Model of dual diagnosis service delivery was conceived.

Literature review

The model is a simple evolution and practical response to treatment options in England reported by the Department of Health in 2002 (Department of Health 2002). Serial Model is different staff in different services at different times (hence sequential). Parallel Model is different staff in different services at same time (hence parallel). Integrated Model is same staff in same service at the same time (hence integrated). In comparison the Matrix Model is different staff, same service and same time (hence matrix).

In reviewing the literature on the different models of dual diagnosis service delivery, it has not been possible to find authors accredited with the introduction of the terms serial, parallel and integrated models. Instead, the terms have been adopted as common frames of reference. The Department of Health Good Practice Guide 2002 (Department of Health 2002), in describing the background and history to treatment implementation, on page 24, simply states 'Three broad types of service model have been described in the literature: serial, parallel and integrated'. There is no mention of authors. Similarly in *Dual Diagnosis: Substance Misuse and Psychiatric Disorders* (Rassool 2001), in the chapter 'Dual or Separate Service', on page 205, James Edeh states 'Services have evolved over the past decade in response to the multiple needs of dual diagnosis patients, without the results of outcome studies'.

Further searches revealed that the terms serial, parallel and integrated are not always used when referring to treatment delivery. For example, Drake and Mueser state in a paper, 'The research further suggests that traditional, separate services for individuals with dual disorders are ineffective, and that integrated treatment programs, which combine mental health and substance abuse interventions, offer more promise' (Drake & Mueser 2000). They avoid the terms serial, parallel and integrated altogether.

In an American study by Grella & Stein (2006), examining the impact of programme services on treatment outcomes, where the outcomes were that 'Individuals treated in programs that provided specific dual diagnosis services subsequently had higher rates of utilizing mental health services over six months and, in turn, showed significantly greater improvements in psychological functioning (as measured by the Brief Symptom Inventory and the RAND Health Survey 36-item short form) at follow-up. More use of psychological services was also associated with less heroin use at follow-up. African Americans reported poorer levels of psychological functioning than others at both time points and were less likely to be treated in programs that provided mental health services'. The authors describe services in terms of integration. The terms serial and parallel services are never used. This search leads me to the conclusion that the names

serial, parallel and integrated are not formal models or terms, but have become ad hoc descriptions.

The Matrix Model in focus

The Matrix Model could be a solution to a number of identified problems within the treatment field of co-morbidity. Those problems are lack of capacity within mental health services, lack of specialist training within respective professions – meaning mental health workers with low-level substance misuse training and skills, and substance misuse workers with low-level mental health training and skills, lack of communication and joined-up working between the two fields, lack of money to pay for specialist services and lack of resources to build truly integrated services.

In reference to the above points, the advantages of this model are that no extra training is needed because the different staff teams already have the appropriate skills and training; the lack of communication is resolved, as the staff are at point of contact with the client, all physically in the same building (annual leave and sickness accepted); it does not cost any more because there is no need to employ specialist services; the issue of capacity – a huge stumbling block for everyone in the mental health field – is resolved. The clients being worked are existing clients, not extra clients. Therefore no further capacity is needed.

This last point is usually the hardest to understand. Often, mental health workers will think that they are suddenly going to be expected, against their will, to take clients from substance misuse services, thus becoming overwhelmed. Some substance misuse workers may experience anxiety, thinking that severely disordered clients will be 'dumped' on them. This is not how the model works.

The process

The model works thus. When, in the usual course of work, a CMHT discovers that their client has a substance misuse problem, the client is asked whether they want help to address this. If the client does, the CMHT phones their local substance misuse team to make a referral. Just because the client is currently receiving mental health services, they cannot be excluded from access to substance misuse services. It is the duty of the Community Drug and Alcohol Team to refer the client to a service that best matches the client's substance misuse need. The mental health service engagement could be continued as normal. Referrals and assessment, and ultimate delivery of services are a post-code lottery, so initially there will be a need for patience.

The same process could work in reverse for the substance misuse client. Their worker picks up the phone to the general practitioner and asks for an assessment, and the referral is made. Receipt of services is then allocated in the usual manner. The entry threshold for most mental heath services is high, so it is expected that most initial referral traffic will come from the mental health field. Again, this does not need extra capacity, because these service users would be in receipt of services from either substance misuse or mental health, probably in a chaotically serial way over a protracted period of time. The Matrix Model provides a more coherent, joined-up, partnership way of working and could hopefully reduce crisis intervention

There may be some initial anxiety regarding which plan dominates – the mental health services integrated CPA, or care planning in the substance misuse services. The answer is neither, but both need to be done and copies sent to the other service that the dual diagnosed service user is working with. This way, everyone has all the information all the time. It would be most helpful when deciding a formal care pathway involving multi-agency working that this be written in. Otherwise, workers will feel disenfranchised from the process and less likely to be involved.

Ultimately, a major part of the Matrix Model at strategic level is to encourage greater collaboration between services to deliver a single/joint care plan with clear care coordination arrangements and to minimize multiple assessments. Both teams could use this as the single point of reference, and each could have a copy so that each knows what the other plans to do. In the next part of the model, implementation, I will address how we can prevent services refusing to accept a referral because the referee is currently engaged with another service.

Implementation

The way to implement the model is for service managers and commissioners to draw up a formal care pathway for dual diagnosed clients. This

means they have to meet and discuss, draft, trial, redraft and implement a local/regional care pathway together. Initially, for the first few years, someone would have to take the lead. Most mental health trusts have a dual diagnosis specialist, and they would provide temporary support until stable relationships were developed on the back of shared policies, procedures and protocols. If no one is willing to champion the dual diagnosis cause, then the commissioners must provide the impetus, by demanding joined-up working and adherence to the Dual Diagnosis Care Pathway that they have formulized. It is vital that there be a strong connection and partnership between the two teams. Therefore, in order to introduce this locally to each individual team's clinical work, a team could act as an advocate, attending all the individual teams' team meetings so that no extra meetings are necessary. Both fields need to engage in partnership working, not one dominates the other or learn the other's job.

Implementation guidance steps:

1. Make consultation as broad as possible so that it promotes a wide shared ownership and ensure as many strategic staff, frontline staff and service users as possible are involved.
2. Involve as wide a range as possible of stakeholders – like the Strategic Health Authority – to promote the positives of joint commissioning. Local Implementation Team meetings could be used.
3. Needs assessments provide evidence of service provision gaps.
4. Ensure that communication is open and frequent through regular multi-agency panel (MAP) meetings.
5. Adopt a philosophy that dual diagnosis is all of our responsibility through MAP meetings.
6. Commissioners and stakeholders work towards building a formal steering group to develop sustainability.
7. Joint care pathways could be formed.

This partnership/interagency working needs to be strengthened by MAP meetings. These meetings need to be held at least once a month and shared among workers. It is advised that those workers with a current dually diagnosed client attend. It is also vital that some managers attend; otherwise some members of the multi-agency team attending the meeting may feel disempowered and nervous about making big decisions. The meetings do not need special venues. They could take place at the team's own premises, in rooms that would be used for any other staff meeting. Someone needs to take minutes of actions and circulate them. Email could be used as much as possible. Minutes and agendas can be written on the day and kept to bullet points with minimal detail – for example names, dates, times, main issue.

One fringe benefit of these meetings could be a directory of resources. This can be created very simply by each service that attends submitting no more than one page of A4 regarding what their service offers. This directory does not need to be printed formally and could also be distributed by email.

If, in a crisis management situation, the client is referred to services already in place, whether for rapid prescribing, arrest referral or mental health assessment, no one needs formal training in anyone else's job. This is the essence of the Matrix Model.

Regarding the skills base, a premise of the Matrix Model is that it is unrealistic to train all workers to know everyone else's job. Therefore, the gold standard of fully integrated dual diagnosis service delivery, while highly desirable, is highly unlikely because of the massive funding it would require nationally.

Turning Point's Dual Diagnosis Handbook (Turning Point 2007) has this to say about applying skills in practice, 'Services also recognised that it is important to capitalise on existing skills, which need to be differentiated between core and specialist skills. Some service providers felt that dual diagnosis has too much of a mystique about it and staff do not realise that some of their existing skills are transferable and very relevant'. It also says that practice development and supervision need to be imbedded into practice, and that it is possible to build on existing occupational standards to bring the competencies needed to work with people with mental health and substance use needs into one framework. This framework is called the Capability Framework. The Capability Framework written by Liz Hughes, *Closing the Gap* (Hughes 2006), provides plenty of advice on levels of working.

In the Matrix Model, at no point should any additional training be provided or needed, except as would normally occur in an agency's continuing personal and professional development policies. No extra, non-budgeted money needs to be paid out for the acquisition of new skills, up-skilling or upgrading.

Action

The Matrix Model offers a way forward for dual diagnosis service delivery. It circumnavigates the need for specialist services and uses the skills workers already have. The principles of therapy are the same for substance misuse clients as they are for mental health service users. The skills are transferable. Where specialist knowledge is needed, for example implementing clinical governance in line with national guidelines such as the National Institute for health and Clinical Excellence or the National Treatment Agency, then the individual services already possess these. The Department of Health wants joint commissioning, and this, plus willingness all the way from practitioner level to commissioner level, can achieve a lot. Although miracles are not what we expect, even a little bit of willingness to move beyond the fear of failure and accusations of incompetence can save lives. The Matrix Model is a call to arms for practitioners to work with each other. Not against each other or in competition with each other, but in partnership for a common cause. That cause is the alleviation of distress and suffering in our communities.

The central idea of joint working is not new and has been tried in various parts of England within different authorities, usually in isolation or with limited communication of lessons learned. Certain national groups like Turning Point have attempted to take the lead in drawing experience together and making it available nationally through publications like the Good Practice Guide 2007.

Evaluation

Below is some feedback that the author obtained from workers who have experienced attempts at joint working between the substance misuse and mental health fields. Arguments against, a perception of being a 'gofer' for the other agencies as care plans are implemented, and a feeling of the relationship being unequal, fear of the unknown – both fields have developed apart, and a lot has been learnt but not communicated between the fields, jargon and technical language leading to feelings of being deskilled by the other agency, leading to resentment, and in worst cases, sabotage, fear of loss of speciality. If others are learning aspects of your professional work, you may feel challenged and threatened, or even that maybe your job is not as difficult as you thought it was. Arguments for are: opportunities for secondment or temporary placements produce increase in knowledge and skill base, as well as insight into how the other field works; networking produces some interesting and useful contacts, which can provide easy access expertise, for example – free specialist advice is only a phone call away; integrated care pathways reduce replication of work or generate more success, as all the clients' issues can be addressed in an integrated way; joint assessments mean that decisions can be taken straight away regarding who could take the lead on specific issues, then referrals can be made, speeding up the whole process.

Is the author naive, unconsciously incompetent or a hopeless optimist? From many conversations and workshops, the author knows that there is no capacity in most mental health services, and that for those that do gain entry to services, the entry threshold is high. Realistically, in the beginning, the mental health teams will have to take the lead. This will involve proactively including substance misuse services in CPAs, as well as co-locating to work in each other's agency rooms, whether in a high or low secure ward, a community room or in a voluntary drug agency. Service user feedback has been sparse unfortunately, and this is something the author would like to improve on. The reason for so little feedback is that much of the work on the Matrix Model has focussed on policies and practice in an attempt to change things locally in Bristol. The assumption in working on the Matrix Model was that integrated services are the most desirable.

In conclusion, the point of formulating this theoretical framework is to provide a common frame of reference to move forward in a very practical way now. This model is only a phone call away from implementation, and any worker can make that call to their opposite number in the other field.

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