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**JUSTICE**

National Offender  
Management Service



# A Guide for the Management of Dual Diagnosis for Prisons

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# 1. Introduction

Dual diagnosis, or the co-existence of mental health and substance misuse problems, is not a new phenomenon. Psychiatric services have had long-standing challenges in helping patients with mental health problems who drink to excess. Similarly, drug and alcohol services have always worked with a number of clients with substance misuse problems who also suffer from a variety of mental health problems, including depression, anxiety states and psychosis. What has changed over the past two decades is a dramatic increase in the range and availability of street drugs (EMCDD, 2007). So dual diagnosis is nothing new, but it has become far more common both in the community and within prisons.

By its nature, responsibility for dual diagnosis overlaps a number of the health and social care services provided in prisons, including primary and secondary mental health services, drug treatment services, chaplaincy and peer support groups (such as the Listeners). Prisons vary in the way in which the functions of mental health and substance misuse interventions are divided between these respective departments. Therefore, these guidelines are intended to be used as a framework that can be adapted by individual establishments to provide co-ordinated services to this highly disadvantaged client group.

# 2. Defining dual diagnosis

The term 'dual diagnosis' covers a wide range of problems that have both mental health and substance misuse in common. Dual diagnosis can consequently mean different things to different service providers, but it can be summarised within four principal definitions:

**A primary mental health problem that provokes the use of substances**

*(As may be the case with someone suffering from schizophrenia who finds that heroin reduces some of his symptoms.)*

**Substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses**

*(Emergence of depression post-detoxification – insomnia and low mood; also the emergence of a psychiatric disorder to which the individual was vulnerable pre-substance misuse.)*

**A psychiatric problem that is worsened by substance misuse**

*(For example, a person with heightened anxiety of danger from others who uses cannabis to relax, but finds that the cannabis can increase their paranoia, leading to increased alienation.)*

**Substance misuse and mental health problems that do not appear to be related to one another**

*(For example, someone who has an ongoing anxiety problem that is neither lessened nor worsened by drug or alcohol use.)*

These guidelines have been written to assist all services within prisons (primary care, mental health, drug treatment) to manage patients who have a mental health and a substance misuse problem.

Compared with people who have either a mental health or a substance misuse problem, clients with a dual diagnosis are more likely to have had difficulties with education, employment, accommodation, sexual abuse, personal relationships, general health and neurological damage (Banerjee, Clancy and Crome, 2002; Social Exclusion Unit, 2002).

*In accordance with the mental health in prisons strategy (Department of Health, 2001), patients with a severe mental health problem must always have a full risk assessment and be treated within the Care Programme Approach (CPA).*

### 3. Who has responsibility for the care of dual diagnosis?

#### Overall care

Everyone working for the Prison Service has a duty of care towards every prisoner. This duty includes any prisoner with a co-existent mental health and substance misuse problem.

#### Primary care

Since 2004, responsibility for the commissioning of healthcare services within public prisons has transferred to the National Health Service. NHS primary care trusts commission healthcare services to ensure that responsibility and accountability for both mental and physical health are clearly defined.

#### Mental health

Facilitation and co-ordination of the delivery of primary mental health interventions (i.e. interventions that are planned for the management of non-severe mental health problems) is the responsibility of the primary healthcare manager.

#### Physical health

The responsibility to manage the delivery of general medical and nursing services is also that of the healthcare manager. The Mental Health Policy Implementation Guide states:

*'Assessment of the physical health needs of these people [with mental health problems] lies entirely within the remit of primary care, and as described above, the physical health consequences are significant e.g. a third of people with dual diagnosis will be sero-positive for either HIV, Hepatitis B or Hepatitis C.'*

(Department of Health, 2002)

There are strong links between physical well-being and mental health. It is important that there are firm connections between the mental health care providers and the physical health care providers.

#### Substance misuse

The overall responsibility to facilitate the delivery lies with the healthcare manager. In many prisons the responsibility for the direct delivery of clinical substance misuse interventions within the prison (i.e. management of withdrawal from alcohol and all drugs of dependence, opioid maintenance prescribing and prescribing to protect against relapse into problem drinking or drug use) lies with the clinical substance misuse manager or senior practitioner.

Responsibility for the delivery of CARATs (Counselling, Assessment, Referral, Advice and Throughcare) services resides with the CARATs service manager. These systems are now coming together in a singular multi-disciplinary treatment team, as a key element of the integrated drug treatment system (IDTS) (HMPS, 2006).

### **Medicines management**

The overall responsibility for ensuring care and control of medicines, including safe and effective prescribing, lies with the chief pharmacist. In many prisons this may be the lead pharmacist of the commissioning PCT. However, where medicines management services are commissioned it is important that prison healthcare staff, including prescribers who may be commissioned on a sessional basis, have access to expert pharmaceutical advice. In view of the high prevalence of mental health and substance misuse problems within the prison population, it is desirable that this pharmaceutical advice should come from specialist mental health pharmacists. It is important that pharmaceutical services provide more than just a supply service in order to ensure safe and effective use of medicines. Commissioners should refer to the Healthcare Commission 2007 review *Talking about medicines: The management of medicines in trusts providing mental health services*.



# 4. Mental health – legal framework

## Care Programme Approach

From October 2008, there has been one single CPA process (replacing the old 'enhanced' and 'standard' CPA system). Throughout this document, all references to CPA will relate to this new single process.

The Department of Health (DH) has identified, in particular, mental health service users:

- who have parenting responsibilities;
- who have significant caring responsibilities;
- with a dual diagnosis (substance misuse);
- with a history of violence or self harm; and
- who are in unsettled accommodation.

In relation to the CPA, DH states that:

*'The default position for individuals from these groups would normally be under (new) CPA unless a thorough assessment of need and risk shows otherwise.'*

(DH, 2008)

Responsibility for access by this client group to CPA rests with the head of mental healthcare services within each prison. A care co-ordinator, who is usually but not always a member of the mental health service team, has lead responsibility for delivery of CPA.

## Mental Health Act 2007

Individuals suffering from "any disorder or disability of the mind" come within the scope of the Mental Health Act 2007. This definition includes sexual deviancy.

This change to the Mental Health Act, and the publication of the guidelines *Personality disorder: No longer a diagnosis of exclusion* (NIMHE, 2003), suggest that personality disorder qualifies for treatment via mental health services.

At present, a significant majority of people with personality disorder remain undiagnosed. People who have a personality disorder may also have another serious mental health problem, such as a psychotic or major affective disorder. Clinical presentation can be complicated further by substance misuse. Unfortunately, when personality disorder is overlooked, there is an increased risk of treatment failure, leading to disengagement with services.

## Multi-Agency Public Protection Arrangements

Multi-Agency Public Protection Arrangements (MAPPA) support the assessment and management of the most serious sexual and violent offenders.

The aim of MAPPA is to ensure that a risk management plan that is drawn up for the most serious offenders benefits from the information, skills and resources provided by the individual agencies being co-ordinated through MAPPA.

MAPPA were introduced in 2001, and bring together the police, probation and prison services into what is known as the MAPPA Responsible Authority.

Other agencies are under a duty to co-operate with the Responsible Authority, including social care, health, housing and education services.

There are four key features within MAPPA:

### 1. Identifying offenders to be supervised under MAPPA

This is generally determined by the offender's offence and sentence, but assessed risk is also factored in. There are three formal categories:

- Category One: Registered sex offenders;
- Category Two: Violent or other sex offenders; and
- Category Three: Other offenders.

### 2. Sharing of information about offenders

MAPPA promote information sharing between all the agencies, resulting in more effective supervision and better public protection. For example:

- Police will share with offender managers information that they have gathered about an offender's behaviour from surveillance or intelligence gathering.
- Local authorities will help to find offenders suitable accommodation where they can be effectively managed.

Victims' needs are required to be represented in MAPPA, so that additional measures can be taken to manage risks posed to known victims.

### 3. Assessing the risks posed by offenders

Most MAPPA offenders do not present a risk of serious harm to the public: the MAPPA enable resources and attention to be focused on those who present the highest risks.

### 4. Managing the risk posed by individual offenders

MAPPA offenders are managed at one of three levels.

### **Level One: involves normal agency management**

Generally offenders managed at this level will be assessed as presenting a low or medium risk of serious harm to others.

### **Level Two: often called local inter-risk agency management**

This includes most offenders assessed as being at high or very high risk of causing harm.

### **Level Three: known as Multi-Agency Public Protection Panels (MAPPPs)**

MAPPPs are appropriate for those offenders who pose the highest risk of causing serious harm or whose management is so problematic that multi-agency co-operation and oversight at a senior level is required, with the authority to commit exceptional resources.

### 5. Current practice within the Prison Service

Most prisons across the country practise what is known as a parallel approach to dual diagnosis. A parallel approach involves the provision of care by more than one treatment service at the same time.

The most common example of this would be a prisoner who is under the care of the primary healthcare team for the management of his mental health problem, and receiving help from the drug treatment services team to address his substance misuse problem. An alternative version of this model would feature the involvement of a secondary (specialist) mental health team alongside the substance misuse services.

An important variation on this approach involves three separate teams working with a prisoner: the mental health team providing the patient with mental health care, the drug treatment services providing a range of substance misuse interventions, and the primary healthcare team providing other clinical services.

The parallel approach is a recognised and accepted response to dual diagnosis. Its principal advantage lies in the fact that a client receives specialist help for each of the different aspects of his or her problem. The main disadvantage of this system lies in the need for sharing important information between two or sometimes three treatment teams, and the potential that this holds for miscommunication. It can also be perceived as providing fragmented care to the recipient. For it to meet the complex needs of this group of people in prison, the parallel approach must therefore be developed to become as fully integrated as possible.

#### Relative merits of parallel and integrated approaches

	Parallel	Integrated
Recognition of problem	More difficult since knowledge and skills are not widespread	Can be successful where knowledge and skills are shared
Management of risk	Unsatisfactory where communication is limited	Satisfactory where care planning is ensured
Delivery of services	Can be perceived by clients as fragmented	Very cohesive if well managed
Continuity of care	Satisfactory where care pathways are clear, but vulnerable to fragmentation	Satisfactory where care pathways are clear

### **Integrated approach**

The introduction of the integrated drug treatment system in prisons (HMPS, 2006), which brings healthcare and CARATs teams far more closely together, provides a basis for integrated care of dual diagnosis, involving joint care planning, case reviews and co-ordinated through-care.

A number of larger prisons have now established specialist dual diagnosis services, which combine some of the most relevant functions of mental health and substance misuse with strong links to primary healthcare, wider supportive prison services and community mental health teams. This system is described in more detail in Section 6.

# 6. What works?

There is a relatively small body of evidence for what is effective in the treatment of dual diagnosis in the UK and elsewhere. Recommended approaches tend to be less precise than in other areas of treatment. Instead, broader principles of good practice are more appropriate to guide planners and practitioners. These principles are as follows.

## Integrated treatment

A co-ordinated approach from all professionals involved both within the prison and from community services. This often involves a *biopsychosocial* model of working that addresses medical, psychological and social needs.

DH (2002) and the Royal College of Psychiatrists (2002) recommend the integrated approach.

## Staged interventions

The mental well-being of a patient with a dual diagnosis is dependent on the harmonisation of interventions. Rapid changes in environment and/or pharmacology can threaten this balance, worsening a mental disorder.

## Social support interventions

Both mental health problems and drug dependence are conditions that have been found to respond favourably to cohesive social support (e.g. Gumley, 1999; Smith, Meyers & Miller, 2001). This approach has to take account of stigma and the related fear in the social network, which impedes reintegration for individuals with dual diagnosis.

## Longer-term perspective

Clients with a serious mental health and a substance misuse problem are at increased risk of becoming isolated from carers and families, becoming homeless, acquiring HIV, engaging in violent behaviour and committing suicide. This poor outlook suggests that treatment programmes should feature realistic goals and be gradually paced.

## Interventions matched to level of need

Clients with a mild to moderate mental health need are best served within a primary care setting – access to primary care in both prisons and the community is generally easy, and suitably trained practitioners (Hughes, 2006) have the ability to manage less severe mental health problems.

# 7. Recommended approaches

Two treatment approaches are described below. Option A is a specialist team model; Option B is a model that utilises existing provision.

## Option A: Specialist dual diagnosis team

In view of the large number of prisoners with both mental health and substance misuse problems, some prisons have established specialist dual diagnosis teams. In the main, these teams comprise professionals with a background in psychiatry, psychology, social care and substance misuse. The service offered by these teams may be described within four categories:

- 1. Assessment.** The dual diagnosis team takes referrals from other service providers within the prison, and sees the client with a view to evaluating his or her care needs across a wide number of domains, including mental health, cognitive ability, social functioning (pre and post release), skills for living and substance use. These factors also need to be assessed in terms of functioning prior to entry into prison, as containment can limit the expression of certain difficulties that emerge on transfer or release.
- 2. Consultation.** Where the dual diagnosis team judges that the client's range of problems does not necessitate their direct involvement, they make a recommendation to the referring department (usually the integrated drug treatment system (IDTS) team) on future case management. As it represents a resource of expertise, the dual diagnosis team remains available for future supervision and consultation.
- 3. Individual case work.** In instances where the dual diagnosis team decides that the client needs specialist help, it provides this service, including care co-ordination, as part of the CPA.
- 4. Education and advice.** The dual diagnosis team provides training to primary healthcare and substance misuse teams in order to increase their knowledge base and thereby enable them to provide services to clients with more complex needs. Again, this work includes ongoing supervision of the staff who have received training.

One substantial risk with this approach is that responsibility for dual diagnosis can be mistakenly regarded as sitting with just a few overburdened practitioners. Very clear pathways of care, and specific skills and knowledge training for mainstream staff (primary mental health and substance misuse), are necessary in order to neutralise this risk. The use of both shared care protocols and regular case review meetings is beneficial.

A difficulty with a fragmented model of care is that progress can often be undetected by one service. Thus, one service may see little or no change in the targets/goals they have set, but another service may see progress in a different set of targets. Also, decisions made by one service can be detrimental to another service. For example,

a practitioner working with an individual with avoidance of emotions (common in personality disorder and substance misuse) may be working with them on increasing their willingness to experience painful emotions. If the individual then presents at another service highly distressed and appearing at risk, they may receive medication or psychological interventions that remove their exposure to painful emotions, thus undermining the therapeutic model. Integrated case notes are therefore invaluable for ensuring that risk plans and care plans are shared.

A model of care may be established in accordance with Section 8: 'Good practice'.

### **Option B: Utilising and integrating existing services**

This is the more practical approach for the majority of prisons.

In this model, primary healthcare, mental health and substance misuse teams meet in order to decide how they can manage the mental health and substance misuse needs of prisoners who have a dual diagnosis.

The system they design should be written up in the form of a clear and straightforward protocol. This protocol should include statements on each of the following:

#### **1. What is dual diagnosis?**

Establishments may wish to adopt the four definitions from page 2, or generate their own definitions.

#### **2. What is the most practical way of providing care to patients/clients from each of these four categories?**

These care pathways will make up the majority of the protocol. They should address methods of assessment, referral, joint care planning, care reviews, and arrangements for release from prison. Outside agencies benefit from being invited in to help with pre-release planning at an early stage, and to begin the process of engagement with the individual.

#### **3. Confidentiality**

What information may be shared between treatment teams? What information may be shared with outside agencies (see Appendix A: Guidance on consent and confidentiality). This is a vital issue and needs clear guidelines. Frequently, outside agencies are given insufficient information due to unhelpful boundaries on confidentiality.

#### **4. Who co-ordinates care?**

How is a CPA Care Co-ordinator chosen? How does their role link with the other IDTS and community services? How is self-harm and suicide risk managed across teams? (*ACCT: Assessment, Care in Custody and Teamwork*, PSI 18/2005).



### 5. How will training and supervision be provided?

Can reciprocal training be arranged, with drug treatment team members providing substance misuse advice and training to healthcare and mental health staff members, and mental health specialists offering advice and training to substance misuse and general health practitioners? Can a local dual diagnosis specialist be brought in to provide joint training and supervision?

### 6. What will be the model of care?

This will be explored in Section 8: 'Good practice'.

### 8. Good practice

The most important elements of good practice in the care of patients with dual diagnosis are early identification of need, continuity, specialist skills and flexibility.

#### Early identification of need

On admission for clinical management of dependence, the substance misuse team should be alert to any history of mental health problems (or current mental health issues) which might worsen if detoxification is undertaken. These conditions include psychotic disorders (including schizophrenia and drug-induced psychosis), bipolar affective disorder, clinical depression, behavioural problems or any symptoms that a patient states have worsened when he/she has stopped taking drugs or alcohol in the past.

Mental health assessment should be readily accessible as part of the reception function, i.e. a reception nurse in primary care is able to pass patients with a positive mental health screen to a mental health trained practitioner immediately as part of the initial assessment. This way prisoners will be allocated to the right location from the outset, to receive the immediate care identified by the practitioner.

Mental health assessment is a complex process. Accuracy is of high importance to ensure that the prisoner gets the most appropriate treatment as soon as possible. Assessors should have training and expertise in physical health, mental health and substance misuse. With regard to mental health they would need expertise across Axis I (mood disorders, psychotic disorders, anxiety disorders) and Axis II (personality disorders) as well as the interactions between substance use, physical health and cognitive ability. Assessment should lead onto formulation, which is the process by which an understanding is reached of the ways in which individual factors combine to create problems that a detailed care plan should address.

As part of any dual diagnosis service, practitioners and commissioners should optimise access to psychological therapies for offenders with mental health problems (NHS, 2009).

#### Safe prescribing

It is vital that systems are in place for reviewing prescribing and that these systems ensure that interventions can be made speedily and advice given to prescribers from specialist mental health trained pharmacists.

#### Opiate or benzodiazepine dependence

Opiate-dependent patients arriving in prison custody with serious mental health problems should be stabilised – rather than detoxified – for a minimum period of two weeks. During this time the mental health team should be asked to assess the patient. A plan of care should be made jointly, between the substance misuse team and the

mental health team, taking into account patient choice and the views of other agencies including community services (see Section 9: 'Continuity of care').

As a standard intervention for all other opiate-dependent offenders arriving in prison (including individuals with mild to moderate mental health problems), five days of stabilisation should be prescribed (DH, 2006), during which time ongoing monitoring and assessment will inform the planning of care.

In some cases of co-existent serious mental health problems and opiate dependence, long-term maintenance may be indicated (RCPsych, 2002). If a reduction regime is preferred, this should be at a pace that the patient can manage, agreed by all, and closely monitored by both substance misuse and mental health teams. Any deterioration in the patient's mental state should result in a review of treatment, with consideration of returning to, and maintaining, levels of medication at which the patient was stable; or provision of additional appropriate mental health interventions.

Benzodiazepine withdrawal may cause the emergence of symptoms of psychosis; patients with a previous history of thought disorder may have a greater vulnerability to this effect. In the event of such an episode, substance misuse and mental health teams should review jointly the patient's benzodiazepine (diazepam) reduction regime and monitor the effect of this adjustment regularly. A period of stabilisation may be required before any further reduction in diazepam is considered. Anxiety and self-harm can emerge as a result of withdrawal of benzodiazepines (*Prison drug treatment and self-harm*, PSI46/2005); stabilisation followed by a slower reduction may again be indicated. Chronic benzodiazepine use can also cause ongoing difficulties with cognitive processing and memory, which can last beyond completion of a reduction programme. It is therefore important to assess the ongoing cognitive capacity of individuals after detoxification. Cognitive capacity is relevant to both psychological treatment planning and social and occupational treatment planning in the future.

### Stimulant dependence

Withdrawal from stimulants can cause a brief but sometimes profound depression. This may take anything from one week to several months to resolve as the central nervous system adapts physiologically to the changed chemical environment. During this time a prisoner may be at enhanced risk of suicide or self-harm. If their low mood gives cause for concern, a risk assessment should be carried out in accordance with the prison risk management system (*ACCT: Assessment, Care in Custody and Teamwork*, PSI 18/2005).

It is also important to note that stimulant use is common among those who suffer from chronic boredom or a high stimulation threshold which is common in individuals with a personality disorder, in particular borderline or antisocial personality disorder. Thus, identification of an underlying personality disorder will be important for treatment planning (NICE, 2009a; 2009b).

The management and treatment of self-harm and suicide are complex. A comprehensive assessment and formulation are critical to making plans for appropriate risk management and treatment.

Additionally, stimulant use can cause a psychotic episode ('amphetamine psychosis'). Cessation of stimulant use, sleep and nourishment will usually reverse this problem.

One of the criteria for borderline personality disorder is 'transient psychotic symptoms when under periods of stress'. Stimulants increase stress, so psychotic symptoms need to be carefully assessed as they can be part of amphetamine psychosis, a psychotic disorder or a personality disorder.

As with other substances, the cessation of consumption can lead to a reappearance of a concealed serious mental health problem. Engagement in the integrated drug treatment system psychosocial interventions across the first 28 days of custody (HMPS, 2006) can help to identify emerging problems of this kind.

Some clients in prison value supportive individual and group interventions throughout the early weeks of stimulant withdrawal. Complementary interventions such as guided relaxation and acupuncture have also been regarded as helpful in stabilising mood during this phase. *Integrated Drug Treatment System: the First 28 Days: Psychosocial Support* (NOMS, 2006) describes interventions that are suited for the management of problematic drug use and the psychological impact of withdrawal. These interventions include ones specifically for primary stimulant users.

Placing individuals with dual diagnosis into group treatments needs to be considered carefully. Many people with significant mental health difficulties have had highly traumatic childhoods and recent histories. They are also likely to have some difficulties with socialising. These issues are particularly relevant for those with a personality disorder. Thus, careful and complete assessment and psychological formulation will be important for making decisions about group or individual treatments. It does not need to be a psychologist who makes this decision, but must be a team of people with psychological assessment and formulation skills.

Relapse to severe stimulant dependence on release from prison can raise very substantial health, social and re-offending risks. For this reason, continuity of care is a vital element of any stimulant intervention – including ensuring that community-based services are involved in CPA and release planning, and have an opportunity wherever possible to meet and engage with prisoners well before their release. Continuity of care should include a package of care tailored to the individual which includes substance misuse, health, mental health, and robust social care.

### **Child protection and welfare**

The 'Hidden Harm' report by the Advisory Council on the Misuse of Drugs (ACMD, 2003) stated that parental problem drug use can and does cause serious harm to children at every age, and that reducing harm to children from parental problem drug use should become a main objective of policy and practice. It concluded that effective treatment of the parent can have major benefits for the child, and services and clinicians need to work together to protect and improve the health and well-being of affected children.

The UK guidelines for drug treatment (DH, 2007) state that assessment of drug-misusing parents should take into consideration:

- the effect of drug misuse on functioning, for example, intoxication or agitation;
- the effect of drug-seeking behaviour, for example, leaving children unsupervised, contact with unsuitable characters;
- the impact of the parent's physical and mental health on parenting;
- how drug use is funded, for example, sex working, diversion of family income;
- emotional availability to children;
- effects on family routines, for example, getting children to school on time;
- other support networks, for example, family support;
- ability to access professional support; and
- storage of illicit drugs, prescribed medication and drug-using paraphernalia.

With consent, information should be gathered from other professionals.

Ryan (2008) recommends the following approach by practitioners:

- document whether the patient has childcare responsibilities;
- document information given to the patient when take-home doses are given;
- use integrated care to the fullest extent with patients who are parents;
- involve other professionals at the earliest stage if any concerns arise; and
- follow Area Child Protection Committee or Local Safeguarding Children Board procedures.

### Limit settings

In setting limits, it is very important that they are clear, achievable, fair, appropriate to the desired behaviour and consistently applied. There must also be room for flexibility and an awareness that these limits can change.

As stated above, response to crossing of limits must be applied consistently, in order to avoid the risk escalation of problematic behaviour through intermittent reinforcement.

Fazel and Danesh (2002) found that 65% of male and 42% of female prisoners had a personality disorder. In both groups, antisocial personality disorder was the most prevalent, but there were also high rates of borderline personality disorder. A statistical review of prisons found that:

*"... The most striking association between substance misuse and mental disorder was that between drug dependence before coming to prison and an assessment of personality disorder."*

(Singleton, 1999)

### Specialist skills

Differing levels of skills and knowledge are required to work with people with a dual diagnosis. These vary from core competences, such as the capability to contribute to the delivery of some aspect of care for people with dual diagnosis, to specialist competences, which feature the ability to advise on the planning and co-ordination of care across different services for a wide complexity of need. These capabilities are set out in the dual diagnosis (Hughes, 2006) and personality disorder (NIMHE, 2003) capabilities frameworks.

### Flexibility

The concept of dual diagnosis covers a very broad range of problems of varying intensity. It is important, therefore, that care should be planned on an individual basis, and should consider:

- an individual's readiness for change and engagement with services (this can be improved by using motivational interviewing);
- any current substance misuse and associated risks (from sharing of injecting equipment, for instance);
- a client's social network. This is particularly important in view of the high degree of isolation experienced by this patient group. Vulnerable adults in prison are often poor in social problem solving (Husband, 2008). Specific treatments in social problem solving have been developed;
- meaningful daytime activity which is consistent with a person's level of ability to engage and in line with positive longer-term goals, such as employment or continued education. Occupational therapy models are helpful here;
- sound pharmacological management. This should accord with treatment that the patient has received in the community or (if recently transferred) from a local prison;
- relationship needs: rebuilding relationships with partners and with children; and
- cognitive capacity – Corrigan and Deutschle (2008) found very high rates of traumatic brain injury among those with a co-morbid substance dependence and personality disorder. This will influence ability to re-engage in the community and comply with treatment plans.

# 9. Continuity of care

## Continuity of care on release for clients with mild to moderate mental health problems

This client group will not ordinarily be subject to the Care Programme Approach (CPA). They should have their care continued through two principal routes:

- To ensure continuity of ongoing substance misuse needs, clients should – with their consent – be referred by the CARATs key worker/offender manager to their local drug/alcohol treatment service. For guidance on referral to the local Criminal Justice Integrated Teams (CJITs), please see *Delivery of the Drug Interventions Programme in Prisons* (NOMS, 2006).
- To arrange continuity of mental and general healthcare, clients within this category should be referred to their GP in accordance with PSO 3050 (HMPS, 2006). Where a prisoner who is receiving medical care that needs to continue after discharge does not have an external GP, it is important that healthcare staff help the prisoner to register with one prior to discharge.

## Continuity of care for individuals managed under the Care Programme Approach

Clients whose care is planned and co-ordinated within the CPA, and who also have ongoing substance misuse needs, will require the care co-ordinator to take the lead for release planning, in direct contact with the community mental health team in the patient's home area (DH, 2002).

In the case of existing Drug Interventions Programme clients, CJITs and the local drug/alcohol services will need to be advised of forthcoming release but should not be regarded as the lead agent for release planning in view of the pre-eminence of enhanced mental health care needs. (For further advice for CJITs, see Drummond, 2008.)

Continuity of care for people with a dual diagnosis involves the forging of strong links with a patient's home Community Mental Health Team and with the client's Community Drug Team. The CPA will need to address needs across a wide range of provision: social care, housing, financial needs, reintegration into social networks, training, education and employment.

It is important to be aware that in the community, the local mental health service has the main responsibility for co-ordinating the care of patients with a dual diagnosis involving the CPA:

*'The statutory mental health sector has the responsibility for co-ordinating and providing a multi-agency approach to people with co-morbidity.'*  
*Substance Misuse and Mental Health Co-Morbidity*  
*(Dual Diagnosis) Health Advisory Service (2001)*

Clear and detailed commissioning is required to ensure that all parties understand their responsibility towards people in prison with a dual diagnosis.

Many establishments already have active working relationships with both local mental health and local drug service providers. Mental health trusts may provide secondary (i.e. specialist) psychiatric services to prison residents, or a local community drug service (which has an established working relationship with their local mental health trust) may also be providing drug treatment services in the prison. In these circumstances, arrangements for joint working may be relatively easy to achieve.

Patients received into prison with an existing CPA will have that CPA continued (DH, 1999b). In these cases, the mental health team within the establishment will discuss with the community mental health team (CMHT) which service (i.e. the mental health team in prison or the CMHT) will provide a care co-ordinator.

For patients who have no history of mental health treatment, but who demonstrate evidence of severe mental illness, the mental health team within his or her establishment will need to initiate the CPA when appropriate. Representation should be sought from the patient's home mental health service (CMHT or child and adolescent mental health service (CAMHS)), and this community team will be involved in the planning of all subsequent care.

While in prison, where there is less ready access to illicit drugs, a patient's mental state may appear stable. A relatively low-stimulus environment such as prison can further mask existing mental health problems. The release care plan (or plan for transfer to a less secure prison) needs to take into account the previous history of substance misuse, as the patient may be liable to return to problematic drug and/or alcohol use on release. Planning should take account of any risk that may accompany a return to drug use, including reactivation of previous mental health problems.

For guidance on the transfer of prisoners under the Mental Health Act, see *Procedure for the transfer of prisoners to and from hospital under sections 47 and 48 of the Mental Health Act 1983* ([www.dh.gov.uk/assetRoot/04/12/36/31/04123631.pdf](http://www.dh.gov.uk/assetRoot/04/12/36/31/04123631.pdf)).



# 10. Therapeutic issues

## Dependence

Street drugs are usually psychoactive drugs that have effects on the mind. Rapid withdrawal from drugs of dependence can upset a patient's mental equilibrium, heightening their risk of impulsive self-destructive behaviour. It is therefore recommended that a patient coming into custody with complex needs should be provided with clinical treatment to stabilise their withdrawal from opiate or benzodiazepine dependence. Consideration should be given at this early stage to the indication for opiate maintenance. DH (2006) recommends that anyone entering prison custody as a current stimulant user should be monitored for any sudden lowering in mood for the first three days of custody. Additionally, heavy stimulant use carries a risk of cardiac or cerebrovascular events. For this reason, monitoring should include blood pressure and neuro-observation as well as evaluation of mood.

Details should be established of the planned care provided by the patient's community mental health and dual diagnosis services prior to custody. The patient's informed wishes and the advice of community providers should be taken into account when clinical substance misuse care is planned. If detoxification is the preferred action, the opinion of the Royal College of Psychiatrists is that a gradual reduction programme would be in the patient's best interests (RCPsych, 2002). Simultaneous provision of full psychosocial support is a very important component of planned care (HMPS, 2006).

## Complications of withdrawal

Some patients undergoing detoxification may show no signs of mental disorder until they reach an advanced stage in their detoxification programme. Timely and measured clinical intervention may help to contain these developing problems (see Section 8: 'Good practice').

Depression can be a negative consequence of withdrawal – this may take some time to improve, and may require psychological and pharmacological interventions.

Sleep disturbance is also common for a period after detoxification has completed and may only gradually improve. Insomnia can lead to increases in depression, anxiety and paranoia.

## Drug interactions

Individuals who are prescribed psychotropic drugs for the management of a serious mental health problem can experience side-effects, some of which can be distressingly marked. Psychotropic medication can also interfere with other prescribed drugs, making both delivery of effective medical treatment and compliance with that treatment difficult to secure. Regular review of prescribed medication is important to guide clinicians to the best prescribed care for the patient.

### **Compliance with planned treatment**

As previously mentioned, clients with complex needs are among the most social disadvantaged of our citizens. Many may have had negative past experiences of mental health services, drug treatment or social care, causing them to have a deep suspicion of the intentions of formal services. A sense of stigma may compound resistance to engage with treatment services. Sensitivity to these potential issues is a vital element in the construction of a care model. Engagement skills are an important means to enhance treatment compliance.

### **Planned care**

As previously stated, clients with a serious mental health problem will need to be provided with care under the CPA. All care plans (whether under the CPA or not) should be negotiated with the client; this procedure may help to engender trust on the part of the client.

### **Safer custody**

Dual diagnosis clients have a higher than average risk of suicide (DH, 2002). Care of clients should be planned with this vulnerability in mind. Risk assessments should be made in accordance with the at-risk procedures in place at the individual prison (i.e. the ACCT system). Close and continued communication between residential, health and substance misuse teams is essential to the best management of risk. To help reduce risk through an individualised care approach, it is important that representatives from as many disciplines as possible attend or contribute to ACCT case reviews.

### **Histories of abuse**

In view of the high prevalence of sexual abuse in the personal histories of this client group, some therapeutic work around sexual abuse survival may be indicated.

This work has to be carefully planned and conducted. Significant problems arise when interventions for childhood abuse are undertaken poorly or not fully completed. This leaves the individual with recurring memories and extremely painful thoughts which significantly increases the risk of either self-harm or relapse to damaging substance use. This work requires a trusting relationship with the therapist and a considerable length of time. If there is a possibility of prison transfer or discharge coming up, it is best to let this issue wait for a community team who can spend the time building a trusting relationship and working on the issues. It is also important to note that other forms of abuse are also highly damaging, in particular emotional abuse.

Safer sex education may also be required. Clients who have been involved in sex work will also need training, education and employment work to provide a viable alternative to prostitution.

## Physical health and well-being

People with complex needs have limited opportunities to pay attention to their physical health. This client group can be helped greatly by a health check and management plan to address oral health, smoking, hazardous and harmful drinking, diet, anorexia or obesity.

Individuals with mental health problems rarely come across the option to be tested for blood-borne viruses and to get treatment should they need it. While they are in prison this would be an ideal opportunity. Vaccination against both Hepatitis A and B should be offered. High-quality psychological care is essential for both pre-test and post-test counselling.

Sexual health work is also important for this client group. This incorporates discussion of the risks associated with unprotected sexual activity, screening and access to treatment for sexually transmitted diseases. Again, skilled pre- and post-test counselling is required. Staff should make clients aware of how they can access condoms, dental dams and water-based lubricants within the prison.

## Harmful levels of drug use

Substance misuse workers, by virtue of their training and professional experience, may regard low or moderate drug use as non-problematic. While this is true for the great majority of substance users, for people with serious mental health problems relatively small and infrequent consumption of drugs such as cannabis or amphetamine can have profoundly detrimental effects.

## Black and minority ethnic clients

People of Afro-Caribbean ethnic origin are far more likely to be diagnosed as suffering from schizophrenia than are British White people. A black person is also more likely to be imprisoned in the UK than a white person. These facts combine to create a substantial need for services that can address the needs of this particularly disadvantaged group (HM Prison Service PSO 2800; Race Relations (Amendment) Act 2000).

Access to prison drug services by black and minority ethnic (BME) prisoners is often very limited. Clinical teams should therefore monitor the utilisation of their service by this particularly disadvantaged group.

Ongoing links with local community organisations should be developed to help make services more approachable. Areas that could be addressed to help BME patients include:

- active BME staff recruitment (Race Relations (Amendment) Act 2000);
- active BME prisoner recruitment for Prisoner Advisory Drug Services (PADS);
- staff training programmes;

- the formulation and display of an anti-discriminatory policy in alliance with prison race relation teams (HM Prison Service PSO 2800);
- compilation of a directory of BME community services including all faith groups;
- links with interpreter services;
- culturally relevant health promotion subject matter and materials;
- particular regard to confidentiality issues; and
- establishment of specialist stimulant (i.e. crack) treatment teams.

Further guidance on the successful engagement of BME drug users and the equitable delivery of services to people with diverse needs in prison can be found in *Making Equality Real* (NOMS, 2008).

### Securing help from other providers

Clients with complex needs require co-ordinated help from a broad range of services. Referrals to a wide variety of organisations should be possible, including:

- housing
- social support and ancillary services
- benefit advice and legal advice
- employment
- leisure.

The care co-ordinator should act as the central point of referral and information.

### Stigma and shame

Stigma and consequent shame of mental illness can be a substantial problem for individuals, particularly those in prison. Shame brings with it the urge to 'hide'; for many individuals the emotion may be so great that lashing out at others, or even death, seems the only escape. However, close observation may only serve to increase shame. Therefore institutions need to consider how to manage the balance between safety and exacerbation of problems. Also, for many individuals with a personality disorder, close proximity to other people can be both frightening and painful. Thus close observation and regular questioning (by well-meaning staff) can be distressing and could lead to an escalation of attempts to escape (through harm to self or aggression/violence).

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# Appendix A: Guidance on consent and confidentiality

## The sharing of confidential information

The general principle for the sharing of information within the Integrated Drug Treatment System is that:

*“Any information required to provide adequate continuity of drug treatment should, with the client’s informed consent, be shared between CARATs and healthcare teams and with partner services such as Criminal Justice Integrated Teams, community drug treatment providers and Probation offender managers.”*

*Integrated drug treatment in prisons plan 2009/10: Guidance notes*  
(National Treatment Agency for Substance Misuse 2008)

It is essential that at each point of contact where information is to be shared between agencies/service providers, client confidentiality is observed. When consent is sought from a client, s/he must be informed about the uses to which the information will be put. Informed consent can be seen as having been gained when the client has been given sufficient and suitable information and is able to understand and assess the risks of participation. Substance dependence or the experience of withdrawal symptoms are not necessarily impediments to consent to share information, but the timing of a request for consent should be considered for newly arrived prisoners who display cognitive impairment that may be related to acute intoxication or withdrawal.

Through the assessment process and use/completion of the Drug Interventions Record (DIR) as appropriate, CJIT workers will gain from clients prior to entry into custody written informed consent to share information from their assessment (to facilitate continuity of care) with the IDTS (CARATs/healthcare) team in prison. IDTS (healthcare and CARATs) teams will need to ensure that they, too, gain informed consent at the appropriate stages in their clients’ period of treatment.

The legal contexts for both consent and confidentiality in relation to drug treatment in prison are set out below.

## Legal context: Consent to treatment

The law presumes that an adult (a person aged 18 and over) has the capacity to take their own healthcare decisions unless the opposite is proved. It is important not to underestimate the capacity of a client with a learning disability to understand. Many people with learning disabilities have the capacity to consent if time is spent explaining the issue to the individual in simple language, using visual aids and signing if necessary. Further guidance on this is set out in the Department of Health’s booklet *Seeking consent: working with people with learning disabilities* (DH, 2001).

*“Seeking consent should usually be seen as a process, not a one-off event. People who have given consent to a particular intervention are entitled to change their minds and withdraw their consent at any point if they still have the capacity (are ‘competent’) to do so. Similarly, they can change their minds and consent to an intervention that they have earlier refused. It is important to let each person know this, so that they feel able to tell you if they change their mind.”*

*Seeking Consent: Working with People in Prison (DH, 2002)*

### Legal context: Disclosure of information

There is a range of statutory provisions that influence the way in which client information is used or disclosed. Details of these can be found on the Department of Health website at [www.dh.gov.uk](http://www.dh.gov.uk).

The key principle of the common law of confidentiality is that information confided should not be used or disclosed further, except as originally understood by the confider, or with their subsequent permission.

While judgements have established that confidentiality can be breached ‘in the public interest’, these have centred on case-by-case consideration of exceptional circumstances.

Under common law, staff are permitted to disclose personal information (for instance, to a probation officer) in order to prevent and support detection, investigation and punishment of serious crime and/or to prevent abuse or serious harm to others where they judge, on a case-by-case basis, that the public good that would be achieved by the disclosure outweighs both the obligation of confidentiality to the individual client concerned and the broader public interest in the provision of a confidential service.

Guidance for professionals on factors that may be considered in such judgements is provided by professional regulatory bodies such as the General Medical Council, the Nursing and Midwifery Council and the Royal Pharmaceutical Society of Great Britain ([www.rpsgb.org/protectingthepublic/ethics/](http://www.rpsgb.org/protectingthepublic/ethics/)).

**The Data Protection Act 1998** imposes constraints on the processing of personal information in relation to living individuals. It identifies eight data protection principles that set out standards for information handling. In the context of confidentiality, the most significant are:

- Principle 1, which requires processing to be fair and lawful and imposes other restrictions;
- Principle 2, which requires personal data to be processed for one or more specified and lawful purposes; and
- Principle 7, which requires personal data to be protected against unauthorised or unlawful processing and against accidental loss, destruction or damage. It also provides for an individual’s right of access to personal data.



Within the Human Rights Act 1998 there is a requirement that actions that interfere with the right to respect for private and family life (e.g. disclosing confidential information) must also be justified as being necessary to support legitimate aims and be proportionate to the need.

Current understanding is that compliance with the Data Protection Act 1998 and the common law of confidentiality should satisfy human rights requirements (*NHS Code of Practice: Confidentiality* (DH, 2003), [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4069253](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069253)).

Where a client has been identified as at risk of self-harm/suicide, information that is relevant to ensure appropriate care and support must be shared with the ACCT Case Manager. Information on the client's needs and proposed/existing drugs interventions should be provided at ACCT case reviews.

**As both healthcare and CARATs teams operate within the same legislative consent and confidentiality framework (i.e. the Data Protection Act 1998, the Human Rights Act 1998 and the common law of confidentiality), any information required to provide adequate drug treatment should, with the client's informed consent, be shared between CARATs and healthcare teams.**







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