

DUAL DIAGNOSIS STRATEGY: an implementation plan for delivering good practice in working with service users with a dual diagnosis (mental illness and substance misuse)

This strategy is associated with the following NHSLA standards;
Level 1 – 1.4.3
Level 2 - 2.4.3
Level 3 – 3.4.3

The following National Service Framework:
National Treatment Agency (NTA) Models of Care (update 2006) and

The following DH Policy Implementation Guide:
Mental Health Policy: Dual Diagnosis Good Practice Guide

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POLICY APPROVED BY: Executive Management Team

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Document Control Sheet

Policy Title	Dual diagnosis: An implementation plan for the implementation for delivering good practice in working with service users with a dual diagnosis (mental health and substance misuse)
Purpose of Policy/Assurance Statement	<p>This strategic document describes the necessary objectives that will be put in place to ensure that NELFT staff teams have the appropriate skills for working with service users who have a dual diagnosis of mental illness and substance misuse.</p> <p>This policy assigns responsibility to lead members of staff for implementation of the strategic objectives.</p> <p>This policy contains an implementation plan for the delivery of the overall aims and objectives.</p>
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Contents Page

	Page
Assurance Statement	4
1 Introduction	4
2 Aims and Objectives	5
3 Duties and Responsibilities	6
4 Context	6
5 Needs assessment	9
6 Training and development	10
7 Human resource	12
8 Clinical care, case management and pathways	13
9 Equality and diversity	17
10 Process of Implementation	18
11 Monitoring Arrangements	18
12 Equality Statement	18
13 Policy Number – to be issued by Communications Manager	18
14 Training	18
15 Links to Other Policies	19
16 References	19
Appendix 1 – Implementation Plan	20
Appendix 2 – Example of an inpatient integrated care pathway	22
Appendix 3 – Risk issues	23
Appendix 4 – Equality Impact Assessment Screening Tool	26

ASSURANCE STATEMENT

This strategy describes the objectives that need to be in place to ensure that; NELFT staff teams have the appropriate skills for working with service users who have a dual diagnosis of mental illness and substance misuse; and that corporately, there is an agreed way forward for working with this service user group. This document assigns responsibility to lead members of staff for implementation of the strategic objectives.

1. Introduction

This strategic document sets out how the Trust intends to improve services for individuals with a dual diagnosis of mental illness and substance misuse. This strategy relates to adult service users in both inpatient and community settings. A further strategic document will outline objectives for working with children and young people with a dual diagnosis.

The strategy is underpinned by relevant national and local policy including;

- NTA Models of Care, DH 2002 and update 2006
- Policy Implementation Guide: Dual Diagnosis Good Practice Guide, DH 2002
- NSF for mental health – five years on, DH 2004
- Dual diagnosis in mental health inpatient and day hospital settings, DH 2006
- NELMHT: Service development strategy for complex needs, mental health and substance misuse, draft 2007

- 1.3 This document is set within the context of the Trust's strategic objectives of recovery orientated services and the Integrated Business Plan.
- 1.4 The strategy and implementation plan will link with the relevant Adult Treatment Plans of local Drug and Alcohol Action Team (DAAT) partnerships and also with Local Implementation Teams (Local Implementation Teams) delivering the Mental Health National Service Framework in NELFT boroughs.
- 1.5 It is widely accepted that the core business of NELFT has shifted from the management and long term care of people with 'simple' psychoses (schizophrenia, schizo-affective & depressive disorders) to a population with more complex disorders and needs. There is a need for NELFT's acute inpatient services to become more specialised, providing services for those with the most complex needs for shorter length of stay. Also, community services will need to develop and expand to provide more individualised care to service users with a dual diagnosis.
- 1.6 The management of dual diagnosis is everybody's business within the Trust.
- 1.7 The development of the Trust's own inpatient facility for people with complex needs and dual diagnosis in 2010 makes the implementation of this strategy imperative.

- 1.8 The strategy highlights areas to be reviewed and suggests a baseline for the development of key documents e.g. training strategy for staff; and policies for managing risk and managing substance misuse in inpatient settings.

2. Aims and Objectives

The Dual Diagnosis Strategy is a new strategy whose purpose is to draw together a number of inter-related work streams into a coherent Trust wide developmental framework that will standardise aims and processes across NELFT.

The aim of the strategy is to develop effective; responsive and integrated clinical services for service users with a dual diagnosis across both mental health and substance misuse services and promote the concept that dual diagnosis is “everybody’s business”. These services will ensure equitable access to existing and planned provision across NELFT. In addition, the strategy will embed competencies for all staff in working with service users with a dual diagnosis. This will enable dual diagnosis to become everyone’s business within NELFT.

The strategy provides a contextual background; considers organisational priorities; and contains an action plan to deliver the Trust’s programme of work on dual diagnosis over the next two years.

- 2.1 The strategy should be seen as a response to the growing evidence of needs of adults with dual diagnosis and to implement the following overarching aims:

- To provide a leadership and management structure
- To provide a source of factual information, consultation, supervision and training
- To enable NELFT to act as a specialist resource to other stakeholders within the local health economy
- To enable mental health interventions for people accessing substance misuse services and substance misuse interventions for people accessing mental health services.

- 2.2 The objectives of the strategy are to;

- Develop a consistent, coherent and integrated model of service provision within NELFT’s services
- Review existing needs assessments and map current presenting need across provision
- Develop and implement an agreed care pathway to guide the service user through and between substance misuse and mental health services
- Develop a comprehensive range of services for the treatment and management of dual diagnosis across NELFT which are culturally sensitive to the needs of service users and carers
- To embed the culture that the management of dual diagnosis is everybody’s business within NELFT.
- Develop education and training packages which support and enhance an integrated delivery model

- Develop a culture of continuous evaluation and development which includes learning from good practice
- 2.3 The aims and objectives of the strategy will be achieved through a development and implementation plan shown at Appendix 1. In summary, the plan will look at a range of areas that will describe an integrated governance framework for the delivery of dual diagnosis services. These areas will include;
- Human resources
 - Training and development
 - Equality and cultural competence
 - Assessment including risk assessment and risk management
 - Care and referral pathways
 - Individual case management and CPA
 - Review of organisational competence

3. Duties and Responsibilities

3.1 Lead Consultant for Addictions

The consultant will provide leadership and strategic direction with a focus on supporting the training of medical staff and developing services.

3.2 Operations Director, Specialist Services

The Operations Director will lead on the development of internal and external partnerships and all stakeholder groups that will deliver the overall aims and objectives of the strategy. The Operations Director is also responsible for ensuring that the integrated governance framework is developed and maintained. Areas of risk will be identified through this process and will be included on the Directorate and Corporate risk registers as appropriate.

3.3 Training and development lead

The training and development lead will be responsible for ensuring that appropriate modular training is developed and that this training is made available as part of the core competency framework for all staff working with service users and carers.

3.4 Lead nurse

The lead nurse will ensure that all policies and processes developed as part of the Implementation Plan are reviewed against existing clinical and governance criteria.

3.5 Specialist Dual Diagnosis Workers

Specialist dual diagnosis workers will be responsible for delivering dual diagnosis training providing advice to teams locally and to carry small dual diagnosis caseloads.

3.6 Frontline staff

All frontline staff have the responsibility to respond to dual diagnosis presentations. The dual diagnosis training plan will ensure frontline staff are competent to do this.

4. CONTEXT

4.1 Scope

This policy covers services for adults and older adults who have a mental illness or a personality disorder and who have a concurrent substance misuse problem.

4.2 Objectives

The objective of this strategy is to outline systems which ensure that clear clinical care pathways; risk management processes; and investment planning processes enable the safe and appropriate management of service users with a dual diagnosis.

4.3 Definitions

(i) Substance use or misuse for the purposes of this document includes alcohol; illicit drugs including volatile substances; and prescription drugs used in a non-beneficial or potentially hazardous way.

(ii) Dual diagnosis is defined as: complex needs: co-morbid mental health and substance misuse problems: where a mental health disorder and substance use are interacting and impacting significantly on the quality of a service user's life.

(iii) Dual diagnosis is the presence of problematic drug and/or alcohol use in someone with a severe and/or enduring mental illness.

(iv) A severe and/or enduring mental illness is defined as one that would warrant the person being referred to secondary mental health services in the absence of problematic substance use.

(v) Problematic substance use is defined as that which would warrant the person being referred to the drug or alcohol service in the absence of a mental illness.

4.4 Policy context

The policy context for NELFT's developing dual diagnosis strategy is described in the introduction to his document.

4.5 Background

National evidence suggests that substance misuse among people with mental health problems should be seen as usual rather than exceptional; that treatment for substance misuse problems often improves mental health problems; and the healthcare costs of untreated people with dual diagnosis are likely to be higher than for those receiving treatment.

Within NELFT, dual diagnosis is so common as to be core business. The prevalence of dual diagnosis is estimated to be; 50% in generic mental health in-patient settings, 25% in CMHT settings, up to 80% in community drug and alcohol teams and almost universal in complex needs services (e.g. low secure,

PICU, forensic and rehabilitation settings). Dual diagnosis is associated with a number of adverse mental health outcomes including suicidality; anti-social behaviours; violence to others; poor treatment concordance; and increased hospital admission rates.

People with dual diagnosis may be excluded from both mental health and substance misuse services. Individuals with complex problems are at risk of falling between services; and policy development is often split between two strategic and implementation frameworks between two stakeholder groups – the DAATs and the Local implementation team (Local Implementation Teams).

This strategy aims to bring together national guidance, local needs information, and service provision and development, to create a framework and action plan to progress the provision of services for service users with dual diagnoses.

The Policy Implementation Guide¹ identifies that the primary responsibility for the treatment of individuals with severe mental illness and problematic substance misuse should lie with mental health services. This approach is referred to as 'mainstreaming' and aims to lessen the likelihood of people being shunted between services or losing contact completely. Secondary treatment services should co-operate to meet the needs of people with dual diagnosis through existing mental health and drug and alcohol services. Any interventions designed to meet these needs should be reflected in individualised care plans that are jointly developed and agreed with service users, their family or carer.

4.6 **Organisation and management of services**

The Trust will collaborate with local stakeholders and partners to ensure that policies and procedures take account of inter-agency priorities. Stakeholders will include;

- The DAAT
- The LIT
- Service users and carers

4.7 **Clinical governance**

Governance arrangements will describe clear lines of responsibility and accountability for the quality of clinical care and will include a programme for service improvement and policies aimed at managing risk and safety.

The following policies and protocols will be developed as part of the Implementation Plan to reflect the needs of people with dual diagnosis including:

- Shared treatment protocols which can be applied in substance misuse and mental health services – to include integrated care pathways and shared assessment processes
- Arrangements between services for care co-ordination and risk assessments – to include responsibilities and identification of care co-ordinator

¹ Dual Diagnosis Good Practice Guide, DH 2002

- A framework which clarifies how staff will work with service user motivation rather than excluding people from services – this will look at issues such as recovery focussed services; building on strengths and using harm reduction responses where indicated
- Identifying a range of treatment options and ensuring that treatment protocols are in place – this has included reviewing and updating the Prescribing Policy
- Information sharing – this will be important for agreeing parameters when working with external partners and in particular, criminal justice agencies

Service user and carer standards will be developed to monitor:

- That people feel included and consulted about the services they need
- That access to the service is equitable and rapid
- How families and carers can be involved in providing support to their significant other

5. NEEDS ASSESSMENTS

5.1 Baseline

In recent years, NELFT has carried out two baseline assessments with the aim of clarifying the presenting needs of service users in both mental health and substance misuse settings. This has identified a baseline which has established that dual diagnosis is prevalent amongst service users presenting to both mental health and substance misuse provision in NELFT. This baseline also enabled the successful bid for DH capital funding to build NELFT's own inpatient facility for complex needs and dual diagnosis service users.

Stakeholders across internal and external partnerships have been engaged in a process to review current resource and plan for the future. The NSF for mental health has clearly identified dual diagnosis as the most challenging clinical problem currently facing mental health services². It is imperative the Trust can demonstrate presenting need and predict likely future trends. This will enable the Trust to assess impact on resource and inform investment discussion with commissioners.

5.2 Gap analysis

Whilst the baseline assessment has revealed valuable information about the likely presence of dual diagnosis within NELFT services, a further audit could identify the range of presenting need i.e. the likely percentage of people with high substance misuse needs and high mental health issues through to the likely percentage of people with high mental health issues and low substance misuse needs. This work would inform pathways development and referral routes as well as identifying the specific training needs and skill sets of staff groups.

The cross directorate expert group will undertake work to identify the range of need in order to inform resource investment and the future service model for working with people with a dual diagnosis.

² NSF for mental health – 5 years on, DH 2004

Closing this gap will enable the Trust to form a robust internal policy framework that clearly places dual diagnosis at the core of its mental health services.

6 TRAINING AND DEVELOPMENT

6.1 Introduction

NELFT has been providing in house dual diagnosis training to staff for a number of years. This training has been based on the pan London 5 day dual diagnosis model and is delivered by dual diagnosis workers, who are also accredited trainers, within the Trust.

Not all of the Trust's dual diagnosis workers are involved in delivering training and consequently access to training is inconsistent across the boroughs.

In addition, the pan London model is usually delivered locally on a once weekly basis for 5 weeks. This can work well for community teams but is difficult for inpatient teams because of shift working and ward based duties.

The recent Healthcare Commission review (2008) has highlighted that the Trust needs to review the accessibility and quality of its dual diagnosis training in order to ensure that staff are able to screen; detect and work with people with a dual diagnosis.

6.2 Policy and practice drivers

Since the introduction of the pan London training, further policy documents such as the Dual Diagnosis Capability Framework³ and the Ten Essential Shared Capabilities for Mental Health⁴ have highlighted the need for training to be embedded within mental health services.

These new policy frameworks aim to assist the implementation of the DH Dual Diagnosis Practice Implementation Guide which is underpinned by the statement that 'care for those with a serious mental illness and substance use should be provided by the mental health services'⁵.

In addition, the recent Healthcare Commission review identified the need for the Trust to ensure that dual diagnosis training and practice is embedded in delivery of our mental health services.

6.3 Aims of training

The aim of the training strategy will be to ensure that all qualified and non-qualified permanent staff in NELFT will have access to evidence based dual diagnosis training which can be delivered in a modular framework.

³ University of Lincoln, 2006

⁴ NIMHE, 2004

⁵ DH, 2002

Training will be designed to ensure that staff will be able to deliver effective care to service users with a dual diagnosis in both community and inpatient settings.

The training will include three levels – core, generalist and specialist. The training framework will include three main sections as defined in the Dual Diagnosis Capability Framework – values and attitudes; utilising knowledge and skills and practice development.

6.4 **Objectives of training**

The primary objective of delivering this training strategy is to ensure that all NELFT staff will be equipped to screen and detect the presence of dual diagnosis within their service users groups.

This evidence based dual diagnosis training package will be strength based and recovery promoting in line with NELFT's underpinning values.

6.5 **Skills gap audit**

There will be a need to carry out a skills gap audit in order to inform targeted training for community and inpatient teams.

6.6 **Core training**

Core level skills are those that will be needed by all frontline staff in order to ensure that they can deliver effective care to service users with a dual diagnosis.

This level of training will be aimed at all workers who come into contact with service users especially as a first point of contact.

Core level training will be offered as both an 'e learning' package and as face to face training.

Core level training is primarily concerned at ensuring staff have the necessary skills, attitudes and knowledge in order to screen, detect and be aware of service users needs in relation to dual diagnosis.

6.7 **Generalist training**

Once core training has been undertaken, staff will be able to access generalist training. This will encompass modules 2 and 3 and will be aimed at understanding and being able to deliver effective care in relation to comprehensive assessment; engagement and management issues.

These modules will be delivered in face to face settings only as they are primarily concerned with skills, attitudes and competencies.

Generalist training is aimed at those workers who will regularly come into contact with service users with a dual diagnosis who have a moderate range of problems as part of their generic role and function within mental health services.

6.8 **Specialist training**

Specialist training will be aimed at workers in community and inpatient settings who have a specific interest and skill in working with service users who have a chronic, long term and complex dual diagnosis.

This training will equip workers with the skills to deliver treatment to service users with a dual diagnosis within a harm reduction and motivation enhancing framework.

Modules 4 and 5 of training will be concerned with the delivery of treatment.

6.9 **Capability framework**

All training and development responses will be delivered within a capability framework that includes the following components;

- Role legitimacy
- Therapeutic optimism
- Acceptance of the uniqueness of each individual
- Non-judgemental attitude
- Demonstration of empathy⁶

7 **HUMAN RESOURCE**

7.1 **Current dedicated resource**

Historically, dual diagnosis workers in the Trust have been commissioned by the local DAAT partnerships and as such, investment across the four boroughs has always differed. At present, the DAAT's commission the following;

- Barking & Dagenham – 2 band 7 workers located in DRIVE substance misuse team
- Havering – 1 band 6 worker located in New Directions substance misuse team
- Waltham Forest – 2 band 7 workers located in the Assertive Outreach Team (AOT)

In addition to the above, the PCTs commission the following;

- Barking & Dagenham – 2 band 7 workers located in the AOT
- Redbridge – 1 band 8a worker located in the AOT

7.2 **Reviewing resource**

In line with national guidance, the Trust needs to see dual diagnosis as the preserve of its mental health teams and human resource needs to be constructed in this way. There should be a review of the core roles and functions needed in order to deliver dual diagnosis services. Section 8 addresses the clinical care parameters and care pathways that need to be in place.

The inconsistency of investment across the boroughs presents a challenge in ensuring that there is equity of resource across the boroughs. Whilst reconfiguration of workers is a possibility, this will need to be explored with the

⁶ Closing the Gap: A capability framework for working effectively with people with combined mental health and substance misuse problems, University of Lincoln

existing investors. In addition, the majority of investment has been made by the DAAT partnerships. If dual diagnosis is core business for NELFT and is evident in the majority of service user presentations, then clearly there is a need to review core funding arrangements with PCT commissioners.

Such discussions will be informed by both the local needs assessments and gap analysis and also by the Autumn Assessment Dual Diagnosis Themed Review 2007⁷.

7.3 **Centre of excellence**

If the Trust is to create a centre of excellence in terms of its existing dedicated resource, then clear parameters need to be set for training provision and case management for workers.

7.4 **Using current resource effectively**

The following proposals detail what can be put in place immediately within the existing staff resource.

- A **cross directorate expert group** of specialist complex needs; mental health; personality disorder and substance misuse multidisciplinary staff who will provide consultation, supervision, training, liaison across teams and provision
- Joint working in the community between Tier 3 substance misuse services and specialist mental health services within the case management boundaries proposed below
- Specialist mental health input in terms of training and consultation into Tier 3 substance misuse services for clients with mild to moderate mental health problems.
- Specialist substance misuse service input in terms of training and consultation into inpatient and community mental health services for service users with SMI and non Tier 3 substance use.
- Specialist psychological assessment, treatment formulation, psychotherapy and appropriate psychological services for this client group.
- Appropriate supervision and support for staff working with this client group.
- Liaison, consultation, training and support for non statutory borough based substance misuse services

8 **CLINICAL CARE, CASE MANAGEMENT AND PATHWAYS**

8.1 **Screening**

The cross directorate working group (see 7.4) will identify substance misuse screening tools to be used on entry to inpatient wards and as part of the assessment process in community mental health teams.

The working group will also identify screening tools for mental health to be used as part of the substance misuse assessment.

⁷ CSIP, 2008

Screening will be an integral part of mental health and substance misuse assessments.

8.2 **Clinical care**

The Trust propose the following fundamental principles which define the approach to clinical care for individuals with a dual diagnosis. These principals need to be built into the NELFT service change programme and subsequent team/service operational policies.

(i) All people that present to services with a severe mental illness and a drug and/or alcohol misuse problem must receive an assessment for both aspects of their presentation.

(ii) The appropriate adult mental health team will assess mental state and the appropriate community drug and/or alcohol team will assess the substance misuse issues.

(iii) Wherever possible the assessment should be undertaken jointly to reduce duplication.

(iv) People with dual diagnoses can initially present to either mental health or substance misuse services. It is the responsibility of the service that the client first contacts, to “hold” the case until a full assessment has been completed and to notify its partner service that such an assessment is required.

(v) In keeping with national directives, the expectation is that a client with a dual diagnosis will also have a severe mental illness e.g. schizophrenia, bi polar affective disorder, severe depression. They will therefore be in receipt of a Care Programme Approach.

(vi) The management of the case will be the responsibility of the mental health team assisted by staff from drug and alcohol services. However, if the mental health issues are minimal i.e. mild to moderate depression and/or anxiety it may be appropriate following assessment that case management will be the responsibility of an appropriate substance misuse worker who will be able to access a named mental health worker for assistance as required.

(vii) Following assessment, both teams will identify suitable workers who, together with the client wherever practicable, will formulate a single care plan to which both services will contribute. Any amendment to any element of the care plan will be notified to the client and to any member of either team involved in its delivery.

(viii) Where case management is disputed, the consultants from both services will discuss who is the most appropriate person to undertake the role of Responsible Medical Officer. This in turn will enable team leaders to identify an appropriate key worker/care co-ordinator. If the situation remains unresolved, the matter will be reported in the first instance to the appropriate Assistant Medical

Directors to facilitate an agreement and failing this to the Medical Director who will facilitate a decision.

(ix) Occasionally a person will be engaged with one or other service and only after some time will it emerge that they have dual diagnosis issues. As soon as this becomes apparent, contact with the partner service must be made in accordance with (iv) above.

8.3 **Case management/Care Programme Approach (CPA)**

The consultation document for CPA sets out concerns that some key groups who should meet the characteristics of enhanced CPA (or new CPA) are not being identified consistently and that services are sometimes failing to provide the support they need⁸. One of the key groups identified was those with a dual diagnosis.

The importance of assessing substance misuse, having a care plan related to this and for staff to be trained to work with people with dual diagnosis, has been consistently highlighted. Drug and alcohol misuse should be considered in all assessments undertaken by mental health services. Current and past substance use should be asked about and an assessment made of the risks with an appropriate risk management plan.

Staff in mental health settings should routinely ask service users about recent legal and illicit drug use. The questions should include whether they have used drugs and if so what type and method of administration, quantity and frequency of use.

8.4 **Care pathways**

Integrated care pathways (ICP) are necessary for the delivery of co-ordinated care for service users with a dual diagnosis. The implementation plan details the need for process mapping for service users with a dual diagnosis to ensure that care pathways are coherent and consistent. An example of an ICP is shown at Appendix 2.

8.4 **Designing the pathway**

Each ICP should be based on evidence of effective practice and needs assessment. The actual structure of the pathway will be influenced by the availability of resources locally; in particular the range and capacity of services and the skills, knowledge and experience of staff within the different teams involved.

There is a need for better collaboration between NELFT's community drug and alcohol teams and mental health teams in order to deliver the integrated care pathway. This work will be delivered by the cross Trust multi-disciplinary virtual team.

8.5 **Risk assessment and risk management**

Risk assessment and risk management will be core to the screening, assessment and case management of people with a dual diagnosis.

⁸ CPA – Refocusing the Care Programme Approach, DH 2008

The Trust's policy on managing substance misuse on acute psychiatric inpatient wards has been reviewed and updated in line with DH guidance; Dual diagnosis in mental health inpatient and day hospital settings⁹ (see 8.6).

Serious untoward incidents (SUIs) will be reviewed as part of the Specialist Services Integrated Governance processes.

Detailed risk assessment and risk management processes will be included in specific policies for managing care in teams. These will include a six domain model for assessing risk in relation to substance misuse. A full description of the domains can be found in Appendix 3.

- (i) Risks associated with patterns of substance use, presence of dependence, intoxication and withdrawal.
- (ii) Biomedical problems
- (iii) Impact on psychiatric symptoms and type of risk behaviour
- (iv) Degree of motivation for changing substance use
- (v) Recovery potential
- (vi) Potential for relapse or continued use

8.6 **Inpatient units**

Service users have a right to receive care in a safe environment that is free from drug and alcohol use. This is a key issue for all service users; those who currently have a substance use problem; those who have had a problem and those who have never had a problem.

The policy for managing substance use and drug dealing on inpatient units has been reviewed to ensure that it takes account of the following;

- The Trust's statutory responsibilities under Health and Safety Regulations
- Searching of service users
- Incident management
- Restriction or exclusion of visitors
- Confidentiality
- Post incident review and recording
- Destruction and disposal of drugs

The outcomes of care provided on inpatient units should primarily reflect the reason for admission. These should include:

- the maintenance of a safe environment for the client, other patients, staff and visitors

⁹ DH 2006

- The effective management of symptoms related to the client's problem(s). This will include the provision of safe and effective substance use interventions on inpatient units.
- the resolution of the acute phase of difficulty that they have been experiencing
- involvement of the client in decisions relating to the current and future management of their problems
- a plan to provide effective on-going care management in the community, if required

8.7 **Community teams – mental health and substance misuse**

The Trust's current operational practice and processes can be described as a mainstreaming approach with a parallel service being delivered.

All service users who meet the definition of dual diagnosis (see 4.3) where mental health and substance misuse needs coexist will be referred for a complementary assessment.

The following guiding principles characterise the current operational practice and liaison:

(i) If the service user meets criteria for mental health services the care co-ordinator responsibilities and CPA are with Mental Health Services.

(ii) All services ensure service users are subject to CPA (mental health) care p – substance misuse, care co-ordination and have full risk assessments which are regularly reviewed.

(iii) Risk Management plans are carried out subject to Trust policy and guidance.

(iv) Mental Health and Substance Misuse Services work jointly to contribute to care plans, treatment plans and risk management plans. This covers and offers the range of partnership liaison services from joint assessments, joint working to one off stand alone telephone advice/consultation.

(v) Mental health and substance misuse services should utilise existing external partnership arrangements for opportunities of joint working ensuring a comprehensive package of care.

(vi) Disputes between services are resolved via informal dispute resolution process, using the immediate line manager and management structure of each practitioner, team or service. It is likely that this will include a multidisciplinary Team discussion. If this does not bring about a conclusion, a senior manager may assess and resolve the matter or it may be referred to the Medical Director/Director of Nursing for a final position on the issue.

(vii) Any unmet need should be recorded in the Care Plan. If lack of provision constitutes to heightened risk this is reported via risk management procedures

and recorded and monitored accordingly, via the monthly Integrated Governance Group.

(viii) All community mental health teams will have access to appropriate drug testing equipment.

9 EQUALITY AND DIVERSITY

9.1 BME groups

Black and minority ethnic groups may not have ready access to and can be poorly served by mental health and substance misuse services.

The Trust will ensure that it works closely with DAAT and LIT partnerships to identify the needs of people from BME groups to ensure that services are culturally competent and able to respond to specific needs.

9.2 Women

Service planning will take account of the needs of women with mental illness and substance misuse. Trust services will ensure that the general and specific needs of women with a dual diagnosis are met.

10 Process for implementation

10.1 Implementation

The key areas of implementation are detailed in the implementation plan – see Appendix 1.

10.2 This strategy will be posted on the Trust intranet site, where all staff will be able to access and comment on it.

10.3 This strategy will be publicised within the Trust and in the internal Trust news.

11 Monitoring Arrangements

11.1 The implementation plan details the key areas to be monitored and the lead person responsible for ensuring that work areas are delivered.

11.2 The Operations Director Specialist Services will have the overall responsibility for ensuring that the implementation plan and strategy is delivered.

11.3 The numbers of staff receiving dual diagnosis training will be audited.

11.4 The numbers of shared care plans will also be audited.

12 Equality Statement

12.1 This strategy is not expected to have particular implications for black or ethnic minority groups. All staff will be expected to practise within cultural competence parameters.

13 Policy number: CG053

14 Training

14.1 Training and development is described in Section 6 above.

15 Links to Other Policies

15.1 The Dual Diagnosis Strategy has a direct link with the following existing policies;

- Pharmacological Management of Alcohol and Drug Dependence in In-patient Psychiatric Settings Policy
- Addictions Services Prescribing and Dispensing Policy
- Drug Testing Policy
- Risk Policy

16 References

16.1 The following national guidance documents have been referenced in the preparation of this document;

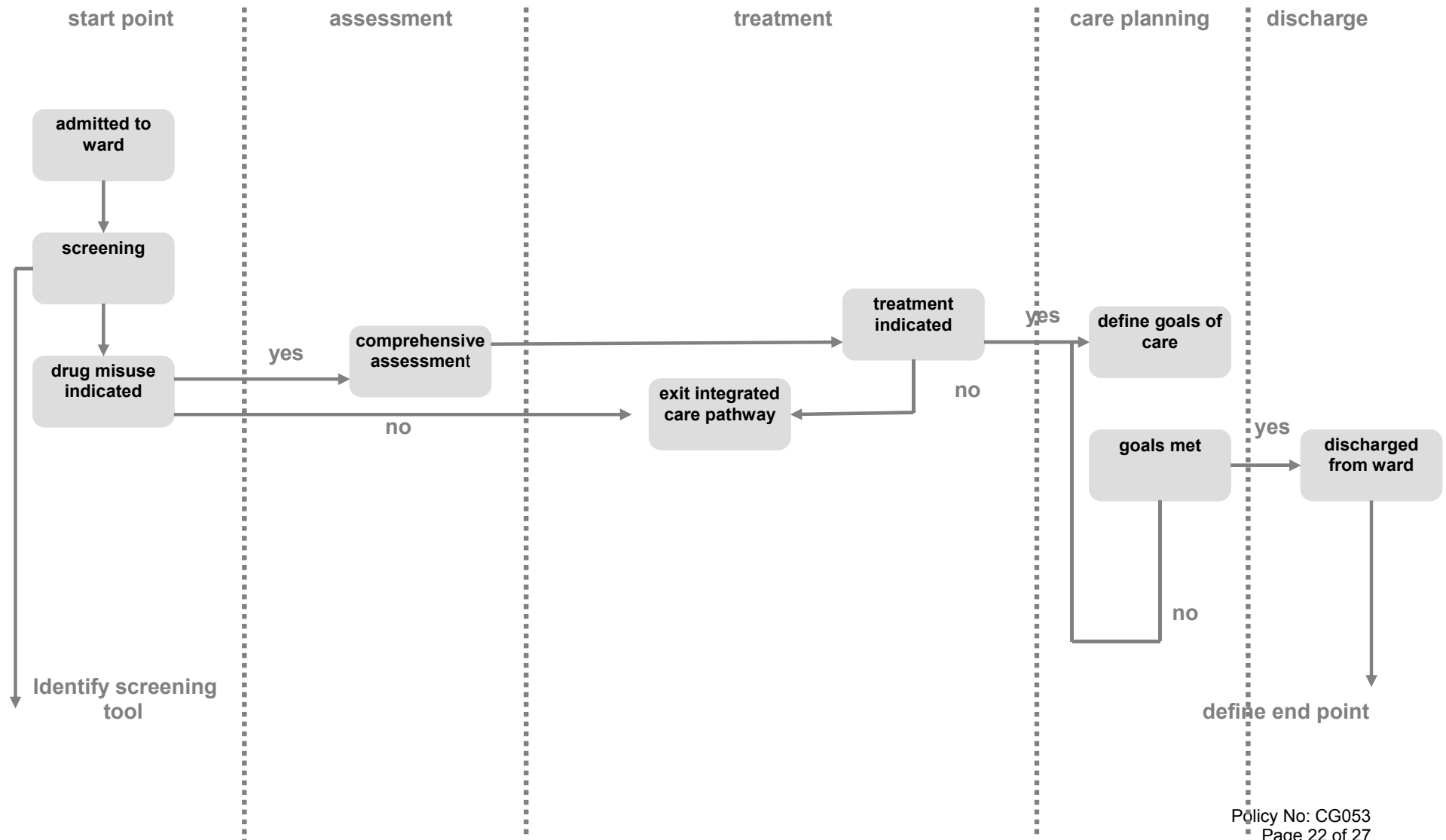
- (i) Policy Implementation Guide: Dual Diagnosis Good Practice Guide, DH 2002
- (ii) Models of Care, NTA 2002 (updated 2006)
- (iii) National Service Framework for mental health – 5 years on, DH 2004
- (iv) Ten Essential Shared Capabilities for Mental Health, NIMHE 2004
- (vi) Dual Diagnosis Capability Framework, University of Lincoln, 2006
- (vi) CPA – Refocusing the Care Programme Approach, DH 2008

Appendix 1 – outline of implementation plan

TASK		NHSLA
STRATEGIC FRAMEWORK		
consultation	Responsible	
draft strategy to be circulated with deadline for comment	SB	1.4.3
amendments incorporated	SB	
national and local drivers		
embed national targets in NELFT service model	SB	
develop local ambition targets for services	AMc/SB	
ensure Vital Signs targets embedded in service model	SB	
identify local outcomes measures	AMc/SB/expert group	
service model		
develop vision for new service model	AMc/SB/JF	
agree service model with partners	AMc/SB	
develop operational policies	SB/expert group	2.4.3
embed local and national targets in service model	SB/expert group	
needs assessment		
review existing NELFT needs assessment	AMc/expert group	
identify brief screening tool to use with % of existing service users	expert group	2.4.3
performance		
conduct baseline assessment of data collection requirements	expert group	
review data collection systems	expert group	
agree minimum data set with partners	SB/expert group	
develop balanced scorecard parameters	SB/expert group	
develop local delivery agreement	expert group	
investment planning		
identify gaps in commissioned services	SB	1.4.3
identify priorities for 2009/10	SB/AMc	
consult with PCT and DAAT partners to identify joint priorities	SB	
submit investment plans	SB/expert group	
stakeholder groups		
establish cross policy stakeholder group to include DAAT and LIT leads	SB/AMc	
establish working group of frontline staff from MH & SM services	expert group	
resource identification		
review current specialist staff roles	Directors/AMc	3.4.3
review borough based staff roles and evaluate effectiveness	Directors/AMc	3.4.3
review composition of dedicated staff resource	Directors/stakeholders	3.4.3
integrated governance		
ensure DD risk and management is part of integrated governance	SB/AMc	1.4.3
COMMUNICATION STRATEGY		
communication strategy		
hold a dual diagnosis summit for all stakeholders	SB/expert group	
WORKFORCE DEVELOPMENT		
training and development		
review training needs analysis	AMc/expert group	3.4.3
identify skill set for staff dependent on work area	AMc/expert group	3.4.3

commission modular training for all staff (awareness)	MD	3.4.3
commission modular training for all staff (screening and assessment)	MD	3.4.3
commission specialist training for identified staff teams	MD	
roll out training	MD	
embed a capability framework	AMc/SB/Directors	3.4.3
CLINICAL CARE FRAMEWORK		
screening		
Identify screening tool to be used in inpatient and community settings	AMc/expert group	3.4.3
care and referral pathways		
review care pathways	AMc/stakeholders	
establish clear responsibility guidance for MH, PD and SM teams	AMc/SB/JF	2.4.3
establish clear pathway across MH and SM services	AMc/stakeholders	2.4.3
embed the principle of integrated care pathways	SB/AMc/JF	
risk management		
embed risk assessment and risk management processes in clinical care	AMc	3.4.3
personality disorder		
review care pathways	AMc/SB/JF	
establish clear pathway across PD and SM services	AMc/SB/JF	2.4.3
children and young people		
establish working group for children and young people	SB/TR	
draft policy guidance for children and young people	TR/expert group	1.4.3
inpatient services		
establish management process based on DH guidance	SB/stakeholders	3.4.3
embed protocol through training	Directors	
SERVICE USERS AND CARERS		
consultation		
facilitate a dual diagnosis forum for service users and carers	SB/expert group	
establish service user standards for dual diagnosis	SB/expert group	3.4.3

Appendix 2 – example of an inpatient integrated care pathway



Appendix 3 – risks associated with substance misuse and dual diagnosis

Definitions

A substance in this context refers to illicit drugs, the hazardous or 'binge' use of alcohol or prescription psychotropic drugs. Substance misuse in this context subsumes the following clinical syndromes:

- Acute intoxication (may be with or without delirium)
- Withdrawal syndrome
- Withdrawal delirium (e.g. *delirium tremens*)
- Harmful use/misuse
- Dependence syndrome
- Substance –related organic mental disorders. The commonest in clinical practice are Delirium Tremens and Wernicke's Encephalopathy
- Other disorders such as alcoholic hallucinosis and alcoholic dementia

Clinical features and differences of syndromes

All staff must be aware that a patient, especially a newly admitted one, may move between the stages of intoxication, sobriety, withdrawal and withdrawal delirium very quickly and require frequent assessment of their needs and risks, including physical observations, level of nursing observations and medical treatment.

Dual Diagnosis refers to a combination of a mental disorder and substance misuse i.e. substance misuse and / or a learning difficulty, organic mental disorder, mental illness or personality disorder.

Only standard diagnostic systems such as ICD-10 should be used when describing patterns of substance use and patterns of dual diagnosis. Non standard terms such as "drug-induced psychosis" or "addictive personality" are vague, misleading and likely to lead to poor risk management plans. All Trust staff should be able to, and prepared to assess substance use specific risks as the Trust provides a range of specialist substance use services, and substance use is the norm amongst users of other psychiatric services, especially those who present with risk behaviours.

Alcohol and type of drugs

There are five main groups of drugs based on their pharmacological properties. All staff should be able to carry out a systematic assessment of alcohol and drug used based on these different groups. All staff should however, always ask about the use of other or unusual drugs, especially when the service user experiences a dramatic change in their mental state.

(i) Alcohol

Staff should know the definition of an **alcohol unit** (8 grammes or 10millilitres of pure ethyl alcohol), standard definitions of terms such as binge drinking) and be familiar with simple screening tools such as the AUDIT (Alcohol Use Disorders Identification Test).

(ii) Opioids

Morphine, heroin, opium, methadone, subutex, codeine, tramadol and other opioid-like prescription analgesics).

(iii) **Sedatives**

Anxiolytic and hypnotic drugs including benzodiazepines (such as lorazepam and diazepam), “ z drugs” such as zopiclone and barbiturates. They are cross tolerant with alcohol. Drugs such Gamma-hydroxybutyrate (GHB, liquid ecstasy) are also best included in this group.

(iv) **Cannabis/Cannabinoids**

There are specific cannabinoid receptors in the brain so it is useful to consider cannabis in a group of its own. The cannabinoids have sedative and hallucinogenic properties and may be cause physical dependence. There is no such thing as a specific cannabis-associated psychosis. Cannabis is rarely used alone; alcohol abuse is very common.

(v) **Stimulants**

Includes cocaine, amphetamines and khat (quat). These drugs directly or indirectly enhance the effects dopamine, adrenalin and noradrenalin.

(vi) **Hallucinogens**

Includes a diverse group of chemicals. The best known such as LSD and magic mushrooms (which contain psilocybin) enhance the effect of serotonin. Ecstasy has a mixture of stimulant-like and hallucinogenic properties.

Risk areas / issues in relation to substance use

The principle of assessing substance use associated risk is assessing the individual, the drug(s), and the environment or context in which they use. Substance use-associated risks should be assessed in six domains (American Society of Addiction Medicine):

Domain I - risks associated with pattern of substance use, presence of dependence, intoxication and withdrawal.

These include:

- The drug(s) used, amounts, route and site of administration. Compulsion to use and difficulty reducing or stopping use.
- Effects of intoxication e.g. accidents, respiratory depression/ overdose, falls etc
- Effects of withdrawal e.g. withdrawal seizures
- Risk of diversion of prescription drugs, “double scripting” etc.
- Re-instatement of problematic use after a period of abstinence. Re-instatement of substance use following hospitalisation or imprisonment can be extremely hazardous due to loss of tolerance to drugs/ alcohol. Where opioids like heroin are involved the loss of tolerance may be fatal due to respiratory depression.

Domain II – biomedical problems.

Common examples include:

- Hypertension, hyperthermia, stroke, hepatitis and other blood borne viruses.
- Other injecting related risks e.g. thrombosis, septicaemia.
- Pregnancy and contraception / fertility.
- Sexual health and sexually transmitted diseases.
- Amnesia and cognitive impairment.

Domain III – impact on psychiatric symptoms and type of risk behaviour.

The relationship may be complex. However the following psychiatric syndromes especially link risk behaviour and substance use:

- Pathological jealousy (cocaine/ alcohol commonly implicated)
- Anti-social personality disorder (psychopathy)
- Borderline personality disorder.

Risk domains that should be routinely asked about include: social, housing, criminal justice problems (violent and non-violent), domestic violence, childcare/ child protection issues.

Domain IV- degree of motivation for change of substance use.

The following should be considered:

- Assessment / structured non –judgemental feedback alone can be very effective in promoting change.
- Matching services to clients pace of change and desired goal are more effective than trying to “force” change. Ambivalence to change is normal.
- Attempts at abstinence may be difficult or frankly hazardous to achieve without help e.g. assisted alcohol detoxification or methadone stabilisation treatment.

Domain V – recovery potential.

The potential for recovery in future involves an assessment of protective or positive factors:

- Length and severity of addiction including previous periods of abstinence / attempts to change.
- Previous response to treatment (e.g. adequate doses of methadone).
- Personal strengths and resources (e.g. previous work record).
- Family, community and other ecological resources.
- External motivators e.g. probation order.

Domain VI – potential for relapse or continued use.

Ongoing risk factors for continued use or relapse following abstinence include:

- Attitudes and substance of family, peers etc. Family or friends who use drugs (or alcohol), condone substance use, or engage in “rescuing” behaviours (e.g. paying for drugs) can perpetuate the problem.
- Lack of structure, routine, housing, employment.
- Ongoing stressors or life events (including active psychiatric illness).
- Presence of external triggers/cues e.g. paraphernalia at home.
- Internal triggers or cues (self medication).
- Lack of alternative coping strategies.
- Associating drugs / alcohol with celebrating or having fun.
- Automatic beliefs e.g. permissive thoughts (one drink will be OK) or catastrophising thoughts (I need a hit to make it through the day).

This 6 domain model is particularly helpful for care planning and risk management of substance use, whether in or by substance misuse or general psychiatric services.

Where there is a dispute between professionals or services about the management of a substance using patient, the patient should be reviewed with this 6 domain structure. If necessary this should be combined with other structured assessments such as the HCR-20 and guidance from colleagues in Forensic and / or Personality Disorders services (IMPART).

Equality Impact Assessment Screening Tool

Directorate/Department	Specialist Services
Policy or Procedural Guidelines Title/Service	Dual Diagnosis Strategy
New or Existing Policy/Service?	New policy
Name and role of Assessor	Sue Boon
Date of Assessment	27 th October 2008

		Yes/No	Comments
1	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	• Race, Ethnic origins (including, gypsies and travellers) and Nationality	No	
	• Gender	No	
	• Age	Yes	Policy is for adults only
	• Religion, Belief or Culture	No	
	• Disability – mental and physical disability	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
2	Is there any evidence that some groups are affected differently?	Yes	
3	Is there a need for external or user consultation?	Yes	DAATs and Local Implementation Teams will be consulted in regard to service modelling and investment Service users and carers will be consulted in regard to service modelling
4	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	Yes	A strategy for children and young people needs to be seen in the context of safeguarding children; and existing policy guidelines for mental health services and substance misuse services in relation to this service user group.
5	Is the impact of the policy/guidance likely to be negative?	No	
6	If so, can the impact be justifiable?		
7	What alternatives are there to achieving the policy/guidelines without the impact?		It is recommended that because of the additional risks in relation to children and young people that a further policy should be created for this client group

8	Can we reduce the impact by taking different actions?		No

Recommendation	
Full Equality Impact Assessment required:	NO <input type="checkbox"/> YES <input checked="" type="checkbox"/>
Assessor's Name: Sue Boon	Date: 5th November 2008
Name of Director: Sue Boon	
Assessment authorised by: Name: HKB (member of the Equality and Diversity Group)	Date: 5th November 2008