



SCAN Consensus Project 2

Substance misusing clients with mental health problems

A brief practitioner's guide for Criminal Justice Integrated Teams

The authors of this brief guide

Professor Colin Drummond, MD, FRCPsych *SCAN lead, Professor of Addiction Psychiatry, National Addiction Centre, Institute of Psychiatry, Kings College London*

Tom Phillips, RMN, MSc *SCAN Policy Advisor, Consultant Nurse in Addictions, Humber Mental Health Teaching NHS Trust*

Dr Billy Boland, MBBS, MRCPsych *Specialist Registrar in Psychiatry, St George's, University of London*

The Specialist Clinical Addiction Network (SCAN) is a national network for UK addiction specialists. At present this includes Consultant Psychiatrists, Specialist Registrars and Associate Specialists who work in the field of addiction. Staff grade doctors in addiction psychiatry may be registered as affiliate members.

SCAN is funded by the Department of Health and jointly supported by the Department of Health, the Royal College of Psychiatrists and the National Treatment Agency for Substance Misuse, but is independent of all three agencies.

SCAN's main aims are to provide support and promote networking to enable specialists to maximise treatment effectiveness.

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Introduction

Who is this guide for?

This guide has been designed specifically for staff in Criminal Justice Integrated Teams (CJITs) but it may also be useful to other service providers. Staff in these services see many clients who have both substance misuse and mental health problems (also known as comorbidity or dual diagnosis). While it is not the core role of CJITs to manage or treat the mental health element of a client's co-occurring mental health problems, it is important to be able to recognise and refer clients with these problems to appropriate care and with the appropriate degree of urgency.

Why has this guide been produced?

Research has clearly established that there is a very high level of mental health problems co-occurring in those with substance misuse disorders. While the most severe and enduring forms of mental illness, such as schizophrenia, are uncommon in clients presenting to CJITs, the common or less severe mental health problems, such as anxiety, depression and personality disorder, are often present. The problems may complicate management of care, and sometimes present risks to the client or others. It has become apparent that there is a need for improved advice for CJIT staff about the range of mental health problems likely to be seen, the relevant services for managing such problems, which clients may benefit from the various services, and how they can be accessed.

How was this guide developed?

The Home Office commissioned this guide. Its development was overseen by a steering group with wide stakeholder involvement, including the Department of Health and other government departments, agencies involved in the organisation and delivery of substance misuse and mental health services, and the CJITs themselves. A Working Group (detailed on page 31) developed a background briefing document on the available literature and a team from the Specialist Clinical Addiction Network (SCAN) then distilled this information down to this brief practitioner's guide for CJIT staff.

How to use this guide.

This is intended to be a step-by-step practical guide on how to identify, assess and refer substance misusers with co-occurring mental health problems to relevant services. Given the constraints of space, the guide should not be seen as a comprehensive textbook on mental health problems and further reading is encouraged (see 'Further reading' on page

29). However, it is intended that this guide should provide sufficient information to inform the decision making of CJIT staff.

The customisable template

The guide includes a template for CJITs to record relevant local contacts who can advise on, or accept urgent and non-urgent referrals of clients with co-occurring mental health problems. In order to obtain the information required to complete and update this template accurately, a responsible CJIT lead(s) needs to be identified. This template will help to ensure appropriate access for all CJIT staff to information on the local services which will support their effective and efficient liaison in everyday practice.

How to identify mental health problems

This section describes the more common mental health problems that can occur in drug and alcohol misusers. It is not intended as a completely comprehensive list but rather to provide awareness of the more common types of presentation and to give a framework for CJIT responses.

There is no simple classification for mental health problems as various dimensions can overlap. Some forms of 'severe mental illness' can actually present with little current problem (e.g. well-controlled schizophrenic illness) whilst some forms of common mental health problems can be unusually severe (e.g. there can be very severe and disabling cases of anxiety disorder). Whilst the 'severe mental illnesses' will be seen much less often by most CJIT staff, some awareness of what they are, and having adequate information to inform risk assessment in such clients is important. Common or less severe mental health problems will be experienced much more often by CJIT clients, so their broad recognition by CJIT staff is very important, as well as an ability to consider what are the most appropriate routes locally for assessment and support.

Hence, in this guidance, we divide the disorders pragmatically into these two main groups based on broad diagnostic categories and the likely differing pragmatic CJIT responses. The groups are:
 (1) 'common or less severe mental health problems' – such as anxiety, depression, personality disorder;
 (2) 'severe mental illnesses' (SMI) – such as schizophrenia and bipolar affective disorder.

1. Common or less severe mental health problems

There are many types of mental health problems in this category and they are often found as co-occurring problems in substance misusing clients. Even though these disorders are not typically as severe as 'severe mental illnesses' (SMI), some clients can sometimes present significant risks to themselves or others in conjunction with substance misuse problems.

Depressive disorder

The principal problem is low mood or loss of interest or pleasure. This is often accompanied by negative thinking, hopelessness and guilty thoughts, and with low energy, poor concentration and changes in appetite and sleep. Sometimes suicidal ideas and impulses are also present.

Depression often occurs in discrete, recurrent episodes with periods of good mental health in between. Often depression is precipitated by negative life experiences (e.g. a bereavement, divorce, loss of job). Sometimes a depressive disorder can be triggered following childbirth (postnatal depression).

It can be difficult to distinguish between a client feeling unhappy because of problems in their life, which is very common, and a client having a depressive 'disorder' that needs treatment from a GP or mental health team. Depressive disorder is generally treated in the community, in primary care, whilst more severe cases will need to be managed by a mental health team or mental health professional, particularly if there are features of psychotic depression, where the problem is compounded by depressive delusions (see

below for definitions of 'psychotic' and 'delusion'), or where there is considered to be a high risk of self-harm or suicide.

Depending on severity, treatment for depression may be increasingly stepped up in intensity (NICE, 2006):

- for mild forms, using simple 'watchful waiting', guided self-help or brief interventions; to
- for more moderate or severe forms, more extensive psychological therapies (such as cognitive behavioural therapy) and social support, often with the addition of antidepressants (e.g. SSRIs); and
- for very severe cases, the infrequently-used electroconvulsive therapy (ECT).

Depression is common in clients who are alcohol dependent, and the risk of suicide is increased in those intoxicated with alcohol. Where the depression appears secondary to current excessive drinking in alcohol dependence, a thorough assessment and assisted detoxification are needed before antidepressant treatment should be considered. Most such 'secondary' depression will actually improve within a few weeks following the assisted withdrawal so only a minority will then require antidepressants. A cocaine or amphetamine "crash" after heavy use is also commonly accompanied by a period of days of marked depression, which may be a period of higher risk.

Anxiety disorders

Anxiety symptoms are relatively common in substance misusing clients and may be mild and short-lived, but some clients suffer from particularly severe or acute anxiety which can be very distressing for the client and those around them.

The most severe anxiety presentation is usually *panic disorder* (or panic attacks), where the client has episodes of acute anxiety and feelings of panic, and tends to take avoidance actions to prevent the feelings. Generalised anxiety disorder is usually diagnosed where anxiety is present most of the time. This can also be quite disabling in some people. Other forms of anxiety disorder can be severe but tend to be more circumscribed and include phobias where the client is afraid of certain places, objects or situations (e.g. agoraphobia, claustrophobia, spider phobia).

Anxiety disorders, including panic disorder, should be investigated and managed by a GP or mental health team. Drug treatment can involve short-term use of tranquillisers or SSRI-type antidepressants. But these conditions can often be managed with self-help manuals or cognitive behavioural therapy, either in primary care or a specialist therapy service. A classic physiological symptom which often accompanies an acute anxiety attack is 'hyperventilation' (over-breathing), which can worsen the attack. Try to have a calm and reassuring approach and ask the client to re-breathe into a paper bag to counter the symptom.

In clients attending substance misuse services, anxiety symptoms are commonly a complication of the drug or alcohol misuse. In such cases, most respond to adequate substance misuse management (including treatment of withdrawal symptoms) but a minority will continue to experience anxiety problems after stabilisation of the substance misuse behaviour. These clients are likely to need further specialist mental health assessment and treatment. Anxiety can itself be provoked by taking various drugs including cannabis, stimulants (e.g. cocaine), alcohol and even benzodiazepine tranquillisers, and commonly during withdrawal from many drugs including opiates, alcohol and benzodiazepines.

Obsessive-compulsive disorder (OCD)

This is less common in substance misuse clients than anxiety disorders.

OCD is characterised by:

- obsessional thoughts which the client finds intrusive and worrying (e.g. that the client's house is going to burn down, or that the client will be contaminated by bacteria), and
- compulsive behaviours (e.g. that to prevent the house burning the client needs to repeatedly check the lights are off, or to avoid contamination repeated hand washing is essential).

Symptoms occur with varying severity leading to different levels of distress and disruption to the client's life.

The main treatment is cognitive behavioural therapy but some drug treatments are also effective.

Post-traumatic stress disorder (PTSD)

This is common in substance misuse clients who are at much higher risk of experiencing traumatic events than the general population.

PTSD is characterised by:

- re-living a particularly traumatic experience (or flashbacks);
- avoiding people or places associated with the trauma;
- feeling emotionally "numb";
- experiencing irritability or being easily startled;
- disturbed sleep; and
- symptoms of depression and anxiety.

The main approach to treatment is cognitive behavioural therapy from a specialist service.

Eating disorders

These are relatively common in substance misuse clients and can occasionally be life threatening when severe weight loss occurs.

The two main types of eating disorder are:

- *anorexia nervosa* where there is severe restriction of food intake, loss of weight and distorted body image (feeling overweight, although actually underweight); and
- *bulimia* in which the client often binges on food, followed by self-induced vomiting.

Both conditions are associated with guilt and depression.

Drug and alcohol misuse may often be closely associated with an eating disorder (e.g. using stimulants to suppress appetite or bingeing on both alcohol and food), often driven by the same compulsive behaviour.

These are best initially assessed by the GP but more severe cases will need referral to a mental health team or specialist eating disorder service.

Since alcohol dependence and many forms of drug dependence can lead to extreme loss of weight, it can be difficult to distinguish between a primary eating disorder and malnutrition due to drug and alcohol dependence. This distinction will often require more specialist assessment.

Personality disorder

Personality disorders are common in substance misuse clients.

There are many different types of personality disorder and most primarily involve:

- abnormal ways of relating to others (e.g. emotional over-involvement, detachment, suspiciousness, aggressiveness, violence, narcissism), or
- having negative feelings about one's self (worthlessness, low self esteem, self-harm).

They are usually present from early in life and develop before the substance misuse. In many cases it is difficult to distinguish between behaviour which is a consequence of drug or alcohol dependence, and that which existed before the dependence developed. Often it comes down to a combination of the two, in that substance dependence can exacerbate pre-existing personality traits.

Sometimes people with severe personality disorder can pose a significant risk to others (e.g. violence) or themselves (e.g. suicide and self-harm). Hence, having a personality disorder does not necessarily mean a person is any less of a risk than someone with a severe mental illness.

Specific treatment is primarily psychotherapy, provided by a specialist service. This is usually only considered once a client is drug and alcohol free.

2. Severe mental illness

There are many different types of severe mental illness (SMI) but they often involve a degree of psychosis (where there is evidence of loss of touch with reality, and often including hallucinations and delusions). The two classic forms are schizophrenia and bipolar affective (or manic-depressive) disorder. From the CJIT perspective it is not critical to be able to identify which specific form of SMI a client may suffer from, so this section is merely an overview of the kind of SMIs that can be encountered.

Clients with SMI typically represent only a relatively small proportion of the caseload of substance misuse services but their mental illness can complicate clinical management, affect engagement and compliance, and can sometimes present serious risks to the client or to others. Clients with previously unidentified SMI may present to services for the first time as a result of their substance misuse problem. More commonly, these mental health problems are already enduring and chronic when they present to a CJIT, and many such clients will already be known to their GP or local mental health services, even if currently disengaged from these services.

Schizophrenia

This is a severe and often chronic form of mental illness which is characterised by:

- abnormal beliefs or delusions (e.g. that the client is being persecuted or pursued),
- hallucinations (e.g. hearing voices that are not audible to anyone but the client),

- disorders of thinking (which can be difficult for the listener to follow or understand); and
- disorders of behaviour (unusual postures or mannerisms).

In the more chronic stage of schizophrenia there is often social and intellectual deterioration. It may also be accompanied by disturbances of mood (e.g. severe depression or elation) and can be difficult sometimes to distinguish from a severe mood disorder (see below).

Many people with schizophrenia misuse substances including stimulants, alcohol and cannabis, which can worsen the condition.

Clients who take cannabis and stimulants (e.g. cocaine, crack, amphetamine, methylamphetamine) can develop short-lived paranoid or psychotic states (lasting hours or days): with feelings of paranoia and misinterpretations of events, or even hallucinations (hearing and seeing things) and delusions. This is an acute effect of these drugs and is often self-limiting after the client stops taking the drugs without the need for further treatment. It can sometimes be difficult to distinguish between such a drug-induced psychosis and psychotic symptoms arising from the SMI. Particularly if prolonged or severe, the problem may require a specialist mental health service to diagnose and manage such clients.

During the 'acute phase' of schizophrenia (with active and developing symptoms) there can be high risks to the client or others, particularly if the client is severely deluded (potential violence to others) or depressed (suicide risk). Treatment usually involves antipsychotic medication. Assessment under the Mental Health Act, and sometimes compulsory hospitalisation, will be needed in an acute phase where the risks are significant and the client refuses to undergo treatment.

Bipolar affective disorder

This is a disorder of mood (*affect*) which is characterised either by:

- repeated episodes of elation (*mania = severe excitement or over-activity, hypomania = less intense*), where a client talks rapidly and is hyperactive, or
- alternating episodes of elation and depression, often with periods of normal mood in between (sometimes called manic-depressive episodes).

These episodes of high or low mood can alternate rapidly over weeks or months, or more slowly over years, with periods of several months or years of good mental health in between.

Again, some acute drug effects (e.g. of cocaine, amphetamine or even of alcohol) can mimic the changes in mood seen in bipolar disorder, and if severe or persistent will require a specialist mental health team for diagnosis and management.

In the acute phase of this illness, clients can be at risk to themselves or others - there is a high risk of suicide. Treatment is usually with *mood stabilisers* (e.g. lithium or carbamazepine) and antidepressants during a depressive phase or *antipsychotics* during a manic phase. Again, severe states may require assessment under the *Mental Health Act*.

How to assess mental health problems

General approach to assessment of mental health issues

It is important to ask questions in an empathic and non-judgmental way, and to take plenty of time to build a rapport with the client before discussing what they might perceive to be intrusive questions.

It is also important to be clear with the client about confidentiality. There will be occasions where the identified risks warrant disclosing information to others and the client needs to know this may happen. However, it is also necessary to gain the client's trust and allow them to disclose highly personal information or concerns. Reassurance must be provided about the strict application of confidentiality to any personal or sensitive information disclosed. CJIT staff will usually need written consent from the client for referral on to other services - allowing disclosure subject to local information-sharing protocols. However, referral can be made without consent if there are over-riding concerns about the risks to the client or others. (See also the *Drug Interventions Record – Background Information for CJITs and CARATs*. Home Office, 2007, and *Managing Drug Misusers under Probation Supervision – Guidance for Probation, CJITs and CARATs*. Home Office, 2007)

In addition to questions which elicit information about symptoms and risks, there are important features/signs that can be observed which provide a pointer to possible mental health problems.

It is not expected that CJIT staff should be competent to carry out a comprehensive mental health assessment, which requires specialist training and competence for complex cases. This guidance is designed to assist CJIT staff to identify important mental health symptoms, signs and risk factors that are relevant to determining the urgency and type of referral and care the client requires.

Whilst an individual client may need to be referred to a specialist service, CJIT staff may be involved in offering basic support and education in relation to maintaining mental wellbeing, compliance with medication and assessment and reassessment of risk. It is important to know what, if any, mental health medications are being prescribed whilst a client is accessing treatment through the CJIT team.

Assessing severity and risk to assist in determining next steps

In order to determine the most appropriate referral where a mental health problem is suspected, it is important to find out more about what the client is experiencing, to establish:

- if there is a serious problem;
- how urgently it needs to be addressed; and
- whether any specific risks are involved.

Regardless of the type or cause of the mental health problem experienced by a client, the intensity of symptom(s), and the degree of distress or disruption it causes, can be an indication as to which particular service – primary care, specialist substance misuse or specialist mental health services – should be consulted. A specialist substance misuse service in this context refers to one able to offer specialist assessment and treatment of substance misuse and mental health issues, usually with access to a psychiatrist specialised in addiction. Assessment of severity and level of risk, together with an

understanding of the referral paths locally, should enable a well-informed and pragmatic response.

The greater the severity of problems, the more likely the client will require the involvement of a specialist service rather than simply involving primary care. If a client is acutely distressed and considered to be high risk, their mental health is likely to require immediate assessment from an emergency specialist mental health service.

For problems of intermediate risk and severity, where there is uncertainty about the best way to respond, CJIT staff may find discussion with a local specialist substance misuse practitioner helpful. This may help to determine whether an early referral to a specialist mental health service would be preferable to awaiting the outcome of a referral solely to the specialist substance misuse service.

If there is only a mild mental health problem with no other immediate risks identified, it may be dealt with by recommending a visit to the GP or by arranging a non-urgent appointment with the specialist substance misuse service where the issue can be assessed further.

Introducing mental health enquiries with clients

Some general opening questions to ask to assess potential mental health problems and to initiate discussion include:

- Is there anything you are worried or concerned about at the moment?
- Is there anything that might be upsetting you?
- When was the last time you felt completely well in your thoughts or feelings?
- Have you ever had involvement with mental health services in the past?

Assessment of mood

Both low mood and elation in substance misusers can often be related to intoxication or withdrawal. If so, other symptoms and signs are likely to be present (e.g. slurring of speech, poor coordination and poor concentration with intoxication, and shaking and sweating with alcohol and opiate withdrawal). Asking how much alcohol or drugs have been recently consumed and when they were last taken should help to clarify this relationship.

If low mood is associated with feelings of guilt, worthlessness, or hopelessness, this may increase the risk of suicide and this will require more in-depth assessment by an experienced professional. Likewise, unnatural levels of euphoria not related to drug or alcohol intoxication will require more specialised mental health assessment. Clients who are severely depressed will often appear sad or tearful, but they may also be slow in their movements, and have difficulty concentrating. Irritability may be a feature. They may also complain of loss of interest in normal activities, disturbed sleep, and poor appetite. Clients who are manic will have pressured speech (rapid with few or no breaks), be overactive and restless, irritable, and loud. They may also have poor sleep and appetite and have poor concentration and may be easily distracted. It is important to recognise that manic states do require urgent mental health assessment because of the rapid harm that can be done to the client's life. In some cases there can be increased risks to others.

Opening questions to ask about *recent mood* include:

- How have you been feeling in yourself recently?
- How do you feel at the moment?
- During the last month, have you often been bothered by feeling down, depressed or hopeless?
- During the last month, have you had little interest or pleasure in doing things?
- During the last month, have you felt unusually well in your moods?
- Does your mood appear to fluctuate frequently?

Assessment of suicidal thoughts and self-harm

Clients who have recently self-harmed should be assessed for risk of further attempts.

All clients should be asked about suicidal thoughts or intentions as part of a routine initial assessment as these need to be closely monitored. Many people who have not been formally trained in mental health assessment can find it difficult to ask clients about suicidal thoughts. However, providing this is done in an empathic way, clients usually accept enquiries from professionals about self-harm.

This assessment should include identification of the main features known to be associated with risk of further self-harm and/or suicide, including depression, alcohol dependence, hopelessness, continuing suicidal intentions. (See more detailed section on *Risk Assessment* below.)

Opening questions to ask about *self-harm* include:

- Have you felt like there is no point in going on?
- Have you felt like harming yourself?
- Have you thought about trying to take your own life?
- Have you actually harmed yourself in the past? Can you tell me what happened?

Assessment of delusions (abnormal beliefs)

A delusion is “a false belief which is out of keeping with a person’s background and unchanged by logic”. For example, a client may falsely believe that he is a victim of a plot or conspiracy to harm the client. A feature of this *paranoid delusion* is that the client may believe this is the work of a powerful organisation such as the police, church, etc. There are many different types of delusions and these can be associated with stimulant and cannabis use, severe alcohol withdrawal and mental disorders. Sometimes even apparently extreme beliefs may have some basis in fact, such as a client’s neighbours may actually be carrying out a vendetta. So it can be helpful to ask another informant, such as a partner or friend, about the reality or otherwise of the situation. The cause of delusions can be very difficult to establish at an initial assessment. An assessment from a specialist mental health service should be sought where CJIT staff think there is a likelihood that the client is suffering from delusions which are not already known or being treated. In some cases, CJIT staff may wish to seek further information on past and present mental health service involvement from the client’s GP first if this is feasible.

Opening questions to ask concerning possible *delusions* include:

- Have you been concerned about anything strange going on around you?
- Do you feel as if you are the focus of attention, or that others may have it in for you?
- Are you fearful about anything in your life at present?

Assessment of hallucinations (abnormal perceptions)

A hallucination is 'a false perception (sight, hearing, smell, taste, feeling) occurring without any true sensory stimulus'. For example, a client may describe hearing 'voices' that are issuing commands, making suggestions or commenting on the actions of the client. These 'voices' may be threatening or friendly. It may be that the client simply hears voices or sounds that are not particularly related to the client, such as people talking or music. In all cases the important thing to establish is whether there is a true stimulus (e.g. voice, sound or object) or whether this is a false perception. Hallucinations may be associated with hallucinogenic drugs (e.g. LSD), stimulants and cannabis use, alcohol intoxication/withdrawal and a wide range of severe mental disorders. There may also be visual hallucinations (such as seeing insects or more complex images), and these are more prominent in some clients experiencing withdrawal or in drug intoxication. A specialist mental health assessment should be sought in every case where CJIT staff suspect a client is experiencing hallucinations. If a client is in acute withdrawal with clear associated physical distress (e.g. sweating and shaking in alcohol withdrawal), urgent medical assessment at an A&E department may be needed. Voices telling a client to self-harm or harm others are of concern, particularly if this is associated with paranoid delusions.

Opening questions to ask concerning possible *hallucinations* include:

- Do you ever hear things like voices or sounds that are not really there?
- Do you ever see strange things in the room like people, animals or other things that are not really there?
- Do you hear voices telling you to do something or act in a particular way?

Considerations in assessment of risk

Potentially all substance misusers presenting to services are vulnerable to risks both to themselves and to others, and therefore an assessment of risk should be undertaken in all cases. This should be consistent with the level of assessment being applied, which for CJIT staff is usually screening or triage assessment (as per Models of Care Update, 2006), as well as consistent with agreed local risk assessment protocols.

The key areas to be assessed and monitored in relation to co-occurring substance misuse and mental health problems include:

- Risk associated with substance misuse (e.g. overdose, infections)
- Risk of suicide or self-harm
- Risk of harm to others (including partner, children)
- Risk of harm from others (including vulnerability to abuse or exploitation)
- Risk of self-neglect

- Risks associated with chronic illness
- Risks associated with lack of or poor accommodation

Although specific risk assessment tools may be developed, all information gathered at assessment should be looked at when considering the degree of risk, as numerous factors influence the severity of risk:

- Severity of substance misuse
- Stability/instability of social circumstances (e.g. isolation, homelessness)
- Stability/instability of mental health problems
- Levels of structured support required
- Frequency and severity of risk behaviour (violence, self-harm, suicidality)
- Lack of social support

It is important to recognise that risk assessment is not a one-off event, as changes in any of the above factors, as well as physical health, will influence the level of support, monitoring and service input required. Risk should therefore be viewed as a dynamic process which requires ongoing assessment and review. CJIT protocols should identify local processes to be employed in the assessment of risk, management plans and review systems.

Where risks are identified, information should be shared across services in accordance with CJIT information sharing and confidentiality policies.

CJIT staff need to practise in an environment which minimises risks to themselves and they should be aware of issues such as the management of their environment, lone working, alarm/security systems and managing challenging behaviour, as per local CJIT protocols and standards.

The highest risk is clearly associated with clients who have made specific threats of harm to themselves or others, or have clear intent to do so. However, some clients who have clear intent do not necessarily volunteer this information. So this requires specific questions to identify thoughts or intent. Occasionally, even this will not elicit a client's true intentions, and it may be relatives or carers or other professionals who raise concerns about risk. In all cases, identified risk needs to be clearly documented (including in relevant case files) and communicated to relevant people (supervisors, police, other professionals) consistent with the appropriate local information sharing policy and with the practitioner's duty of care. When in doubt about possible serious risk arising from the client's mental state, a specialist mental health assessment should be requested.

Description of services for mental health problems

Delivery of mental health provision will vary across the country in the way that services and teams are configured. Although many services and teams may share similar names (e.g. community mental health teams, crisis resolution services, dual diagnosis services) they often work in very different ways and target different client populations. For example, psychiatric liaison services, which are often attached to A&E Departments, may or may not assess clients who present primarily with substance misuse problems. However, the psychiatric liaison service will assess people presenting with acute mental health problems regardless of their substance misuse. For these reasons, it is not possible to provide a common description of the function of each service which would apply to every area in the country. It is therefore recommended for all CJITs to identify a lead worker(s)/manager(s) to contact and build relationships with service providers and/or commissioners to be familiar with the configuration and referral pathways for their locality and share this within the CJIT more widely.

The template provided in this document will assist in recording relevant information. It may be necessary to liaise with a number of key service providers and commissioners to identify all the required information and clarify the local referral pathways to primary care and to specialist substance misuse and mental health services. It may be useful to engage at the level of the Drug (and Alcohol) Action Team (D(A)AT) and Local Implementation Team (LIT) or equivalent partnerships to identify and contact all relevant parties.

Description of the service pathways may then be recorded systematically. Where any gaps are identified, this format can be used to inform CJIT service managers and relevant commissioners to assist them in addressing this. Associated descriptions of referral pathways should particularly emphasise emergency access routes for those at high risk, as well as defining more routine care pathways for those experiencing ongoing or less urgent mental health problems. These referral paths and criteria for referrals need to be agreed between agencies based on the local provision of services.

Local CJIT protocols may usefully help to describe in what circumstances the police (e.g. management of acute violence) or ambulance service (e.g. transferring a client to hospital/A&E department) should be involved. Also CJIT staff need to be aware of local information sharing protocols and agreements.

Routine induction and in-house training for CJIT staff should include knowledge and understanding of related protocols and referral pathways for this client group with co-occurring mental health problems.

Below, this guidance sets out typical roles and responsibilities of the key elements of the care system for clients with co-occurring mental health problems.

General practice

GPs are typically gatekeepers for specialist mental health and other services; and can be important coordinators of complex care. Therefore they should always be informed and updated regarding the care

clients are receiving and any medication being prescribed. GPs often have a role in the assessment and care of a range of mental health and substance misuse problems and should be aware of, and be able to gain access to, specialist mental health and substance misuse services in their area.

Some GPs with a special interest in substance misuse have more specialist skills and competencies, and can provide more advanced substance misuse or mental health interventions than other GPs. Some practices have counsellors or mental health professionals who can carry out a wide range of mental health assessments and interventions in primary care settings. Other practices may rely more on specialist mental health services to provide much of the care for clients with mental health problems.

The GP is usually the best first point of contact for the non-emergency assessment and care of mental health problems, particularly where there are only mild co-occurring substance misuse problems present – they will usually be most familiar with the client’s situation and previous care and may already provide access to mental health support. Some substance misusing clients will not be registered with a GP and, if presenting with co-occurring mental health problems, can often appropriately be referred to the specialist substance misuse service in such circumstances, whilst being encouraged or supported to obtain GP support.

Specialist substance misuse services

Specialist substance misuse services (SMSs), are usually multidisciplinary and led by a consultant in addiction psychiatry or a substance misuse specialist in primary care, with both mental-health-trained and non-mental-health-trained substance misuse workers. Such teams have a key role in the on-going assessment and management of substance misuse problems, including risk behaviours, for those clients with co-occurring mental health problems. However, these services rarely have the resources to provide an emergency response to mental health problems. Further, in most areas the specialist SMS will not usually provide the lead role in managing people who have severe mental illness (SMI), but may provide more of a supporting role in liaison, or partnership, with a community mental health team (CMHT), or other specialist mental health services. The specialist SMS, particularly with a consultant in addiction psychiatry or a nurse consultant in dual diagnosis, can provide non-urgent:

- full risk assessments of whether the client is dangerous or at risk of suicide;
- comprehensive assessment of clients with co-occurring mental health and substance use problems;
- management of clients with co-occurring mental health and substance use problems, including management of antipsychotic and antidepressant therapies, and developing close links or dual services with mental health services; and
- implementation of *Mental Health Act* (1983) and incapacity legislation (*Mental Capacity Act, 2005*) for clients presenting to substance misuse services, where appropriate.

Many specialist SMSs can also provide prompt access to advice for CJIT staff (e.g. through a specialist SMS duty worker or access to senior mental health liaison) and providing advice on referral paths in uncertain cases may be a useful resource for CJIT staff.

Some substance misusing clients presenting with co-occurring mental health problems, will therefore appropriately be referred to the specialist substance misuse service for initial comprehensive assessment of

both the substance misuse and mental health problems, but care is also needed not to delay access to specialist mental health services in cases with more urgent or severe mental health needs.

Specialist dual diagnosis services are usually accessed through either a CMHT or specialist SMS, and most will not accept direct referrals.

Some specialist SMSs have developed in various parts of the country with access to a GP, where there are no specialist mental health professional staff. Their capacity to manage people with co-occurring severe mental health problems will therefore be somewhat more limited. However, at a minimum these services should still be able to provide a more specialised mental health assessment than is possible in the CJIT, and should know where to refer people with co-occurring mental health problems in their locality.

Specialist mental health services

The range of different types of mental health service and variations in models can make it very hard for CJIT staff to identify the most appropriate service provider for a particular client or presentation.

For emergency mental health assessments of clients in the community, each area will have an agreed protocol concerning referral paths and mechanisms:

- During office hours (usually Monday-Friday, 9am-5pm) in some areas a community mental health team will be able to carry out urgent or emergency mental health assessments. However, some areas will have alternative emergency assessment arrangements with crisis resolution/early intervention in psychosis/home treatment teams, or there may be local arrangements for emergency mental health assessments to be carried out by the psychiatric liaison service via the local A&E department.
- Outside normal office hours each mental health trust will have arrangements for emergency mental health assessments which have been agreed by all local agencies including the police and social services. Often this is done via the A&E department or there may be arrangements for emergency mental health assessments to be carried out by psychiatrists or social workers (e.g. Approved Social Workers) in the client's home, in police custody or other dedicated venues.

For non-emergency mental health assessments, specialist mental health services will have clear main responsibility for severe mental illness and for a range of common or less severe mental health problems that cannot be assessed and managed by primary care services alone. In some areas, substance misuse and mental health services will have protocols for assessment and management of clients with co-occurring mental health problems referred locally from any source, and it would be helpful to obtain copies of such local protocols. Where there is doubt as to whether referral for assessment should initially be to specialist SMS or specialist mental health services, or to both; this may be usefully discussed with the specialist SMS worker - given it may be simpler initially to assess less severe or common mental health problems as part of the specialist comprehensive substance misuse assessment, when this is clearly required anyway.

Police and Forensic Medical Examiners

Within the Mental Health Act (1983; section 136) the police can be asked by anyone to take a person who is suspected of having a serious mental health problem and is at risk in the community to a "place of safety" - usually a mental health hospital or police station - where they can obtain further specialist assessment and care if appropriate. For those already in police custody, the Forensic Medical Examiner (FME) can be asked to carry out mental health or other medical assessments for people detained by the custody officer. The FME can then request further specialist mental health assessment if required.

Making referrals

Decision-making process

The decision to make a referral for more specialist assessment of mental health problems in substance misusers should, wherever possible and practical, be made as a multi-disciplinary team. In many cases CJIT staff may not be able to do this (for example, when working alone in a custody suite) and case supervision will be important in developing effective practice. Sharing information within the CJIT team, or through supervision, can help to ensure that the management of such complex clients is reviewed by other professionals and that risk and contingency plans are scrutinised. This helps to ensure on-going review of and learning about the most appropriate agencies to be approached. Discussing individual cases on the completion of an assessment helps to identify potential areas of concern or risk that may need to be pursued at the next appointment or by other agencies. On-going supervision, which reviews the management of challenging and risk behaviours when appropriate, provides support to staff and identifies areas for development of competencies.

All forms of assessment, including screening and triage assessment, should identify other agencies and services already involved in the care of a client. It is good practice to liaise with these services, consistent with any locally agreed protocols, in order better to understand the nature of the contact and presenting problems. The Drug Interventions Record (DIR) provides the opportunity to seek consent from the client to share information. Such information gained may help place the assessment in context, clarify information provided by the client and also further inform which agencies/services should also be consulted with regard to the client's care. If mental health services have already been involved with the client, CJIT staff should, where appropriate, discuss any concerns with them in line with any local information sharing policies.

The urgency to refer is linked to severity and level of risk, and identifying highest risk will often depend on evidence concerning three key issues:

- the client's intention to carry out acts of harm to self or others;
- the state of distress being experienced by the client;
- the content and strength of irrational thoughts or beliefs.

If it is considered that the client is experiencing high levels of problems in any of these areas, the client should be encouraged to agree to an emergency mental health assessment. If the client refuses, the appropriateness of arranging such an assessment against his wishes should also be considered.

For those clients with a past history of mental health problems, self-harm or harm to others, but where these problems are not currently present, the CJIT worker should consider increasing the level of monitoring and support where there is any of the following:

- sudden deterioration in the client's presentation;
- recent loss (bereavement, breakdown in relationship, becoming homeless);
- imprisonment – the initial period carries increased likelihood of self-harm;
- discharge from hospital;
- escalation in offending;
- poor compliance with medication.

Process of referral

To make a referral, or to liaise with other services by telephone or in writing, CJIT staff will need to:

- work within the local confidentiality and information sharing policies;
- communicate clearly and effectively;
- follow-up in writing if possible, when a referral has been made by telephone.

When making a referral it is helpful for CJIT staff to:

- identify clearly the staff member's name and role, and in what capacity they are working with a client (remembering mental health services may not understand what a CJIT is or does);
- state clearly what help is wanted e.g. assessment of risk, assessment of mental health, provision of specific help etc;
- state the expected outcome of the referral, such as providing telephone advice or written feedback following referral.
- make clear and chronological case records of the referral and take account of referrals in the care plan review

The following specimen template can be used to summarise the assessment and care offered to date (which should include the current concerns, events and changes in circumstances that prompted the referral):

- Reason Mr X presented to CJIT and date of presentation.
- A clear statement if the request is for an urgent assessment.
- Key problems identified – including those relating to substance misuse and mental health and any key social or other areas of concern.
- Identified risks - including previous history of self-harm or harm to others, and any recent threats - indicating if this suggests a need for extra precautions in managing the client (e.g. not seeing Mr X alone, or at home, etc.); and with a clear description of the risks necessitating urgent assessment.
- Current or recent interventions or treatment, if any, provided by your service (e.g. prescriptions and supportive therapies) or provided by other services (e.g. medication prescribed by GP, attendance with a counsellor etc.)
- A list of agencies involved

The service receiving the referral may find copies of previous correspondence useful in carrying out assessment and arriving at a management plan.

Getting the client to the assessment

It is important that the actions taken to assist a client to attend a referral appointment match the level of risk identified. If, for example, it has been determined that the client has a high and imminent risk of self-harm and this requires emergency assessment at the local accident and emergency department, it is important to ensure the client attends by the safest means. This may require ambulance transportation, arranged by dialling 999, and may involve provision of an escort, subject to local CJIT policy. Arrangements for suitable communication with the assessor also need to be considered, including the form of correspondence to be available for the assessment.

Common problems in assessment and how to deal with them

Risk of violence to CJIT staff

While violent incidents are relatively uncommon in working with clients with mental health problems, CJIT staff should always be aware of the potential risk of violence, and how to minimise this, particularly with clients in distressed or disturbed mental states. Local policies on managing the risk of violence, both concerning the client and the environment, should be applied. If not already in place, training on managing conflict and de-escalation techniques should be considered for inclusion as part of ongoing training for CJIT staff.

Where there are substantial concerns about a client who leaves before the assessment is completed

The response will depend to a large extent on the level of concern about the client and any pre-existing protocol. If there is concern that the client is at high risk to themselves or others, it may be sensible first to discuss this further with a manager/supervisor/senior member of staff, before proceeding.

A number of scenarios are possible that involve judging the circumstances of each case:

- it may be agreed to alert the police to concerns so that they can take action as appropriate (e.g. to bring the client to a 'place of safety' under Mental Health Act if appropriate);
- if there have been specific serious threats made towards a member of the public or a family member, the police can be informed in line with local policies on information sharing;
- where there are risks involving children, the police and child protection social services should be involved as per local protocols;
- if the client's address is known, a Mental Health Act assessment might also be requested through the relevant mental health service, mental health social worker, GP or other local arrangement;
- where the concerns and risks are less serious, it may be helpful to contact the client's GP or mental health team - if the client is in contact with these agencies - in line with local information-sharing policies and taking account of the level of concern about safety.

Client is at risk of self-harm but refuses further assessment

Many clients who are distressed and contemplating suicide will be willing to accept further help or assessment. However, sometimes a client can be so severely depressed and determined to commit suicide that they are unable to consider accepting help in a rational way. In such cases, an emergency assessment

by a trained mental health professional will be needed to decide on the most appropriate course of action. Advice of a senior colleague might be sought, and while arrangements are made for the client to be seen, a member of staff or a relative or friend should stay with the client to minimise risk of the client leaving prematurely. In extreme cases, it may be necessary to physically restrain someone from leaving who is at very high risk, but this must only be done with great caution and usually only by specifically-trained professionals (e.g. police, mental health professionals). Whilst this could constitute an assault, even if it is being carried out by professionals in the client's best interests, a judgement is made taking all the circumstances into account, given the public interest in protecting severely mentally ill clients from serious harm.

Responsibilities of CJIT staff in assessing and managing co-occurring mental health problems

Clients with co-occurring mental health and substance misuse problems can be complex and may require a specialist level of expertise to carry out comprehensive assessment and to determine and provide appropriate care. CJIT staff should work within their competence and expertise, and it is not expected that CJIT staff have the same level of expertise as specialist mental health professionals. However, there is a wide range of severity and need in such cases, and many clients will be able to respond very positively to the skills and interventions of CJIT staff through assessment and support. Indeed, some clients may not otherwise engage with specialist mental health services even if offered.

If CJIT staff are unsure about the correct course of action with a particular client, it is important to seek advice from the multidisciplinary team, or senior colleagues and managers, as appropriate in line with local protocols, and taking account of out-of-hours working arrangements and the level of concern. In the case of a client presenting substantial or potentially imminent risks, it is important to err on the side of caution and seek immediate advice, and if necessary make an appropriate urgent referral to a more specialised professional. In pressing but less urgent cases it is best, if possible, to effect completion of the referral before the client leaves the assessment, so that the plan can be agreed with the client.

It is also a key responsibility of CJIT staff to document their contact with clients in case notes, preferably at the time or as soon as possible after seeing the client. This should include any matters that have a bearing on the safety of the client or others. Clear, adequate communication, as described above, should be provided to support CJIT referral in all cases. Even where arrangements have been agreed for client self-referral to services, sending such assessment information can still be agreed with that client.

Finally, CJIT staff need to be familiar with the appropriate urgent and non-urgent referral pathways to mental health, substance misuse and other relevant services in their area. If this is not clear, or if a worker has problems effecting appropriate referral of clients to mental health or other services, this needs to be communicated to the supervisor and/or team manager who will take this up with the appropriate counterpart in the health services or in discussion with commissioners.

Further reading

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Promoting linkages between Criminal Justice Integrated Teams and the Mental Health Treatment Systems

Working Party membership

- Dr Nek Oyefeso** *Reader in psychology of addiction, Section of Addictive Behaviour, Division of Mental Health, St George's, University of London*
- Dr Roger Bloor** *Consultant and Senior Lecturer in addiction psychiatry, Keele University School of Medicine Medical School*
- Mr Mike Flannagan** *Consultant nurse in addiction psychiatry, Surrey PCT*
- Dr Rob Jackson** *Consultant in addiction psychiatry, Bognor Community Substance Misuse Team, Sussex Partnership NHS Trust*
- Dr Clementine Maddock** *Locum Consultant in addiction psychiatry, South West London and St George's Mental Health NHS Trust*

Steering Group membership

- Dr Dima Abdulrahim** *Research Team, National Treatment Agency for Substance Misuse*
- Fiona Bauermeister** *Substance Abuse Interventions Partnerships, National Offender Management Service*
- Caroline Bonds** *Drug Strategy Team, National Offender Management Service*
- Eleanor Church** *Drug Strategy Team, National Offender Management Service*
- Dr Paul Davis** *Consultant Clinical Psychologist and Head of Substance Misuse Psychology, Chair, Substance Misuse Section, British Psychological Society*
- Tom Dodd** *Dual Diagnosis Lead, West Midlands Joint National Lead Dual Diagnosis Care Service Improvement Partnership*
- Dr John Dunn** *Consultant Addiction Psychiatrist & National Treatment Agency Clinical Team Lead (from 2007)*
- Dr Michael Farrell** *Chair Addictions Faculty, Royal College of Psychiatrists (from 2006)*
- Dr Chris Ford** *General Practitioner and Clinical Lead SMMGP (Substance Misuse Management in General Practice)*

Vanessa Fowler *Prison Mental Health Transfer Project, Department of Health*

Dr Emily Finch *Consultant Addiction Psychiatrist and Honorary Senior Lecturer, South London and Maudsley NHS Foundation Trust, and National Treatment Agency Clinical Team Lead (until 2007)*

Ann Gorry *Dual Diagnosis, Women & Gender Programme Lead, East Midlands, Joint National Lead Dual Diagnosis Care Service Improvement Partnership*

Dr Eilish Gilvarry *Consultant Addiction Psychiatrist and Chair Addictions Faculty, Royal College of Psychiatrists, (until 2006)*

Dr Linda Harris *General Practitioner and Director, Substance Misuse Unit, Royal College of General Practitioners*

Sherife Hasan *Treatment Lead, Crime and Drug Strategy Directorate, Home Office*

Fintan Hayes *Regional Deputy Manager, National Treatment Agency - North East (till 2007), Programme Manager, Prisons Integrated Drug Treatment System (IDTS)*

Ian Hulatt *Mental Health Advisor, Royal College of Nursing*

Beverly Love *Aftercare Team Drug Interventions Programme, Home Office (PPO Team since 07)*

Kieran Lynch *Criminal Justice Team, National Treatment Agency for Substance Misuse*

Dave Marteau *Health and Offending Partnerships, National Offender Management Service*

Dr Mark Prunty *Senior Medical Officer Substance Misuse Team, Department of Health*

Dr Sian Rees *Senior Policy Advisor, Mental Senior Policy Advisor Mental Health, Department of Health*

Shereen Sadiq *Aftercare Team Lead, Drug Interventions Programme, Chair of Working Group*

Brent Withers *Mental Health Commissioner, London Borough of Lambeth*

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Template for information of local service contacts and arrangements for referring clients with mental health problems

1. NAME OF CJIT TEAM /AREA COVERED

.....

2. LIST OF 'EMERGENCY' REFERRAL ARRANGEMENTS

Arrangements for accessing urgent mental health assessment in the community:

Mental health teams during office hours

contact person	
team manager	
area served	
days	
times	
contact numbers	
fax	
email	
website	

Mental health teams outside of office hours

contact person	
duty manager	
area served	
days	
bank holidays	
times, contact numbers	
fax	
email	
local crisis phone line	
website	

Local A&E departments

who should be contacted	
contact numbers	
fax	
email	
website	

Local police stations

area served	
contact numbers	
fax	
email	
website	

Local child protection services

area served	
contact numbers	
fax	
email	
website	

Local Approved Social Worker Service

area served	
contact numbers	
fax	
email	
website	

Arrangements for referral to a Forensic Medical Examiner within police custody

3. LIST OF 'NON-EMERGENCY' REFERRAL ARRANGEMENTS

Community mental health services

area served	
contact person	
duty manager	
days	
bank holidays	
times	
contact numbers	
fax	
email	
website	

Specialist substance misuse services

area served	
contact person	
duty manager	
days	
bank holidays	
times	
contact numbers	
fax	
email	
website	

Social Services

area served	
contact person	
duty manager	
days	
bank holidays	
times	
contact numbers	
fax	
email	
website	

Arrangements for local primary care trusts for clients without a GP

contact numbers	
website	

Local A&E departments

who should be contacted	
contact numbers	
fax	
email	
website	

Local child protection services

area served	
contact numbers	
fax	
email	
website	

List of other useful contacts

Samaritans 08457 909090 (Textphone 08457 909192)

Provides 24-hour confidential emotional support.

Rethink National Advice Service 020 8974 6814* advice@rethink.org

Monday, Wednesday, Friday: 10am-3pm; Tuesday and Thursday: 10am-1pm.

Offers useful advice on how to get help for users and carers.

Saneline 0845 767 8000* www.sane.org.uk

Monday to Friday: 12 noon to 11pm; Saturday and Sunday: 12 noon to 6pm.

Out-of-hours telephone service offering advice to anyone affected by mental illness including service users, their families and carers as well as health professionals. Volunteers provide support, practical information, contact details of local services, details of latest treatments and assistance with current mental health legislation.

MindinfoLine 0845 766 0163* info@mind.org.uk www.mind.org.uk

Monday to Friday: 9.15am to 5.15pm.

Run by dedicated team of specialists offering advice on mental illness, where to get help and alternative therapies. Has a large library of booklets and factsheets.

Alcoholics Anonymous 01904 644026 (fax: 01904 629091) lemongsoyork@btconnect.com

www.alcoholics-anonymous.org.uk

Narcotics Anonymous 0845 FREEDOM (0845 3733366) and 020 7730 0009 www.ukna.org

Office open 10am - 10pm, seven days a week. Home divert system outside these hours.

Helpline facility.

Local out of hours phone line for clients (This may be provided 24/7 and will provide drug-related advice, information and access to a next day working appointment) Local tel: (insert)

* Deaf people can access these numbers by first dialling 18001



SCAN Consensus Project 2

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