Dual Diagnosis and access to support

A report exploring how to improve access to support for people with co-existing mental ill health and substance or alcohol needs in Lambeth.

FULFILLING LIVES LAMBETH SOUTHWARK LEWISHAM

COMMUNITY FUND

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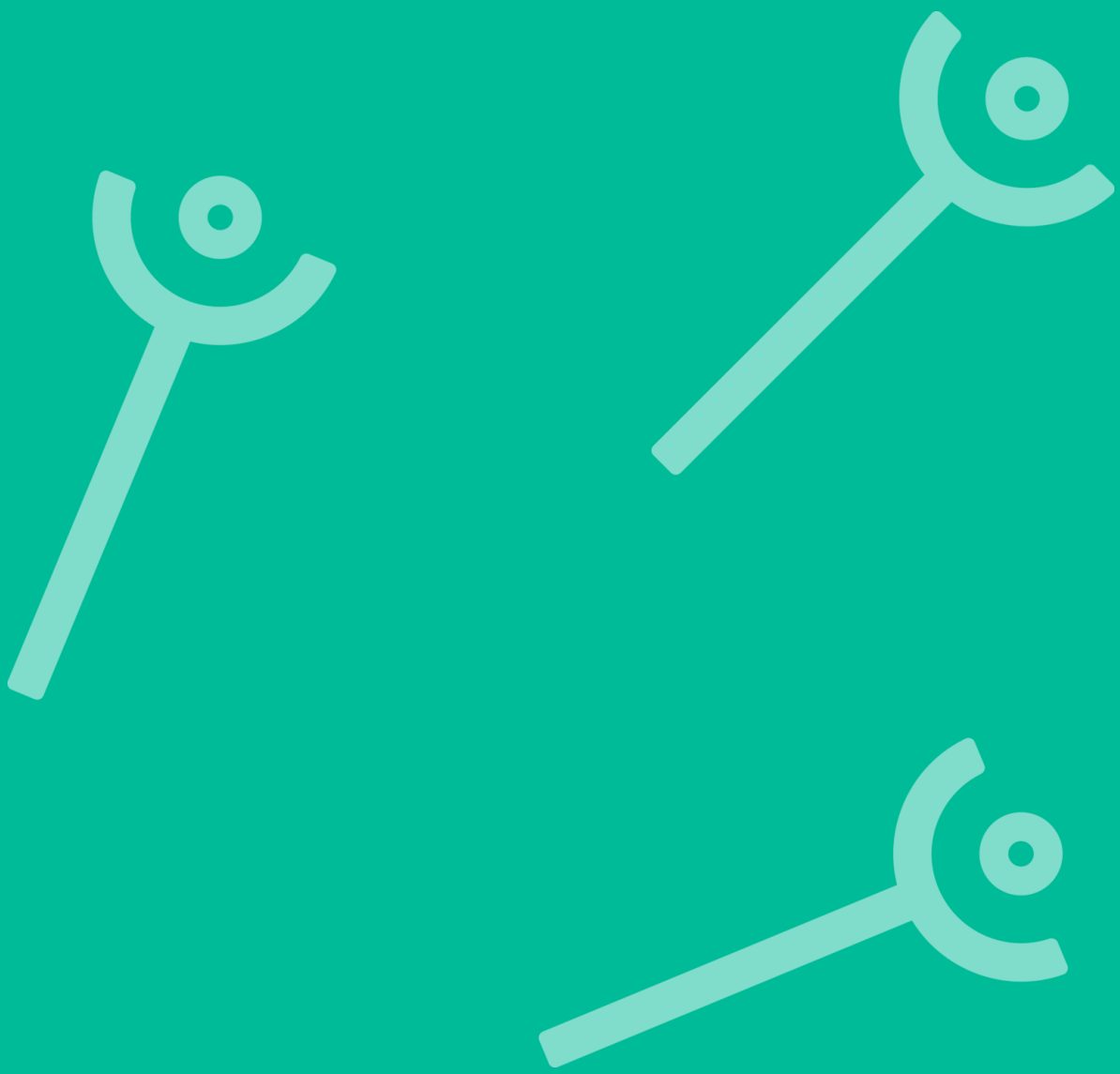

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About Fulfilling Lives LSL

Fulfilling Lives Lambeth, Southwark and Lewisham is part of The National Lottery Community Funded National Fulfilling Lives programme. The people we work with have interconnected needs and experiences of mental ill-health, experience of being homeless/or at risk of homelessness, use of substances and/or been involved with the criminal justice system.

We acknowledge that systems don't work for everyone – particularly people who experience greater levels of disadvantage – and our ambition is to make services easier to access. We do this by working alongside people who need, deliver and commission these services, and by thinking in a pioneering and creative way to initiate and influence change.

Fulfilling Lives LSL works across three main areas:

1.Co-production: to develop a culture where people facing multiple disadvantages are at the heart of design and service delivery

2. Service delivery: alongside people and services, learning and testing different interventions to make change to improve the lives of people facing multiple disadvantage

3. System change: providing learning and evidence that will be used to influence sustainable, long-term change for people experiencing multiple disadvantages, locally and nationally. Our three system-change priorities focus on improving access to support, life transitions and system behaviour.

For more information, please go to www.fulfillingliveslsl.london

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Introduction

"You can't unpick substance use and mental health – they are two interlinked things"

This report provides quantitative and qualitative data exploring access to alcohol and substance use and mental health services by people experiencing co-existing mental health and alcohol/substance use support needs in the London Borough of Lambeth.

It presents a local lens to the findings and recommendations outlined in the National Fulfilling Lives paper "Improving access to mental health support for people experiencing multiple disadvantage"[1]. In Lambeth, there is recognition that people experiencing co-existing substance use and mental health support needs may experience additional barriers to accessing services, and work is being done by Public Health team in Lambeth to collate evidence around this to improve access to services. Through identifying experiences, challenges and barriers, as well as recommendations at a local level, the report seeks to support Lambeth Public Health in their work.

We compiled this report prior to the COVID-19 pandemic following the publication of the national Fulfilling Lives report. The publication of this report was put on hold through the initial period of crisis management; we are now able to share our findings as part of Mental Health Awareness Week 2021.

We use the term 'dual diagnosis' throughout this report but recognise and respect that everyone has different experiences and may have different preferences about the language used to describe their experience.

People with a dual diagnosis and who experience multiple disadvantages are often labelled as 'non-engaging' or 'hard to reach'. Fulfilling Lives LSL do not subscribe to this narrative; we believe that it is not people who are hard to reach but services and systems that are hard to access and navigate.

We believe that everyone should have access to good support for mental health and substance use, and that the barriers faced by those needing mental health and substance use support simultaneously must be removed. Mental ill-health and substance use are both a cause and consequence of multiple disadvantages and are interrelated; substances are often used to self-medicate and manage the impact of poor mental health and complex trauma.

The aims of this report are as follows:
•To provide a local l evidence base to feed into the local Public Health work, with a focus on people experiencing substance use and mental health support needs alongside other layers of disadvantage

[1] https://fulfillingliveslsl.london/understanding-models-of-support-for-people-facing-multiple-disadvantage-a-literature-review/

• To provide recommendations based on the Fulfilling Lives national paper, applied at a local level
• To demonstrate the work taking place at Fulfilling Lives LSL in response to the findings from this research

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Research methodology

This report presents qualitative and quantitative data collated as part of Fulfilling Lives LSL local research activities. The data presented includes:

- Demographic data collated in relation to the people we support
- Data relating to key areas of need on point of referral in relation to the people we support
- Outcomes and service access data in relation to the people we support
- Findings and quotes from focus groups conducted with the people we support
- Findings and quotes from focus groups and interviews conducted with Fulfilling Lives LSL team members

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Insights from quantitative data

4.1 Demographics and support needs

Since the programme started in 2014, Fulfilling Lives LSL has worked with 52 people experiencing interconnecting needs and multiple disadvantages in Lambeth, of whom 44 (85%) were using substances and had diagnosed or identified mental health needs when we started supporting them[2].

The table below outlines the data regarding this group of 44 people.

	Number	Percentage
Total	44	100%
Gender		

[2] It is likely that everyone we support experiences poor mental health to some extent. Many of the factors associated with multiple disadvantages are linked to poor mental health, including homelessness, the impact of trauma and domestic abuse. E.g. Shelter 7 ComRes (2017) *The impact of housing problems on mental health*; Safe Lives (2019) *Safe and Well: Mental health and domestic abuse*

	Female	24	55%
	Male	19	43%
	Transgender	1	2%

Ethnicity			
	White: British	23	52%
	Mixed: White & Black Caribbean	7	16%
	Black/Black British: Caribbean	4	9%
	White: Other	3	7%
	Arab	2	5%
	Black/Black British: Other	2	5%
	White: Irish	1	2%
	Black/Black British: African	1	2%
	Did not wish to disclose	1	2%

Age			
	21-30	1	2%
	31-40	12	27%
	41-50	21	48%
	51-60	9	20%
	61-70	1	2%
Sexual orientation			
	Heterosexual	37	84%
	Bisexual	2	5%
	Lesbian	1	2%
	Did not ask	4	9%

Nationality			
	England	35	80%
	Scotland	2	5%
	Sweden	1	2%
	Egypt	1	2%
	Italy	1	2%
	Poland	1	2%
	Unknown	3	7%

Disability			
	People with disability	6	14%

Religion			
	Not known	22	50%
	None	9	20%
	Christian	9	20%
	Muslim	2	5%
	Jewish	1	2%
	Did not wish to disclose	1	2%

Criminal justice involvement			
	History of offending	42	95%

Care system			
	Experience of care system	7	16%

Sex work			
	Involved in sex work	15	34%
	All 15 of these people are women; this represents 63% of all the women.		

Children			
	Have had children removed from care	15	34%
	Between these 15 people, 48 children have been removed from their care		

Literacy			32%
	Literacy problem	9	20%
	Level 2 (GCSE A*-C, NVQ2)	4	9%
	Entry level (ESOL, Skills for life qualifications, Entry Level Award, Certificate or Diplomas)	3	7%

	Level 3 (A-Levels, NVQ3)	3	7%
	Level 4 (NVQ4)	2	5%
	Not known	13	30%

Where spent majority of time sleeping during first 3 months working with FLLSL			
	Supported accommodation	15	34%
	Own tenancy	10	23%
	Sleeping on the streets	5	11%
	Temporary Accommodation	5	11%
	Family and Friends	3	7%
	Prison	2	5%
	Other	4	9%

Alcohol and substance use This provides a caption of the primary drug/s used which is disclosed. It does not account for all polydrug use experienced by people we support.			
	Heroin use	29	66%
	Crack cocaine use	36	82%
	Alcohol use	20	45%
	Cannabis use	9	20%
	Prescription medication (including benzodiazepines)	11	25%
	New Psychoactive Substances	0	0%

Mental health conditions This provides an overview of the diagnosed mental health conditions. We do not have a formal diagnosis for everyone in this group but when we started working with them it was identified that they have mental health support needs. It is worth noting that some people have had multiple diagnosis.			
	Post-traumatic stress disorder/complex PTSD	1	2%
	Personality disorder	7	16%
	Depression and/or anxiety	14	32%
	Psychotic disorders including schizophrenia	8	18%
	Bi-polar disorder	2	4%

	Multiple diagnoses	4	9%
	Formal diagnosis unknown	6	14%
	Other	2	5%

Access to services			
	Detox	7	16%
	Rehab	7	16%
	Substance use support worker	33	75%
	Counselling	5	11%
	CBT	4	9%
	Psychotherapy	2	5%

4.2 Gender differences

The table below shows the number and percentage of people who have accessed substance use or mental health treatment, spilt by gender; of the total 44 people, 25 are female and 19 are male. There is qualitative evidence outlined in the themes section below that women experience further barriers to accessing support in comparison to men. This is also reflected in the data below, which shows smaller percentages of women having substance use workers, accessing detox, and receiving mental health interventions than men.

	Substance use worker		**Detox**		**Rehab**		**Received mental health interventions[3]**	
Gender	Male	Female	Male	Female	Male	Female	Male	Female
Number	16	17	4	3	2	5	4	2
Percentage	84%	68%	21%	12%	11%	20%	21%	8%

4.3 Differences according to ethnicity

It is essential to consider structural racial inequalities that may exist within the system. Due to the relatively small sample the data may not be representative, but it is interesting to consider.

The biggest difference between ethnic origins appears in access to detox, where no black or mixed heritage people have had access to detox. There are also fewer black and mixed heritage people have been to rehab.

Ethnic Origin	White	Black	Mixed heritage	Other

[3] Community Mental Health Team, Counselling, Psychotherapy or Cognitive Behavioural Therapy

Number of people	27	7	7	3

	Substance use worker			
	White	Black	Mixed heritage	Other
Number	24	5	3	1
Percentage	89%	71%	43%	33%
	Detox			
	White	Black	Mixed heritage	Other
Number	6	0	0	1
Percentage	22%	0%	0%	33%
	Rehab			
	White	Black	Mixed heritage	Other
Number	5	1	1	0
Percentage	19%	14%	14%	0%
	Received mental health intervention[4]			
	White	Black	Mixed heritage	Other
Number	8	4	2	1
Percentage	30%	57%	29%	33%

4.4 Areas of need for people we are currently supporting

In October 2019 introduced a new data set to give more detail around support needs and access to services. The following table presents this data, providing a deeper dive into 14 of the 44 people we have worked with who have a dual diagnosis.

	Total	**%**
Domestic violence		
Victim of violence in a relationship	**4**	**29%**
Physical and sexual health		
Untreated serious health condition	**3**	**21%**
Sexual health checks this year	**7**	**50%**
Bloodborne virus check this year	**9**	**64%**
Bloodborne virus and receiving treatment	**2**	**14%**
Registered with GP	**12**	**86%**
Pregnant	**0**	**0%**

[4] Community Mental Health Team, Counselling, Psychotherapy or Cognitive Behavioural Therapy

Drug and alcohol use		
Using drugs or alcohol	**14**	**100%**
Poly drug user	**12**	**86%**
Intravenous	**3**	**21%**
Heroin use	**10**	**71%**
Crack use	**10**	**71%**
Alcohol use	**5**	**36%**
Cannabis use	**3**	**21%**
Treatment		
Accessed substance use treatment on initial presentation	**7**	**50%**
Re-started a script	**6**	**43%**
Maintained a script for at least one month over a 9-month period	**5**	**36%**
Completed treatment	**0**	**0%**
Not yet started treatment	**3**	**21%**
Mental health		
Mental health condition not diagnosed prior to referral to Fulfilling Lives LSL	**5**	**36%**
We're engaging with mental health services when referred to programme	**4**	**29%**
Admission to crisis services since October 2019	**2**	**14%**
More than 1 mental health diagnosis	**8**	**57%**
Receiving therapeutic treatment	**3**	**21%**
On medication for mental health	**5**	**36%**
On waiting list for talking therapy	**0**	**0%**
Trauma intervention (DBT/EMDR)	**0**	**0%**
Under GP for mental health	**4**	**29%**
Working with START homelessness team	**1**	**7%**
Had a planned discharge from mental health ward	**3**	**21%**
Unplanned discharge form mental health ward	**1**	**7%**
Absconded from section	**1**	**7%**

4.5 Adverse Childhood Experiences

The Adverse Childhood Experiences (ACE)[5] is an evidence-based assessment tool that links adverse childhood events experienced before the age of 18 including physical,

[5] Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C. H., Perry, B. D., ... & Giles, W. H. (2006). The enduring effects of abuse and related adverse experience in childhood. *European archives of psychiatry and clinical neuroscience*, *256*(3), 174-186.

emotional and sexual abuse, to negative outcomes later in life[6]. The table below shows the number and percentage of people we support who experienced each dimension of childhood adversity according to the model. It should be noted that there are some criticisms of the assessment tool, for example that it doesn't consider trauma that occurs in adulthood and is out-dated in some of the measures (for example parental divorce). It is used here solely as an indicator of the level of trauma experienced by people with dual diagnosis according to an evidence-based tool.

We were unable to capture a complete dataset for all 44 individuals; the figures below reflect the experience of a sample of those 44, 16 people completed the full assessment tool.

Adverse Childhood Experiences		
Parents divorced or separated	12	75%
Did not feel loved by family	10	63%
A parent or other adult often made you feel humiliated or scared	9	56%
Sexual abuse from a parent or someone 5 years older than you	8	50%
Experienced neglect	8	50%
Mental ill-health in household	8	50%
Domestic violence in household	7	44%
Substance or alcohol misuse in household	7	44%
Physical abuse from a parent or other adult	5	31%
A member of household in prison	4	25%

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Findings from focus groups – key themes and observations

We recognise the strong commitment to support for substance use and mental health through the Living Well Network Alliance and Lambeth Consortium to provide for the needs of all parts of the community. However, there is local evidence that the specific needs of people with dual diagnosis - experiencing multiple layers of disadvantage - are not always met by the current provision.

We have picked out some key themes which reflect the voices of people with lived experience of dual diagnosis as well as practitioners in Lambeth. Our aim is to share

[6] Studies have found that an ACE score of more than 4 is associated with health-harming behaviours and negative outcomes later in life (for example Bellis et al, 2014; Hughes et al, 2017), including poor diet, smoking, heroin and crack use, binge drinking, self-directed violence, heart disease, cancer and mental ill health.

and amplify these experiences so that we can work collaboratively to further shape services that meet the specific support needs of this group of people.

5.1 An informed approach to service provision

Substance use and mental-ill health are interrelated and often occur as a coping mechanism in response to trauma or adversity. Trauma impacts communication and behaviour; a lack of understanding can result in those receiving services feeling judged and inaccessible. It is important to understand trauma in the context of other forms of oppression such as gender and culture.

There is evidence to link the diagnosis of a personality disorder with experience of trauma. 20% of the people we work with have been diagnosed with some form of personality disorder and a further 3% have been diagnosed with Post-Traumatic Stress Disorder (PTSD) or Complex PTSD, which highlights the need for trauma-informed service provision.

All team members working in services need the appropriate training and support structures to understand that experiences of trauma can lead to developing coping strategies or behaviours that may appear harmful or dangerous.

"Receptionists [in services] should be given training on how to deal with their more vulnerable patients, they need to be more understanding, less rude, judgmental and unhelpful."

The people we support highlight the importance of feeling safe and respected when using services. The way in which services are delivered and the approach that team members take impacts on how a person is able to connect with a service through both practical aspects such as location and opening hours, and in terms of feeling safe and how able an individual is to build consistent and trusting relationships with staff.

"People don't understand my diagnosis (PTSD/Dissociative PD/Depression), they don't understand how it impacts me, every day is a struggle…Have they ever gone to get a bus and come around two days later in a hospital? It's really distressing, how can they say that doesn't affect me?"

"If you are feeling anxious and overwhelmed in the waiting room- you should be able to go and wait somewhere quiet."

The data we have around Adverse Childhood Experiences reflects the high level of childhood and adolescent trauma experienced by the people we support. This is compounded by experiences of the care system (16%), having children removed by social services (34%) and the high prevalence of domestic and sexual violence. To address this cycle of complex trauma an informed approach is required so individuals can engage with services and develop trusting relationships with staff.

"I was put in jail after care when I was 15 because they couldn't manage my behaviour- but I needed help, not punishment."

Many people highlighted the benefit of team members having lived experience; this can help them feel understood.

"You don't want to sit there and feel judged by someone who doesn't understand you."

Also key to delivering trauma informed services is recognition of team members own trauma as well as secondary trauma. A work environment and organisational culture that is sensitive to this, and supports staff wellbeing, is essential. This is developed through workforce development across all levels of an organisation, reflective practice, and an understanding of different aspects of disadvantage including cultural and gendered experiences of trauma.

5.2 Experience of accessing services

The people we support have told us that the combination of needs they experience can act as a barrier to them getting the right support they need.

These practical barriers to accessing substance use or mental health support services appear to be contrary to NICE and Public Health England guidelines. We are not yet able to evaluate whether national guidelines are being followed locally but have evidence of barriers around access for the people we work with.

The people we support have told us about the barriers they experience to accessing mental health support when experiencing dual diagnosis.

"If you've got dual diagnosis it's much harder -You can't get seen until you stop using, you get immediately blocked."

"You are told drug addiction is the cause of mental health, so you go to [the drug service] and they say go back to the CPN [Community Psychiatric Nurse] – so then nobody sees you"

"My substance misuse led to doors being closed on me because of my mental health, no help offered until I am clean. Information not shared and I have keep repeating my story. Felt like no-one cared what was happening to me."

It is vital that all services, in particular mental health and substance use services, are equipped to provide support around both mental health and substance use, with consideration given for people facing multiple disadvantages. This should start from assessment being able to support both substance use and mental health support needs.

"You either need workers in a service who specialise in more than one thing like mental health AND drugs and alcohol, or have different workers in one service who work together."

It is essential to address both substance use and mental ill-health for treatment to be effective. Often people are concerned that reducing drug or alcohol use will lead to worsening mental health or vice versa – a 'chicken and egg' scenario. Often one professional will support substance use and another mental health when they are interconnected and need to be addressed at the same time.

"I didn't know how I was going to stop [drug use] without talking about it [childhood abuse] first."

People also told us that short appointment slots can act as a barrier, in part because it means there is less flexibility if you are late but also because you have less opportunity to build up a relationship with staff. As described in section 4.1, people emphasise the importance of feeling safe and understood in a service.

"Having the time to get to know your worker is really important- sometimes you just get rushed in and rushed out- I bet they [the workers] hate it too - I guess what they need is less people to see [smaller caseloads] so that we have time to build a relationship with each other."

"People who work in the drug services need to understand how stressful it is using, and how you suffer with depression and anxiety most of the time - getting punished for missing appointments, or not having the time to talk to anyone if you are late because you missed your slot isn't helpful."

Once someone has gained access to a drug service, the data shows there is a low rate of access rates to detox (16%) and rehab (16%), despite there being a 75% of people having a substance use worker, which indicates that people are engaging with substance use services but are not getting detox or rehab treatment opportunities.

This may reflect the gatekeeping and criteria around getting referred to and/or securing funding for detox or rehab. Motivation is often measured through attendance at pre-detox groups; however mental ill-health often prevents someone being able to access pre-detox groups. Another barrier experienced is when people may be told they are too 'high risk' in terms of their mental health to meet the criteria for detox or rehab centres.

"Apparently, I was too complex a case, how can you be too complex to get help?"

Often people are given a limited number of chances at detox and rehab; people told us that relapse is part of the journey of recovery and that people should not be judged for needing more than one or two attempts to be successful. Having blanket policies for everyone using a service does not consider individual situations.

"Funding should be available as many times and for as long as you need it- we've all experienced different things in our lives so some might need to try more times or have longer in treatment than others".

There is an emphasis on detox and rehab as available treatments when often people want to explore alternatives or may want support around drug use but do not want to be abstinent.

"There should be more support available for people who don't want to get on a script."

"More options - not every treatment style works for everyone".

Support should be available on a long-term and ongoing basis; this applies to both mental health and substance use support and includes support beyond detox or rehab treatment.

"Support should be available for longer - 12 weeks talking therapy via IAPT just isn't always enough."

A significant proportion of the women we work with who experience dual diagnosis have had children removed from their care (34%); on average each woman has had 3 children removed to the care system. The impact of having a child removed is immense on both the mother and can lead to intergenerational trauma for the child.

"One of the women we support is linked in with mental health services due to needing support around the trauma she has experienced having her children removed from her care. She uses alcohol as a coping mechanism to block out the pain she feels which results in her missing appointments with services."

One woman we work with identified the need for better support for pregnant women and mothers with mental health support needs as this could help keep them together.

"[Better mental health support for pregnant women and mothers] might help prevent the removal of children from their mums who are ill but still love them."

5.3 Understanding women's experiences

Fulfilling Lives LSL are working with a group of women in Lambeth with dual diagnosis who are well known to services and have been for a long time, who are often engaging sporadically in drug treatment, who have frequent involvement with criminal justice system through arrests and short prison stays, are often involved in street based sex work, and who have often been in many different hostels within the pathway.

We were asked to understand what would bridge the gap for this group of women and to ensure their needs are met by current service provision. This is recognised by

partners in Lambeth and it was agreed that we would work with women referred to us from the Lambeth Prostitution Group (LPG).

"When you go to a place like that [drug service] its horrible anyway and then if you're a working girl you see people you really don't want to see when you're there."

The data from the people we work with reflects the high level of involvement in street-based sex work and experiences of sexual and domestic violence. There is a well-documented link between substance use, domestic and sexual violence, and mental ill-health, and often women are using income from sex work or shoplifting to purchase substances in the absence of opportunities for stable income or accessibly treatment.

There is recognition across services in Lambeth working with this group of women that they face additional barriers to accessing and staying in treatment. A shared learning space has been developed bringing together practitioners and commissioners to better understand the barriers and explore collaborative ideas for change. Drug services are often male dominated environments that can feel unsafe and have specific requirements around access that do not suit the unpredictable nature of the women's lifestyles.

"They should have a women's only day - it would be good to separate people."

"All services should have a women's only space."

The learning from these conversations with practitioners and women with lived experience is reflected in the data. Only 8% of women received a mental health intervention compared to 21% of men; and a lower proportion of women (68%) had a substance use worker than men (84%). There is however a higher proportion of women who access rehab (20% of women compared to 11% of men) although access to detox is lower (12% of women compared to 21% of men). It is unknown the reasons as to why this is; we are exploring this area further.

5.4 The challenge of transition

Once access has been gained to a service, often people are required to attend multiple services in different physical locations, at set times with different staff members. This requires the ability to develop several different relationships and sharing their experiences. To receive support beyond an initial assessment, someone needs to be able to navigate different places and advocate for themselves and negotiate different relationships.

"There's so much to do when you first get out [of prison]- housing, probation, drug service, family and that's all in the first day-it's a massive pressure, they should stagger the appointments, and you shouldn't have to do them alone. It's a big trigger for relapse."

The very experience of experiencing multiple disadvantages means that people have more than one support need, requiring them to access several services. The data shows

that alongside dual diagnosis, people we support also experience the criminal justice system, domestic violence, physical health needs. Our data shows that 6% of people had more than 7 different services working with them and 14% of people changed address more than 4 times. The 16% of people who spent time in local authority care would also have experienced a major transition through children's to adults' services.

"I feel stuck in the system, it's like a merry go round, I want to change and step off."

People with experience of dual diagnosis spoke about the benefit of having someone to help navigate their journey through substance use and mental health services, as well as other services they may be accessing, and having trusted relationships with key individuals.

" Having someone who stays with you until everything's sorted out, so you're not trying to sort everything out by yourself".

"Working alongside the same person, build strong relationships."

"It's scary walking into unknown places, so to have familiarity of same people is good."

"Sometimes you feel like you're fighting a losing battle but when you have someone on your side things get groovy, just been trying to get through the obstacles and hoops."

5.5 How services are commissioned

We support the national Fulfilling Lives paper's recommendation for Joint Strategic Needs Assessments (JSNA) to include analysis of individuals experiencing multiple disadvantages. JSNAs take a wider view of social determinants of health which in turn would encourage the commissioning of health services that are suitable to the needs and circumstance of people with dual diagnosis and experiencing multiple disadvantages therefore reducing the barriers when support needs coexist.

We recognise that there are different pockets of funding made available for specific pieces of work, or time-limited interventions.

"I was supporting one of our female beneficiaries when her mental health deteriorated to the point where she wanted to take her own life. We spoke with her worker from the mental health team however this worker was adamant that it was the drugs and to present at A&E. The worker showed no empathy or understanding. This female beneficiary hadn't used drugs for a week as she was trying to get herself back on track. By our beneficiary not using drugs she wasn't able to cope with the trauma she has been exposed to throughout her life, she saw no hope in her future."

Our research demonstrates the need for joined up approaches to service delivery, and support that seeks to prevent crises is available. Commissioning processes should prioritise resourcing person led support that focuses on relationship and trust building, as well as longer term provision.

6

Recommendations

6. Recommendations

1. Develop a more informed approach to service provision

Provide an 'informed' approach to service provision so that services are designed and delivered in a way that recognises the impact of trauma, gender and culture. This means that the physical, psychological and emotional safety and wellbeing of both people we support, and team members are considered in the design and delivery of a service. We would like to see services co-designed with people with previous or current lived experience of dual diagnosis.

Fulfilling Lives LSL approach

We focus on understanding trauma, gender and culturally informed approaches, and what this means in co-produced practice and culture.

We have delivered training to support us in this journey and have worked with our research and evaluation partnership to produce a literature review[7] exploring the evidence on trauma, gender and culturally informed approaches, and are keen to share our learning across the borough.

We are developing a framework and resources for an 'Informed Champion role', to support the wider workforce in other organisations to embed informed approaches within their work and their teams.

2. Remove barriers to accessing services

Ensure that national guidance on co-occurring mental ill-health and substance use is followed locally. Local commissioners and service providers should ensure staff at all levels of the system are supported and challenged to ensure assessment and the provision of services for people with dual diagnosis. Services should include support specifically for pregnant women and those with children recognising the impact of those relationships in their treatment and recovery.

[7] https://fulfillingliveslsl.london/understanding-models-of-support-for-people-facing-multiple-disadvantage-a-literature-review/

Fulfilling Lives LSL approach: We have established a local shared learning forum for particularly focused on the women experiencing dual diagnosis, multiple disadvantages compounded by exploitation, commissioners and service providers to regularly come together to share experiences and learning in regard to accessing services. The shared learning forum provides quantitative and qualitative evidence to understand barriers and barriers are play, to improve service delivery, and to ensure national guidelines are being met. The forum also strengthens communication and information sharing between key stakeholders.

3. Support women with a gender-informed approach

Continue to support the development and delivery of a systems change pilot that focuses on providing flexible gender and trauma informed support women with dual diagnosis and multiple disadvantages**.**

Fulfilling Lives LSL Offer: We have been working closely with Lorraine Hewitt House in Lambeth as well as women with lived experience to co-design and develop a new system change pilot, with the aim of improving access to treatment for women experiencing multiple disadvantages. We have held a series of co-production workshops to co-design the pilot and are now working to support the pilot roll out and delivery. We are keen to share learning from the pilot and our wider work with women experiencing multiple disadvantages, to support services to take a gender and trauma informed approach.

4. Review funding and commissioning process

Develop an understanding of the funding landscape to explore how to best use limited resources for sustainable and collaborative change. Commit to commissioning and delivery which are co-designed, co-delivered and co-evaluated and supported by system thinking and tools to understand how the system responds to people facing multiple disadvantages to deliver effective change.

Fulfilling Lives LSL Offer: A culture of co-production and systemic thinking is embedded throughout service design and delivery at Fulfilling Lives LSL. We have a workstream focused on supporting systems thinking across boroughs, and with our research and evaluation partnership, we have published key resources to support systems thinking.

We continue to deliver ongoing research, as well as creating spaces for shared learning, in relation to people's experiences of multiple disadvantages, access to services and how the system operates.