

HAS

The Health
Advisory
Service

**Substance Misuse and
Mental Health Co-Morbidity
(Dual Diagnosis)**

Standards for
Mental Health Services

First Edition Summer 2001

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The Health
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Substance Misuse and Mental Health Co-Morbidity
Dual Diagnosis
Treatment and Care Standards

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Mental Health Services

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Introduction and Background

*The problem of substance misuse is now in a central position in mental health services and cannot continue to be the domain of a distant speciality*¹ (L. Appleby, 2000)

Introduction

The association between substance misuse and psychological symptomatology has frequently been mentioned in the literature. Evidence now suggests that drug and/or alcohol misuse among patients with mental disorders must be considered as usual rather than exceptional. However, it is widely acknowledged that the provision for mental health and substance misuse co-morbidity in the UK is, at present, not satisfactory.²

The importance of the development of quality services for people with co-morbidity cannot be stressed too strongly. Research shows, amongst other things, that treatment for substance problems often ameliorates psychiatric and mental health problems.³ Substance-misuse treatment is also associated with decrease in substance use, decreased injecting behaviour and thus a reduction of the risk of HIV and hepatitis transmission, and improvements in other related forensic, psychological and physical problems. Interventions for people with co-morbidity are also likely to be cost-effective: the healthcare costs of untreated cases are higher than for those treated.³

Target Audience

This document provides evidence-based standards and illustrative criteria pertaining to the commissioning and delivery of services for patients with mental health and drug and/or alcohol misuse co-morbidity. The standards are aimed primarily at mental health services and professionals, and specifically at adult mental health. Issues pertaining to child and adolescent mental health⁴ and to mental health services for older people are referred to in this document but are not discussed extensively, and further work is recommended.

These standards are not aimed at substance-misuse services, and the development of standards specifically targeted at them is recommended. However, many of the factors identified in this document are also applicable to specialist alcohol and drug treatment and care services. In particular, the standards identify issues pertaining to cross-boundary commissioning between mental health and substance misuse, and to joint working.

Purpose of the Standards

The present standards have been developed as a tool for service development and the development of commissioning practice, as well as an instrument for peer review. They were developed to support the work of the Health Advisory Service (HAS), specifically, the 'Comprehensive Reviews' and 'Focused Reviews' of mental health services and 'Evidence Based Service Development Programmes'. The standards are therefore to be used in conjunction with the other HAS and Substance Misuse Advisory Service (SMAS) standards.⁵

The standards have also been developed to provide guidance to local areas who wish to develop their practice without the systematic support of HAS or the expertise of peer-review teams. In these cases, local areas are encouraged to adopt the

assumption and principle advocated by HAS that guidance and standards must be dynamic ‘drivers’ for change, and that the implementation of change must be central to any standards and practice guidelines.

These standards, and the illustrative criteria in particular, should not be used in a restrictive and directive fashion. Standards and criteria should *not* be used as imposed targets, stifling a sense of local ownership and control, and blocking change rather than encouraging it. Care must be taken to ensure that they are used flexibly and are adapted to local conditions. Any service or practice development has, first and foremost, to be based on local needs, and must include all stakeholders in the process, including service users and carers.

Meeting the Standards at Local Levels

In recent years a number of Trusts have developed services for people with substance misuse and mental health co-morbidity. But in the majority of areas, services aimed at these patients remain underdeveloped, and some organisations will find it more difficult than others to meet these standards.

All the standards have been developed to be achievable. They have *not* been developed as a test or for inspection, but as a tool for service development. The standards identify good practice which organisations should work towards. Meeting these standards will often be an incremental process that requires targeted resources, including resources for training and skills development, and for the development of shared care and partnership working.

Terminology and Definitions

This document uses the term co-morbidity to indicate the co-occurrence of symptoms of two or more disorders, although it is acknowledged that this term ‘may not sufficiently capture the complex interactions between substance misuse and psychiatric disorders’.⁶ Co-morbidity is often referred to as ‘dual diagnosis’.

There is no agreed definition of co-morbidity or dual diagnosis. Krausz⁷ suggests that there are four categories of dual diagnosis:

- Primary diagnosis of a major mental illness with a subsequent (secondary diagnosis) of substance misuse which adversely affects mental health.
- A primary diagnosis of drug dependence with psychiatric complications leading to mental illness.
- A concurrent substance misuse and psychiatric disorder.
- An underlying traumatic experience resulting in both substance misuse and mood disorders, for example post-traumatic stress disorder.

It is crucial to remember that the distinction between ‘primary’ and ‘secondary’ diagnosis is not always clear. Mental health and specialist substance-misuse services should not use the identification of a primary diagnosis as a smoke screen to exclude patients from services.

The nature of the relationships between mental disorders and substance misuse are complex for the following reasons:

- Substance use (even one dose) and withdrawal from substances may lead to psychiatric syndromes or symptoms.
- Intoxication and dependence may produce psychological symptoms.
- Substance use may exacerbate or alter the course of pre-existing mental disorder.
- Primary mental disorder may precipitate substance use disorder, which in itself may lead to psychiatric syndromes.⁸

Policy Context

Central guidance has recommended the development of a national strategy on co-morbidity.⁹ The Department of Health is currently developing national guidance, including a working definition of co-morbidity or dual diagnosis. This document does not provide an alternative definition. What is recommended here is that, until the development of a central definition, shared and agreed definitions are developed by health and social care services at local levels.

Current government policy on the treatment and care of people with substance misuse and mental health co-morbidity is identified in the National Service Framework for Mental Health.¹⁰ This clearly states that the needs of this client group are a mainstream responsibility for mental health services. Other guidance also argues that in order to minimise the possibility that co-morbid patients may be excluded from mental health and substance-misuse services, provision must be made for them as part of mainstream mental health services.¹

The government's drug misuse strategy is outlined in *Tackling Drugs to Build a Better Britain*.¹¹ This strategy emphasises the central importance of primary, secondary and tertiary prevention, and seeks to integrate efforts across central government departments. Guidance on treatment has also been developed and includes the Department of Health's *Drug Misuse and Dependence: Guidelines on Clinical Management*.¹² An alcohol-misuse strategy is currently being developed.

Evidence Base

The present standards are evidence-based, and have been derived from research findings. The available literature provides broad principles to inform our responses to co-morbidity.

However, there is to date only limited evidence concerning the efficacy of treatment interventions for people with co-morbidity in the UK. In particular, there is no UK evidence on what model of care is most effective, and information is not available to inform decisions about models of service delivery nationally.¹³ There is also a lack of definitive evidence on what works with the various populations.

The bulk of research on co-morbidity has been conducted in the USA, and there is a danger of over-relying on evidence that has been generated in North America. Important differences exist between the UK and US health and social care systems, including a different funding system, even of publicly accountable services, and the fact that healthcare in the USA is not rooted in primary care, as is the case in this country.

A number of research studies on co-morbidity are currently being undertaken in the UK and will inform practice. But until these research findings are peer-reviewed and published, the implementation of evidence-based interventions remains difficult.

Existing reviews of approaches for the delivery of treatment and care for people with co-morbidity have detailed the three main models discussed below. These different models often exist within a same area and across out-patient facilities, community teams, in-patient facilities and residential settings such as rehabilitation or hostels. The main service-delivery models have been described as follows.¹⁴

- 'Serial' treatment models, where psychiatric and substance-use disorders are treated consecutively with little communication between substance-misuse and psychiatric services. It is argued that serial models with separate treatment services are not appropriate in the majority of cases. Patients tend to be shunted between services that are inadequate to meet their needs. Moreover, some argue that many substance-misuse services are insufficiently supportive of this group, as they place emphasis on client motivation and personal responsibility.

- ‘Parallel’ models, where substance-misuse and mental health services establish liaison to provide the two services concurrently. Some NHS trusts have set up specific liaison posts between psychiatry and substance misuse to facilitate patient assessment and referral. In other trusts, while there is nominal commitment to such a model, the practical representations of such a service are not satisfactory and ‘liaison may also be a recipe for passing the buck’.¹³ It has also been noted that substance-misuse and mental health services may operate referral criteria that specifically exclude co-morbid patients, particularly in the residential rehabilitation sector. Some commentators argue that improved liaison and communication is not a panacea: the medical model of psychiatry contrasts with the psychosocial orientation of substance-misuse services.
- ‘Integration’ models: clinical experience emerging from the USA suggests that the successful treatment and management of dual diagnosis disorders is best achieved through an integration of substance-misuse and psychiatric treatment.¹⁵ It is increasingly argued that integrated treatment specifically for co-morbidity must underpin an approach based on assertive community treatment, and that specific interventions must provide treatment for both types of disorder without cross-referral to other agencies. Evidence also suggests that clinical teams must provide a treatment approach that incorporates motivational and behavioural interventions, relapse prevention, pharmacotherapy and social approaches. In the USA there is now a marked trend to generate a new speciality of dual diagnosis psychiatry, with staff, facilities and services especially dedicated to this client group.¹⁶

There is, nonetheless, no clear evidence that adoption of such a model by UK services will be effective. It has been argued that the momentum for integrated treatment programmes is not yet based on robust evidence.¹⁵ Some UK commentators fear that integrated services may become too specialised and separate, and could add to the stigma, and other problems such as poor links with other services and problems of geographical (mainly urban) focus.

Adopting a Model of Service Delivery

A Cochrane Systematic Review¹⁷ considers all trials of substance-misuse treatment for people with severe mental illness and current substance misuse, and concludes that there is no clear evidence supporting the advantage of any model over the others.

These standards do not recommend any particular model of service delivery, as evidence for the efficacy of the various service models in the UK is currently limited. Decisions on models to be adopted or adapted at local level must be made at local level. These standards aim to provide sensible suggestions on best practice based on the available evidence, regardless of what models are adopted locally.

Physical Ill-Health Co-morbidity

Although these standards focus on substance misuse and mental health co-morbidity, many patients also face physical ill-health. This is outside the confines of this document. Suffice to say that any comprehensive assessment and management of patients with substance misuse and mental health co-morbidity should also look at a range of substance misuse-related problems. Commissioners and providers should also consider how these medical needs could be addressed by the mental health system. Resources should be in place to in-reach to medical wards, Accident and Emergency departments and, crucially, to provide liaison and support to primary care.

There is now evidence that the majority of substance misusers in the UK are polydrug users¹⁸, and that the chaotic lifestyle of many contributes to ill-health and other problems. Smoking-related disorders are highly prevalent in mentally ill and substance-misusing populations. Among a range of other problems, drug misusers may suffer from venous or arterial thrombosis caused by poor injecting techniques; blood-borne infections (HIV, hepatitis B and C); and endocarditis. Problems relating to the use of stimulants include cardiac disorders, cerebrovascular accidents, convulsions and seizures, effects on the gastro-intestinal system, renal disorders, and respiratory disorders such as ‘crack lung’ – pneumonia which fails to respond to standard treatment – pneumothorax, interstitial pneumonitis, subcutaneous emphysema and bronchospasm. Alcohol-related problems include seizure

and alcoholic delirium, Wernicke's encephalopathy, Korsakoff's psychosis, and so on.^{12,19} It is also important to note that the access to, and use of, primary care by mentally ill and substance-misusing populations is poor, with limited uptake of preventive screening interventions despite high risk.

It has also been noted in clinical practice that many people with co-morbidity have significant organic neurocognitive brain impairment, secondary to both mental illness and substance misuse. Many patients have five- to six-axis morbidity: physical, psychological, substance-misuse problems, neurocognitive impairment, personality development and post-traumatic stress disorder issues. Other common problems faced by these patients include legal and a range of social problems.

Gaps in Standards

There are a number of important issues that are not tackled by the present standards.

Issues pertaining to the care and management of people with personality disorders are not sufficiently identified because of the limited existing evidence to inform response. This is regrettable, as personality disorders in association with major mental illness and substance misuse are common. Currently in the UK exclusion from services on the grounds of personality disorder is a common mistake: an assessment diagnosis is often made on the basis of social history, rather than a careful assessment of mental state.¹ It is important that services develop skills to address this diagnosis access.

The present standards have been developed to focus on the care of people with co-morbidity who are managed within the mental health system. They do not address the needs of people who do not have clear mental health diagnoses and who are not managed by, nor engaged with, mental health services or substance-misuse services. Some commentators argue that individuals with these characteristics may be at high risk of self-harm and harm to others.²⁰ Further research on this group is recommended.

These standards do not tackle issues pertaining to tobacco smoking and smoking cessation; misuse of prescription and over-the-counter medication; or the use of solvents or volatile substances. It is also recommended that such work be developed.

Structure of Standards

The standards on co-morbidity are organised at four levels, along the same lines as the rest of the Health Advisory Service Standards.⁵ These levels may mirror the organisational structures within which services operate. They are:

- Level One: commissioning, planning and integration (where the main agent, or the person to implement the standards, is the commissioner)
- Level Two: inter- and intra-agency organisational issues (where the main agent is the senior manager)
- Level Three: organisation of care (where the main agent is the service manager)
- Level Four: service delivery (where the main agents are the frontline staff).

STANDARDS FOR MENTAL HEALTH AND SUBSTANCE MISUSE CO-MORBIDITY

Level One: Commissioning, Planning and Integration

Needs Assessment/Service Mapping

1 Commissioners and providers are aware of the nature and scale of the problem so that resources are targeted appropriately.

- a) The needs of people with mental health and substance-misuse co-morbidity are explicitly addressed by population needs assessment focusing on substance misuse and on mental health.
 - (i) Needs assessment exercises consider among other factors:
 - prevalence and incidence
 - gaps between existing and required service provision
 - effectiveness and cost-effectiveness of treatment interventions.
- b) Local audits are undertaken with frontline staff to establish their experience of the difficulties in working with the client groups and the gaps in resources.
- c) Local service audits are undertaken to establish whether the operational policies and exclusion criteria of mental health services and drug and alcohol services exclude patients with co-morbidity from treatment and care.²¹
- d) Reviews are undertaken of the appropriateness of the level of resources allocated to meet the needs of this group.
- e) Needs assessments consider the ethnic and social diversity of local populations and the particular needs of black and minority ethnic people.
- f) Users and carers are consulted in the needs assessment process.

Strategic Planning/Strategy Formulation

2 Mental health and substance-misuse co-morbidity is taken into account in the planning of mainstream mental health services.

- a) A multi-disciplinary group involving relevant organisations has developed a strategy for commissioning services for people with co-morbidity.
 - (i) There is a group of relevant stakeholders who consider and document how to ensure that patients with co-morbidity do not fall through gaps in service provision and how to maximise the use of the Care Programme Approach and care planning and management.
 - (ii) There are explicit, clear and shared operational criteria for co-morbidity which promote better access to services and treatment.
 - (iii) Co-morbidity services are part of the Local Implementation Plans. They are established as a long-term part of the system, not a short-term, dispensable bolt-on.

3 Commissioning is based on clear and shared operational criteria for co-morbidity assessment, care pathways, risk minimisation and risk management.

4 Until the development of a definitive definition of co-morbidity by the Department of Health, all stakeholders at local levels agree shared definitions.

- a) There is a 'broad, unrestricted definition' that encompasses drug and alcohol problems and a wide variety of mental health problems, including personality disorders and 'minor' psychiatric disorders and psychological distress.
- b) There is a 'restricted definition' that focuses on severe and enduring mental illness and severe dependent drug misuse.
- c) There is a common language for communication between commissioners of substance misuse and the commissioners of psychiatric services.

Relations with Drug (and Alcohol) Action Team

5 Planners and commissioners of mental health services work with the Drug (and Alcohol) Action Team (DAAT) to ensure that there is a co-ordinated approach to the strategic planning of services for people with co-morbidity.

- a) There is a shared and coherent strategy on the treatment of people with co-morbidity.
- b) The needs of people with co-morbidity are explicitly identified in the DAAT strategy.
- c) Resources are identified by the DAATs and substance-misuse joint commissioning groups for work with people with co-morbidity.²²

Co-ordinated Approach to Commissioning

6 There is a co-ordinated approach to the commissioning of mental health and substance-misuse services to ensure that the treatment of people with co-morbidity is adequately funded, although funding for mental health services and substance-misuse treatment comes from different streams.²³

- a) Mental health planners and commissioners establish working relations with the substance-misuse Joint Commissioning Group.
- b) Collaborative arrangements are in place between mental health and substance-misuse commissioners to ensure a co-ordinated approach.
 - (i) There is consultation between commissioners and relevant agencies before decisions about spending are finalised.
 - (ii) Commissioners keep their colleagues informed of:
 - the nature of the services to be purchased
 - the level of activity expected
 - contracting/service agreement plans and service specifications.

Purchasing Decisions

7 There are clear purchasing arrangements for giving specialist care to people with drugs and/or alcohol misuse and mental health co-morbidity.

- a) Commissioners purchase services combining interventions that are successfully used when disorders occur separately.
- b) Interventions purchased demonstrate that they address treatment strategies and patient motivation.
- c) Both statutory and voluntary sector organisations with relevant expertise are funded to work with patients with co-morbidity (outreach and treatment).
- d) Interventions purchased demonstrate competence in working with the social and ethnic diversity of the population.

8 Local Authorities commission residential rehabilitation and supported housing for people with co-morbidity.

Funding/Resource Allocation

9 Secure and long-term funding is available across the statutory and voluntary sectors for work with people with co-morbidity.

- a) Resource allocation takes into account the high costs associated with the treatment of people with co-morbidity.
 - (i) Funding takes into account the fact that people with a co-morbidity problem use many more health and social care resources than those with a single disorder.
 - (ii) Funding takes into account the fact that people with psychosis and substance-misuse co-morbidity are heavy users of psychiatric inpatient care.
- b) Appropriate resources are identified for the care of people with personality disorders and substance-misuse co-morbidity.
- c) Investment is made in an appropriately skilled workforce, trained in a range of treatment modalities.

Contracts and Service Specification

10 Contracts with providers and service specifications explicitly address co-morbidity.

- a) Contracts and service specifications for mental health services identify and respond to problems of combined psychiatric illness and substance misuse.
- b) Contracts and service specifications identify what services provide for people with substance-misuse and mental health co-morbidity:
 - (i) varying degrees of direct support
 - (ii) support from other agencies.
- c) Contract monitoring explicitly addresses the needs of people with co-morbidity.

Monitoring

11 There are explicit monitoring requirements agreed with providers, and included in service agreements and specifications.

- a) Commissioners and providers monitor the following:
 - (i) Input objectives (based on agreed local definitions of priority groups).
 - (ii) Activity monitoring.
 - (iii) Outcome monitoring (including engagement/retention in services and treatment outcome):
 - Treatment outcomes are measured along three outcome domains:
 - illicit drug use, prescribed drugs, problematic alcohol use
 - physical and psychological health/mental health
 - neurocognitive function
 - social functioning and life context.
 - Commissioners take into account the fact that people with co-morbidity have less favourable prognosis in comparison with people with psychosis only.
 - Commissioners take into account that people with co-morbidity have a less favourable substance misuse-related prognosis than do those with uncomplicated substance-misuse problems.²⁴
 - Commissioners are aware that a diagnosis of personality disorder, especially antisocial personality disorder, has been associated with adverse substance-misuse outcomes.
 - (iv) Costs.
 - (v) Process is evaluated, where relevant.

- b) Service specifications emphasise compliance with central reporting requirements, including the National Drug Treatment Monitoring System.
- c) Where joint purchasing takes place, commissioners agree on monitoring arrangements.
- d) Users and carers are involved in the ongoing monitoring and evaluation process.

Public Health Strategy

12 Co-morbidity is identified in the public health strategy and report of the Director of Public Health.

- a) The public health strategy for preventing homicide, suicide and self-harm explicitly identifies the commitment of local organisations to address alcohol and drug misuse, as well as mental illness.

Users and Carers

13 Service users, carers and families are consulted in service planning and commissioning.

Level Two: Inter- and Intra-agency Organisational Issues

Liaison

14 There are mechanisms for liaison between mental health and substance-misuse services, regardless of what model of service delivery exists locally.

- a) There are named consultants involved in co-morbidity and/or other named staff with responsibility for liaison.
- b) Resources and staff time are allocated for the development of liaison.
- c) The mental health Care Programme Approach and the substance-misuse Care Co-ordination Approach underpin liaison.
- d) There are properly defined channels of communication on a regular basis between substance-misuse treatment and mental health services.
- e) Mental health and substance-misuse services establish a common language for successful communication.
- f) There are management policies and protocols for working with people with co-morbidity shared by mental health and specialist substance-misuse services in the statutory and voluntary sectors.
- g) Accessibility to staff (by staff) at many levels.
- h) Regular case conferences, where relevant.
- i) Where relevant, joint high-risk MAPP panel meetings and high risk Care Programme Approach risk assessment and management meetings.
- j) Joint clinics between general psychiatrists and addiction specialists, where relevant.
- k) Joint training events and programmes (to include voluntary agencies where appropriate).
- l) Other (for example regular case presentations, educational meetings, journal clubs, joint research seminars, joint research projects).

15 There is liaison between the whole range of mental health services and substance-misuse services.

- a) There are systems of liaison between general psychiatry and substance-misuse services.
- b) There are systems of liaison between psychology services and substance-misuse services.
- c) There are systems of liaison between forensic psychiatry and substance-misuse services.
- d) There are systems of liaison between child and adolescent mental health services and substance-misuse services.
 - (i) Protocols on child protection have been developed with Child and Families Teams and other relevant agencies.
 - (ii) The local Area Child Protection Committee has endorsed the protocols.
- e) There are systems of liaison between mental health services for older people and substance-misuse services.
- f) There are liaison mechanisms with a range of relevant departments and organisations (including housing agencies and homeless organisations, employment and training agencies, liver units, HIV units, and with hepatitis and HIV testing and counselling agencies, Accident and Emergency departments, general physicians, obstetrics and gynaecology, paediatrics, geriatrics, trauma, orthopaedics, and with primary care).
- g) There are named lead professionals for contact between mental health services and drug treatment interventions led by criminal justice agencies (Arrest Referral Schemes and Counselling, Assessment, Referral, Advice and Through-care Teams in prisons).

Developing a Strategy: Policy and Protocols

16 A local mental health strategy for working with people with co-morbidity is in place and is adopted by all relevant agencies.

- a) The strategy addresses the following:
 - (i) identifying substance misuse
 - (ii) identifying other mental health problems
 - (iii) working with patients with co-morbidity.
- b) The social care needs of patients with co-morbidity are considered in the strategy alongside their medical needs.
- c) The strategy explicitly tackles the social and ethnic diversity of the local population and the requirement to meet diverse needs.

17 There are explicit local protocols on multi-disciplinary, multi-agency working.

- a) Services for people with co-morbidity are developed to fill gaps that currently exist.
- b) Services for people with co-morbidity operate in such a way as to provide a seamless and fully customised service.
- c) Protocols take into account the mental health Care Programme Approach, as well as the Care Co-ordination Approach and the Integrated Care Pathways recommended for specialist substance-misuse services.

18 Joint protocols are drawn up with the agencies involved.

- a) There are shared protocols between mental health and specialist substance-misuse organisations in the statutory and voluntary sectors.
 - (i) Shared protocols on agreed screening and assessment procedures.
 - (ii) Shared protocols deal with referral procedures.
 - (iii) Shared protocols deal with sharing information on clients.
 - (iv) Shared protocols deal with an agreed management of therapeutic programmes.
 - (v) Shared protocols deal with clients presenting intoxicated with alcohol or drugs to Accident and Emergency and acute psychiatric assessment centres.
 - (vi) Shared protocols deal with the management of clients who become intoxicated on acute wards or in treatment settings where there are other vulnerable individuals at risk.
 - (vii) Shared protocols are developed to support staff undertaking assertive outreach and community management of these patients or their associates (particularly in home visits).

19 Policies and protocols have been developed in consultation with service users and other stakeholders.

- a) Care pathways are identified and agreed by all stakeholders, for which joint protocols are drawn up with the agencies involved.
- b) Mental health and substance-misuse treatment services have their own specific protocols for working with people with co-morbidity.
- c) Protocols on child protection have been developed with Child and Families Teams and other relevant agencies.
 - (i) The local Area Child Protection Committee has endorsed the protocols.

Substance Misuse Treatment Guidelines and Evidence-Based Practice

20 The treatment of alcohol and drugs misuse, including prescribing substitute medication, is in line with the Department of Health guidelines^{12,25} and research evidence.

- a) The treatment of mental ill-health using medication is in line with evidence-based practice and takes account of the significant danger of drug interactions, physical ill-health and, in the case of alcohol, liver damage.

Staff Training (mental health professionals)

21 Mental health services appoint staff with formal training in mental health and substance-misuse co-morbidity, or ensure that staff have access to substance-misuse training once they are in post.²⁶

22 Mental health services have a substance-misuse training strategy pertaining to all staff and professional groups. The strategy is monitored and evaluated.

- a) Substance-misuse training is core to ongoing professional training.²⁷
- b) A range of levels of training is provided.
- c) Training is provided using a range of evidence-based training methods (e.g. *in situ* and distance learning, educational outreach, patient-centred training, reminder techniques).
- d) Training is provided to improve the ability to detect substance misuse and respond appropriately.
- e) Training is provided to improve assessment.
- f) Training is provided on the delivery of brief interventions.
- g) Training includes the management of alcohol and drug-misuse problems (assessment, psychological and medication treatment, psycho-educational and structured rehabilitation techniques).
- h) Staff have training on the range of substance-misuse treatment modalities.
- i) Training is provided on substance misuse-related medical problems.
- j) Training is provided on motivational skills interviewing and relapse prevention.
- k) Substance-misuse training for mental health staff looks at attitudes and prejudice. Training addresses the fact that staff can be resistant to working with people with severe substance-misuse problems, or may over-identify with substance misusers.
- l) Staff have access to a full range of information on the treatment of co-morbidity.
- m) All staff maintain their level of expertise by attending appropriate training events and conferences.
- n) Specialist substance-misuse staff contribute to the training of mental health staff.
- (i) Substance-misuse staff who are involved in training have access to resources and training to develop their own training skills (training the trainers).

23 The training strategy identifies the training needs of all staff and professional groups working in statutory and voluntary organisations.

- a) Training is provided to all professional groups in acute units, community mental health teams, crisis-resolution teams, early intervention teams, assertive outreach teams, CAMHS teams, forensic and mental health services for older people. This includes management, reception staff and staff providing social and welfare support.
- b) GPs and primary healthcare teams are provided with training to recognise co-morbidity and improve the care and treatment of people with these problems.
- c) Training on co-morbidity is provided to the commissioners of substance-misuse and mental health services.
- d) Training is provided for the assessment of individuals with co-morbidity in police stations and other criminal justice settings.
- e) Police officers are provided with training in the application of Section 136 for individuals with substance-misuse problems.

- f) FMEs police surgeons are given regular training on the assessment of prisoners who are intoxicated or have mental health problems.
- g) Training is provided in the application of the Vulnerable Adult and Appropriate Adult policies and practice.

Staff Training (specialist substance-misuse services)

24 Training of staff of specialist substance-misuse services should include recognition and care of service users with mental illness, and collaborative working with mental health services.

- a) Mental health staff contribute to the training of specialist substance-misuse services to enable them to recognise problems and to work collaboratively with mental health services.
- b) Appropriate mental health service staff have training and resources to contribute to the training of staff in specialist substance-misuse services (training the trainers).

Level Three: Organisation of Care

Organisation of Care

25 Provision is made for patients with mental illness and drug and alcohol misuse co-morbidity as part of mainstream mental health services.²⁸

- a) The statutory mental health sector has the responsibility for co-ordinating and providing a multi-agency approach to people with co-morbidity.
- b) Responses are locally co-ordinated across a broad range of agencies.
- c) There is liaison with substance-misuse services.
- d) Fully individualised care plans are offered to patients with co-morbidity.
- e) There is a stepped-care approach to treatment, which is based on the patient's needs and which avoids pigeonholing patients and services and avoids service criteria that exclude patients with co-morbidity.
- f) Consideration is given to special interest staff/service user-support groups to foster training and service development.

Range of Services

26 Service users with co-morbidity in all commissioning areas have access to the full range of specialist substance-misuse services, as well as mental health services.

- a) There is intensive supervision to initiate and sustain early treatment.
- b) Patients are provided with appointee systems where relevant.
- c) Primary care and GP support.
- d) Inpatient treatment, crisis intervention and assessment facilities with staff with knowledge of and skills relating to co-morbidity.
- e) Harm-reduction interventions and hepatitis B immunisation.
- f) Physical healthcare.
- g) Community support and ancillary services (including welfare advice, legal advice, housing complementary therapies, and so forth).
 - (i) A range of supported work programmes and training schemes.
- h) Motivational and other psychotherapeutic interventions, e.g. cognitive behavioural treatment; anger management.
- i) A full range of independent- and voluntary-sector alternatives, including self-help groups and alternative therapies.
- j) Rehabilitation centres that work with substance-misuse problems and those taking medication.
- k) Day treatment programmes are available and funded.
- l) Housing that accepts people with a history of drugs or alcohol misuse.
- m) There are specific services for younger people, especially the 16–18-year range.
- n) The comprehensive range of mental health services.

Assertive Outreach

27 It is a requirement that the remit of all assertive outreach services should include working with people with co-morbidity.

- a) Co-morbid patients who are difficult to engage with services fall clearly within the remit of assertive outreach services.²⁹

Drugs and Alcohol on Hospital Premises

28 There are protocols in place to deal with responding to substance misuse on hospital premises.

- a) There are protocols in place to deal with responding to drug misuse on hospital premises³⁰.
 - (i) Protocols are based on the forthcoming Department of Health guidelines on substance misuse on hospital premises.
 - (ii) Protocols emphasise that decisions are made at clinical level and that they consider the best interest of the patient as well as others.
 - (iii) Protocols emphasise that the co-operation of patients is sought.
- b) There are protocols in place to deal with drug dealers on hospital premises.
- c) There is a policy regarding alcohol use on the ward, the hidden use of which can pose as many risks to patients with mental disorders as illicit drugs.
- d) Protocols are in place making it clear how patients and visitors will be informed of the policy on illegal drugs on the premises and the position with regard to alcohol use.

29 Protocols and procedures to control substance misuse on hospital premises are combined with therapeutic approaches and support.³¹

30 Mental health staff and other employees with substance-misuse problems have access to help and support.³²

- a) There are clear workplace policies with respect to alcohol and other drugs.
- b) Staff are aware of the high professional morbidity in substance misuse and have access to occupational health services and advice on problem prevention.
- c) There are active policies to avoid the stigmatisation of staff with substance-misuse problems.

Level Four: Service Delivery

Staff Competencies

31 Mental health staff have the relevant competencies to work with people with co-morbidity.

- a) Mental health staff have the knowledge, skills and access to formal procedures to aid them in the identification, assessment, management and treatment of alcohol and drug misuse in their patients.
- b) The competency set required to work with people with co-morbidity is defined.
- c) Training is matched to the set of competencies required.

Individual Assessment (general psychiatry)

32 The assessment of all individuals with mental health problems actively considers the potential role of substance misuse.³³

- a) Clinical/assessment is used to detect and assess substance-misuse problems and dependence³⁴ as well as mental health problems plus other axes of problems, e.g. social, neurocognitive, and so forth.
- b) Validated assessment instruments are used to enhance the clinical techniques of screening, detection and assessment of substance-misuse problems and dependence³⁵ and of mental health problems.
- c) The assessment of substance-misuse problems takes place and considers the following:
 - (i) treatment of any emergency or acute problem
 - (ii) confirmation of substance misuse (history, examination, urine analysis, blood test for alcohol use and other biochemical tests, MRI scans and neurocognitive assessment)
 - (iii) assessment of degree of dependence/withdrawal problems
 - (iv) identification of physical, social and mental health problems
 - (v) likely interaction between medication and other substances
 - (vi) assessment of knowledge of harm minimisation, access to sterile injecting equipment, testing for hepatitis and HIV, and hepatitis B immunisation and risk of overdose
 - (vii) determination of client's expectation of treatment and the degree of motivation for change
 - (viii) determination of the need for pharmacotherapy (e.g. detoxification, reduction or maintenance programmes)
 - (ix) medical and psychological interventions.

Individual Assessment (substance-misuse services)

33 Specialist substance-misuse treatment providers identify and respond to problems of combined psychiatric illness and substance misuse.³⁶

- a) Specialist substance-misuse treatment staff regularly screen, or are able to access assessment, for common mental health problems (anxiety, depression, personality disorders and minor psychopathology).
- b) Specialist substance-misuse professionals are able to provide brief interventions for anxiety and mood disorder in drug- and/or alcohol-using patients.
- c) Specialist substance-misuse staff are familiar with pathways for liaison and referral to mental health services and primary care.

Enhancing Motivation

34 Mental health professionals address issues of patient motivation to seek treatment for their misuse of substances.

- a) Management of care addresses issues of motivational enhancement.
- b) Specific measures are in place to enhance the engagement of patients in treatment.
- c) Where appropriate, families/carers are involved in developing treatment care plans and monitoring engagement. This can increase patient motivation.

Treatment Interventions for Substance Misuse

35 Mental health services have developed alcohol and drug treatment protocols.

- a) There are protocols for alcohol and for drug detoxification and any shared care arrangements with specialist substance-misuse services.
- b) There are protocols for outpatient substitute prescribing and any shared care arrangements with substance-misuse services.
- c) There are substance-misuse relapse-prevention protocols.

36 Patients with co-morbidity have access to the range of Tier 1–4 substance-misuse treatment interventions.

- a) Interventions include advice and information, harm-reduction initiatives, pharmacotherapy, psychotherapy, social support, residential and other rehabilitation, relapse prevention and aftercare.
- b) Treatment alternatives to pharmacotherapy are available.
- c) Patients with co-morbidity have access to harm-reduction information and interventions, including interventions to prevent overdose (accidental or suicidal), to reduce the sharing of injecting equipment and unsafe sexual practices.

37 Combined pharmacological and psychological treatments are provided to clients where appropriate (including those in shared care with specialist substance-misuse teams).

- a) The following pharmacological interventions are available:
 - (i) well established regimes for detoxification and the reduction of withdrawal syndromes are used
 - detoxification is linked with substance-misuse rehabilitation where appropriate and long-term benefits are to be achieved
 - (ii) maintenance substitution treatment³⁷
 - (iii) substance-misuse relapse prevention (including pharmacotherapy)
 - (iv) prevention and treatment of medical problems (e.g. convulsions or Wernicke's encephalopathy)
 - (v) rehabilitation for pre-senile dementia and Korsakoff's.

38 Patients with co-morbidity are given help in developing better support systems within the community.

- a) There are referral mechanisms to a wide range of organisations, including those providing:
 - (i) accommodation/support on housing; patients are provided with, and not excluded from, supported accommodation
 - (ii) social support and ancillary services (including welfare advice and legal advice)
 - (iii) employment/work rehabilitation
 - (iv) recreation/leisure.

39 Primary care and specialist services assess whether people with mental health problems know how to access specialist substance-misuse care, where appropriate, and *vice versa*.

- a) All service provision for patients with co-morbidity is clearly signposted from the perspective of the client.
 - (i) Drug treatment and care services are well advertised – often people who need them do not know that they exist:
 - advertising must be placed in, among others, mental health wards, day centres, prisons, GPs’ surgeries.
- b) Mental health services make their access points known to specialist substance-misuse services and their clients.

Aftercare/Continuing Care Rehabilitation

40 There are clear policies on follow-up to inpatient general psychiatric care, after both planned and unplanned discharges.

- a) Patients with co-morbidity have access to continuing outpatient care.
 - (i) The conditions are explicit under which discharged patients can be re-admitted.
 - (ii) Discharge planning takes place urgently when substance misuse precipitates consideration of discharge.

41 Patients with co-morbidity have access to residential and community rehabilitation services that are able to meet their complex needs.³⁸

- a) Patients with co-morbidity have access to substance rehabilitation facilities that accept patients who are on medication for mental health problems.
- b) Where appropriate, patients with co-morbidity have access to substance residential rehabilitation that accepts and is capable of managing people with a history of self-harm, parasuicide and violence.
- c) Residential care placements for people with co-morbidity are made to centres that accept patients on substitute prescribing (e.g. methadone) or who require continued care for substance misuse-related problems (e.g. alcohol problems).

Risk Assessment and Management³⁵

42 Mental health professionals are provided with training to recognise, assess and manage risk of substance misuse.

43 The risk assessment and management of people with co-morbidity explicitly documents increased risk of aggressive and anti-social behaviour, if present.³⁹

44 Risk assessments explicitly document increased suicide risk as a result of substance misuse.

- a) Risk assessment specifically addresses relevant factors for individuals with co-morbidity. This includes addiction severity, polydrug use and the link between suicide and overdose, and other factors known to predispose people to suicide that are also associated with drug misuse (e.g. physical illness, poor family relationships, social isolation, unemployment, stressful events including bereavement, physical and sexual abuse, HIV infection and AIDS and concomitant alcohol use).

45 Risk management incorporates harm-reduction advice.

- a) Risk assessment and management includes advice on accidental overdose.
 - (i) Harm minimisation advice addresses risk of overdose after periods of abstinence.
 - (ii) Harm minimisation advice addresses heightened risk of overdose resulting from misuse of a combination of drugs and alcohol (e.g. methadone, heroin, benzodiazepine, alcohol).
 - (iii) Harm minimisation advice addresses risk of overdose due to unusually pure heroin.
- b) The risk assessment and management of people with co-morbidity consider higher susceptibility to high-risk behaviours such as sharing injecting equipment and unsafe sexual practices and HIV infection.⁴⁰

Management of Substance Misuse and Mental Health

46 There are specific and explicit management procedures to care for and support patients with substance-misuse problems.

- a) Measures are in place to reduce the risk of substance-misuse relapse and to improve the rate of adherence with treatment. The management of people with co-morbidity takes into account the fact that the risk of relapse and the rate of non-adherence increase greatly when patients with primary psychiatric disorders use illicit drugs or alcohol⁴¹, and particularly so when the two are combined with a personality disorder.
- b) Measures are in place to improve medication compliance and compliance with treatment regimes. The management of people with psychosis and substance misuse has been associated with poor compliance with treatment.
- c) Clinicians discuss with patients anticipated responses to substance-misuse lapses and relapses.
- d) Maximise treatment of mental health problems, including review of medication.

Users and Carers

47 Service users, carers and families are involved in service delivery.

- a) Service users and carers are consulted on issues of service provision and service reconfiguration.
- b) Service users are involved in the development and review of their care plan.
- c) Families and other carers have support to care for people with mental illness and substance misuse.

Special Populations

Older People

48 Mental health services for older people explicitly tackle the misuse of alcohol, analgesics and tranquillisers.

- a) Risk assessment takes into account that older men dependent on alcohol and with physical, psychological (especially a history of depression and parasuicide) and social complications are a particular risk group for suicide.
 - (i) Screening instruments or assessments must include domains that apply to older people, including age-related criteria for defining 'heavy' drinking, social and legal problems (housing problems, falls and accidents, poor nutrition, poor activities of daily living, lack of exercise and social isolation).

Young People

49 The needs of young people with co-morbidity must be addressed by child-centred services.⁴²

- a) The needs of young people with co-morbidity are addressed by staff with relevant training in mental health and substance misuse.
- b) The assessment of young people with a history of deliberate self-harm takes into account evidence that they may be at risk of developing drug and/or alcohol dependence.
 - (i) Assessment instruments include screening instruments for drugs and alcohol dependence.

Homeless Populations

50 A strategy is in place pertaining to the treatment and care of homeless patients with mental health and substance-misuse co-morbidity.⁴³

Black and Minority Ethnic Patients

51 Commissioners and providers ensure that all local services are able to meet the diverse needs of local populations, and that the services are accessible to minority ethnic groups and effective at meeting their needs.

- a) Assessments consider the ethnic and cultural background of patients. Mental health service users from black and minority ethnic groups commonly report that mental health assessments are undertaken from a perspective that does not take into account culture and ethnicity.
- b) Mental health services develop and demonstrate cultural competence, with staff having the knowledge and the skills to work effectively with diverse communities.
 - (i) Psychiatrists and other staff are familiar with the Department of Health and the Royal College of Psychiatrists' Register of all psychiatrists in the UK with an interest or special expertise in trans-cultural psychiatry.⁴⁴
- c) Training addresses the risk of misdiagnosis of psychosis and schizophrenia in black and other minority ethnic groups.
- d) There is regular audit of the use of specialist substances by minority ethnic patients with co-morbidity, to monitor equality of service access, utilisation and effectiveness.⁴⁵

52 Mental health professionals consider post-traumatic stress amongst patients with co-morbidity, and refugees and asylum seekers in particular.

Women with Co-morbidity

53 The assessment and care of women with co-morbidity takes into account gender-specific issues.

- a) The assessment and care of women with co-morbidity includes eating disorders, self-mutilation, suicide attempts and low self-esteem.
- b) The assessment of women with co-morbidity considers the high rates of history and current physical or sexual violence amongst women dependent on substances.
- c) The assessment and care of women with co-morbidity recognises that the presence of factors identified in (a) and (b) can be predictive of substance-misuse relapse.
- d) Pregnant women with co-morbidity require support over substance misuse-related problems during the pregnancy and delivery of the baby.
 - (i) Multi-disciplinary care and support is planned prior to delivery, including for neonatal withdrawal where relevant.

Parents with Co-morbidity

54 The care of parents with co-morbidity focuses on the needs of the children, assessing the need for support and interventions to prevent harm.

- a) Staff are familiar with issues of child protection, risk assessment and intervention.
- b) Staff are familiar with the requirements of the Children Act.
- c) Staff address child protection issues, where appropriate.
- d) Parents are provided with support, practical help, parenting skills, benefits assessments and other relevant support.

Notes

1. Appleby L (2000) Safer services: conclusions from the report of the National Confidential Inquiry. *Advances in Psychiatric Treatment* 6: 5–15.
2. Anon. (2000) *Drug Misuse and Mental Health: Learning Lessons on Dual Diagnosis*. Report of the All-Party Parliamentary Drug Misuse Group.
3. Crome IB (1999) Substance misuse and psychiatric co-morbidity: towards improved service provision. *Drugs: Education, Prevention and Policy* 6(2).
4. For more information on substance misuse and young people see HAS (2001) *The Substance of Young Needs II*, update of the HAS report (forthcoming). Health Advisory Service, London.
5. HAS (1999a) *Standards for Mental Health Services for Older People*. Health Advisory Service/Pavilion, London.
HAS (1999b) *Standards for Mentally Disordered Offenders*. Health Advisory Service/Pavilion, London.
HAS (1999c) *Standards for Health and Social Care Services for Older People*. Health Advisory Service/Pavilion, London.
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6. Weaver T (1999) *Dual Diagnosis: The Co-Morbidity of Psychotic Mental Illness and Substance Misuse*. Executive Summary No. 63. Centre for Research on Drugs and Health Behaviour, Imperial College London.
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8. Crome IB (1996) *Psychiatric Disorder and Psychoactive Substance Use Disorder: Towards Improved Service Provision*. Unpublished review for the Centre for Research on Drugs and Health Behaviour, Imperial College, London.
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19. Raistrick D, Hodgson R and Ritson B (1999) *Tackling Alcohol Together: The Evidence Base for a UK Alcohol Policy*. Free Association Books, London.
20. Ward M (2001) *Lessons for Dual Diagnosis Services from Recent Homicide Enquiries*. (forthcoming).
21. There is evidence that people with co-morbidity are often excluded from services. For example, there is some evidence that problem drinkers and other substance misusers with co-morbidity are likely to be excluded from services or referred from one agency to another without being engaged in any meaningful or effective treatment programme. This is particularly true for people with antisocial personality disorders or a psychosis with violent and aggressive features [Raistrick D and Heather N (1998) *Review of the Effectiveness of Treatment for Alcohol Problems*. Unpublished report for the Department of Health, p. 134].
22. This could include, for example, funding workers in community mental health teams or in-patient wards, appropriate residential rehabilitation, and so forth.
23. Joint commissioning does not necessarily mean pooling of budgets.
24. Studies have found that success and failure in opioid detoxification were best predicted by initial psychiatric symptomatology. For example, Korsten *et al.*, in a 2.5-year follow-up study, report that opioid users diagnosed as depressed at the beginning of treatment were less likely to be abstinent at follow-up than other opioid users with a normal affect [Kosten TR, Rounaville BJ and Kleber HD (1986) A 2.5-year follow-up of depression, life crisis and treatment effects on abstinence among opioid addicts. *Archives of General Psychiatry* 43: 733–738].
25. Department of Health guidelines emphasise that the range and complexity of the treatment and rehabilitation of problem drug users requires a continuum of medical practice, skills and experience, ranging from the contributions that can be made by all doctors to those made by specialist practitioners.¹²
26. The Royal College of Psychiatrists (College Research Unit) is currently developing a comprehensive training package aimed at the range of professionals.
27. Crome (1999) has identified inadequacies in both the quality and quantity of medical undergraduate training, and considers that this may partially explain why doctors are ill-equipped to deal with substance-misuse problems. There has been a modest increase in training on substance misuse by departments of psychiatry over the past 10 years. A survey has shown that the average time allocated in formal lectures/seminars is 6.7 hours (range 2–14). This excludes departments that are providing no substance-misuse training at all, and one model department that delivers 30 hours of substance-misuse education and co-ordinates another 30 hours throughout the undergraduate programme. However, although psychiatry has doubled input since

1987, this has been offset by diminished input from other departments. [Crome I (1999) The trouble with training: substance misuse education in British medical schools revisited. What are the issues? *Drugs Education, Prevention and Policy* 6(1): 111–123].

28. Exceptions could include people with sociopathic personality disorders who pose a risk to vulnerable female patients and their children.

29. Exceptions could include cases of primary sociopathic personality disorder.

30. A study found that 68% of 187 nurses surveyed reported illicit drug use in psychiatric units [Stanford T (1995) Drug use is increasing. *Nursing Standard* 9(38); 16–17].

31. It is argued that attempts to restrict the supply of illicit drugs are almost certainly doomed to failure if no other strategy is in place. The most productive strategies are geared towards support and therapy, with attention paid to interventions likely to minimise demand.

32. There is growing awareness that doctors are at risk of developing addiction problems and that they have difficulty accessing appropriate help.

33. US data show that a person with substance misuse problems is three to six times more likely to have additional mental health problems, and *vice versa* [Regier *et al.* Co-morbidity and mental disorders with alcohol and other drug abuse. Results from the Epidemiological Catchment Area (ECA) Study. *Journal of the American Medical Association* 264: 2511–2518].

Also see UK studies:

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Wright S, Gournay K, Glorney E and Thornicroft G (2000) Dual Diagnosis in the suburbs: prevalence, need, and in-patient service use. *Social Psychiatry Psychiatric Epidemiology* 35: 297–304.

34. For a list of assessment instruments see Crome 1999 (*ibid*).

35. For more information see:

Carey KB and Corraia CJ (1998) Severe mental illness and addictions: assessment considerations. *Addictive Behaviours* 23(6): 735–748.

Drake RE, Rosenberg SD and Mueser KT (1998) Assessing substance misuse disorder in persons with severe mental illness. In: Drake RE *et al.* (eds) *Readings in Dual Diagnosis*. IAPSRs, Columbia, MD, USA.

Anon (2001) *Assessment and Management of Risk of Harm in Dual Diagnosis Clients*. London Alcohol Concern and Drugscope, London (in press).

36. US research suggests that among populations in substance-misuse treatment, personality disorders and depression are more evident than psychosis [Brooner RK, King VL, Kidorf M *et al.* (1997) Psychiatric and substance misuse co-morbidity among treatment-seeking opioid abusers. *Archives of General Psychiatry* 54: 71–80].

37. It is now well acknowledged that abstinence may not be the most appropriate option, especially for opiate users. Patients with unremitting schizophrenia may, in fact, benefit from opiate maintenance, while detoxification may precipitate relapse. For more information see Brizer D, Hartman N, Sweeny J and Millman R (1985) Effect of methadone plus neuroleptics on treatment-resistant chronic paranoid schizophrenia. *American Journal of Psychiatry* 142(9): 1106–1107.

38. There is nationally a dearth of such provision, and it is recommended that such services be developed.

39. In all homicides, as well as those in the sample of the National Confidential Inquiry, there was a striking prominence of alcohol and drug misuse. Of all people convicted of homicide, 39% had a history of alcohol misuse, 35% a history of drug

misuse, and 13% had a primary diagnosis of alcohol and drug dependence.¹

Also see a review of reports of inquiries into homicides committed by people with a mental illness, which shows that substance misuse was a major factor in over half the cases [Ward M and Applin C (1998) *The Unlearned Lesson*. Wynne Howard Books, London].

40. Patients with co-morbidity have higher susceptibility to high-risk behaviours such as sharing injecting equipment and unsafe sexual practices (Brooner *et al.*, 1992).

41. The risk of relapse and the rate of non-adherence increase greatly when patients with primary psychiatric disorders use illicit drugs or alcohol, and particularly so when the two are combined with a personality disorder. See:

HAS (1996) *The Substance of Young Needs*. Health Advisory Service. The Stationery Office, London.

Williams R and Cohen J (2000) Substance use and misuse in psychiatric wards: a model task for clinical governance. *Psychiatric Bulletin* 24: 43–46.

42. For more information on young people with mental health and substance misuse co-morbidity, see HAS (2001) *The Substance of Young Needs II*. Health Advisory Service (forthcoming).

43. Homeless people who also have substance-misuse problems are more vulnerable to substance misuse [Ridgely MS, Goldman HH and Willenbring (1990) Barrier to the care of persons with dual diagnosis: organisational and financial issues. *Schizophrenia Bulletin* 16(1): 123–132].

44. The Department of Health and the Royal College of Psychiatrists' College Research Unit have recently developed a register of all psychiatrists in the UK with an interest or special expertise in transcultural psychiatry.

Also see: Graham H and Wanigaratne S (2000) Substance misuse. In: Patel N *et al.* (eds) *Clinical Psychology, 'Race' and Culture: A Training Manual*. BSP Books, Leicester.

45. It is widely acknowledged that black and minority ethnic substance misusers are under-represented in specialist substance-misuse agencies, and that they find such agencies inaccessible.

References

The standards are based on the following references.

Level One: Commissioning, Planning and Integration

Needs Assessment/Service Mapping

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